NHS

London North West University Healthcare

NHS Trust

Annual Report 2021-22

Contents

This information in other languages

The information in this report is available in large print by calling 020 8869 3552.
If you would like a summary of this Annual Report in your own language, please call 020 8869 3552 and state clearly in English the language you need, and we will arrange an interpreter to speak to you.

laddii aad jeclaan lahayd warka ku qoran warbixintaan gacan qabsiga
ɔogu talogalay oo kooban oo luqaddaada ku qoran, fadlan soo wac 020
869 3552 ka dibna si cad Ingiriis, ugu tilmaan, luqadda aad u baahan tahay
vaxaan markaas kuu diyaarin doonnaa turjumaan kula hadla.

ந்த ஆண்டறிக்கையில் இடம்பெற்றுள்ள விவரங்களின் தொகுப்பு உங்கள் மொழியில்
ங்களுக்குத் தேவைப்படுமானால், தயவுசெய்து 020 8869 3552 என்ற எண்ணை
தாடர்பு கொண்டு, ஆங்கிலத்தில், தெளிவாக உங்களுக்குத் தேவைப்படும் மொழியை
றிப்பிட்டால், உங்களுடன் பேசுவதற்கு நாங்கள் ஒரு மொழிபெயர்ப்பாளரை ஏற்பாடு
சய்வோம்.

ા વાર્ષિક અહેવાલમાં સમાવિષ્ટ માહિતીનો સારાંશ જો તમને તમારી ભાષામાં જોઈતો
ોય તો, કૃપા કરીને 020 8869 3552 પર કોલ કરો અને તમારે જે ભાષાની જરૂર હોય
ે સ્પષ્ટ રૂપે અંગ્રેજીમાં જણાવો અને તમારી જોડે વાત કરવા અમે દુભાષિયાની વ્યવસ્થા
રી આપીશું.

إذا كنت ترغب في الحصول على ملخص للمعلومات التي وردت في هذا التقرير السنوي بلغتك، اتصل على رقم 020 8869 3552 واذكر بوضوح، باللغة الإنجليزية، اللغة التي تحتاجها، وسوف نقوم بتوفير مترجم ليتحدث إليك.

چنانچه تمایل دارید که خلاصه اطلاعات موجود در این گزارش سالانه را به زبان خود داشته باشید، لطفا با شماره تلفن 020 8869 3552 تماس حاصل نمود و بطور واضح و با زبان انگلیسی، زبان مورد نیاز خود را اعلام فرمائید. بر این اساس ما ترتیب حضور یک مترجم همزمان را بمنظور صحبت با شما خواهیم داد.

About external links

It should be noted that throughout the document there are links to the websites of external organisations and information outside London North West University Healthcare NHS Trust. These are added to provide further background for readers who want to access it. This information should not be interpreted as having been read by our auditors.

Performance Report

The performance report includes an overview of our organisation highlighting its purpose, progress during the year and key risks to achieving strategic objectives.

Overview

New CEO and Chair in Common

In February 2022 the four north west London trusts jointly announced the appointment of Matthew Swindells as a new Chair in Common.

Whilst London North West University Healthcare NHS Trust, Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust will remain separate organisations, they will seek to maximise potential for working collaboratively for the benefit of our local population, patients, and staff.

The appointment of a Chair in Common is a key next step in strengthening this collaboration as we move towards becoming a formal acute care collaborative in line with national NHS policy.

Matthew Swindells took up the position from 1 April 2022, when Lord Amyas Morse's term concluded.

Our Trust has also welcomed a new Chief Executive Officer this year. Pippa Nightingale joined the Trust as permanent Chief Executive Officer on 14 February 2022. Pippa took over from Chris Bown who joined the Trust in March 2020 on an interim basis.

A word from our Chair and Chief Executive

Working together

As indicated by our appointments, this year the four acute trusts in north west London have worked closely together. This has included creating a joint acute care programme board to guide and coordinate developments across all key operational areas.

We are harnessing our collective resources, joining up care and reducing unnecessary variations in access to care and outcomes for patients. We have created a single view of waits across all our hospitals to understand where good capacity might be able to support other hospitals with longer waits.

Covid-19

Our dedicated staff have now been tackling the Covid-19 pandemic for more than two years. The Delta variant was first detected in the UK in April 2021 (the start of this reporting period), and within two months had spread to become the third wave. The more infectious Omicron variant was detected in November and quickly declared a variant of concern by the World Health Organization.

Our Covid-19 admissions peaked in the two weeks around New Year, with up to 210 inpatients – more than one in six beds. However, high vaccination levels, a lower proportion of infections converting to severe illness, and advances in treatment meant we were able to keep services open. Outpatient and diagnostic capacity remained largely unaffected.

Nonetheless, we did experience an increase in staff absence due to infection and self-isolation. This, together with the need to redeploy staff to Covid-19 wards, required us to reduce the capacity of some elective services and led to some reversal of the inroads we'd previously made to waiting lists.

Thankfully cases have now reduced, reflecting growing population immunity and the impact of the school and booster vaccination campaigns. Related staff absences are now on a downward trajectory. This allows us to focus on and deliver our recovery programme so that patients who are awaiting procedures can be treated promptly.

Covid-19 has not been our only story this year. We have continued to care for patients who needed help for other conditions, and we have shown a deep commitment to transforming care, improving our culture, and making our Trust work better for everyone.

Investment and innovation

Ealing and Northwick Park hospitals have developed a virtual heart failure ward service, with patients relaying information through a phone app to specialist nurses. This represents a new era of home-based healthcare which could be deployed to tackle a range of conditions.

Similarly, innovative use of high-resolution images and videos to assess if patients have skin cancer has cut waiting times from two weeks to just one day. The tele-dermatology pilot enables consultants to virtually triage patients within 24 hours.

Virtual reality software is also advancing treatment of head and neck cancers by enabling our surgeons to virtually pre-plan procedures involving microsurgery, which utilises needles and sutures barely visible to the human eye.

With support of the North West London Integrated Care System, we have allocated £2.3m for the development of a new centre of excellence for breast and urology services at Northwick Park Hospital. This clinically led project will provide the best possible care and minimise the need for cancer patients to visit multiple sites as we plan and implement their care. Access to services for local and vulnerable patient groups remain a key consideration, and so the current breast service at Ealing Hospital will be retained.

A new, dedicated inpatient MRI scanner has opened at Northwick Park Hospital, and in August Central Middlesex Hospital also had a second scanner installed in its ambulatory care and diagnostic centre.

Our Wolfson Unit for Endoscopy was awarded World Centre of Excellence status for the third time, in recognition of its achievements in endoscopy practice, research and medical training. This year the unit continued its training online, with the annual Frontier's Congress attracting more than 3,000 delegates from around the world.

Research and development

Our new dedicated, high specification clinical research facility has accommodated numerous clinical trials, covering Group B Streptococcus in new born babies, to Hyper-Echo studies in hypertension. Our Trust has a long history of leading and participating in research and development and played an outstanding role in the Covid-19 vaccine trials.

Community services

In August our out of hospital services transferred to Central London Community Healthcare NHS Trust and Central and North West London NHS Foundation Trust.

A change in provider enables community services to concentrate on implementing the north west London out of hospital strategy and allows us to focus on acute and specialist services. Services across north west London will see closer working between all relevant health and social care partners, ensuring that together we deliver the best possible care.

Care Quality Commission (CQC) inspections

In April 2021 inspectors from the CQC conducted an unannounced focused inspection of the A&E and maternity departments at Northwick Park Hospital. Our Trust's overall CQC rating remained as Requires Improvement. However, the CQC rated our maternity service as Inadequate.

In October 2021 the CQC carried out a further unannounced inspection of our maternity services at Northwick Park Hospital. Findings from this inspection were published in December. Inspectors welcomed noticeable improvements to our maternity services and the service's rating was raised to Requires Improvement.

Our maternity improvement plan is the driving force behind these continuous and sustainable improvements. Inspectors have noted the close attention we pay to it, with evidence of shared learning among staff, updated risk assessments for every patient and the appointment of two midwives monitoring patient outcomes and service provision.

There is of course much more to do, and we continue to reach out to women and families from all backgrounds as we believe they are best placed to help us shape positive sustainable changes.

Inspectors did not rate our emergency department following the April 2021 inspection, though inspectors found significant improvements, particularly in respect of performance.

An unannounced inspection of our medical care and surgical specialties at Ealing and Northwick Park hospitals took place in February 2022. The report resulting from this inspection was published in May 2022, and our overall rating remains Requires Improvement.

However, the inspectors recognised improvements in several areas and, as a result, have upgraded eight ratings to Good. This includes a new rating of Good for the whole of the surgical service at Ealing Hospital.

The inspectors praised several aspects of our care which were common to all the services they inspected. They found clear evidence of kindness and a commitment to responding to patients' individual needs and treating them with dignity and respect.

They noted how we report incidents and investigate and share learning to improve care. Inspectors said that our teams plan care to meet the needs of our local people and that we engage well with our communities.

In particular, the inspectors noted three areas of outstanding practice at Ealing:

- Our cancer service continuing to provide chemotherapy throughout the Covid-19 pandemic
- Our allied health professionals working in a multidisciplinary and cross-site ways, allowing them to increase their skills and improve outcomes for patients
- The innovative prehabilitation programme produced by a multidisciplinary team of tissue viability nurses, cancer nurses and physiotherapists, improving care for patients having colorectal surgery.

None of our ratings were downgraded during this inspection. This means that we are no longer rated Inadequate in any domain for any service.

Reflections and looking ahead

This is only a sample of achievements in 2021-22. That we have achieved so much despite such extraordinary challenges is testament to our staff.

We look forward with renewed confidence as rates of Covid-19 related staff absences reduce, and our recovery programme continues apace. The year ahead will see greater collaboration with our sector partners, as we explore opportunities for specialist centres, improved patient pathways, and reduced waits.

We thank all our partners in the public, charitable and voluntary sectors for their support in helping us to deliver outstanding hospitals to the communities of north west London.

We also thank our former Chief Executive, Chris Bown, and Chair, Lord Amyas Morse, for their lleadership and guidance during the extraordinary challenges of the last couple of years.

Finally, as we hopefully emerge from the pandemic, we will not forget those who we have sadly lost. In July we opened our memorial rose garden at Northwick Park Hospital in memory of staff who died or who lost loved ones during the pandemic.

Our thoughts and condolences remain with all those who have suffered personal loss due to Covid-19.

Matthew Swindells
Chair

Pippa Nightingale MBE
Chief Executive

Who we are

This section provides an overview of who we are, summarises the services we provide, and reflects on our vision, values, goals, and strategic objectives.

It explains how we adapted to Covid-19 and how, as we recover from the pandemic, we need to safely restart our services, rebuilding them to better than before.

During 2021-22, we provided hospital and community services to the people of Brent, Ealing, Harrow and beyond. In July 2021, most of our community services transferred to the management of our local community providers - Central London Community Healthcare NHS Trust with some services going to Central and North West London NHS Foundation Trust.

We continue to provide sexual health services, community dental services, and services at Meadow House Hospice on the Ealing Hospital site.

Our team of more than 8,000 clinical and support staff serve a diverse population of around one million people. We are a university teaching hospital, training clinicians of the future. We are also a research active organisation, with thousands of patients participating in ground-breaking research programmes each year.

We run acute hospital services at:

- **Central Middlesex Hospital:** Our planned care site including our planned a range of outpatient services and a 24/7 urgent care centre.
- **Ealing Hospital:** A busy district general hospital providing a range of clinical services, as well as a 24/7 emergency department and urgent care centre.
- **Northwick Park Hospital:** Home to one of the busiest emergency departments in the country. The hospital provides a full range of services including one of the few double-A rated stroke services in England.
- **St. Mark's Hospital:** An internationally renowned specialist hospital for colorectal diseases, based at Central Middlesex Hospital.

Our vision, goals, and values

Our vision

To provide excellent care in the right setting

Our goals

We aim to:

- Provide excellent care quality and patient experience
- Engage with our staff to develop them and transform services
- Become a sustainable organisation that builds partnerships with purpose.

Our HEART values

Our HEART values are honesty, equality, accountability, respect and team work. We put our patients at the HEART of everything we do.

Our strategic objectives

Our Board adopted a total of 24 objectives:

- seven are for the care quality and patient experience goal
- nine are for the culture, staff, and transformation goal
- eight are for our partnership goal.

The most recent review of progress showed advances were made against each of the 24 objectives, with 90 per cent of the milestones set either achieved or partially achieved over the course of the year. The most comprehensive advances were made against our second goal, involving people and transformation.

The areas in which we were unable to make significant progress were all affected by the pandemic, particularly our ability to deliver NHS standards, objective 1.4.

Goal 1: Excellent care quality and patient experience

1.1 Minimise excess deaths and maintain services at a near normal level during the Covid-19 pandemic, Chief Operating Officer and Chief Medical Officer

1.2 Support the safe delivery of care with robust infection prevention and control measures, Chief Nurse and Chief Medical Officer

1.3 Continue the journey to outstanding with a Good rating in our next CQC assessment, Chief Nurse

1.4 Improve compliance with our statutory duties in referral to treatment, two week wait, and our A&E waiting time performance, Chief Operating Officer

1.5 Implement our Digital Care Record Programme and Digital Strategy, Director of Strategy

1.6 Run more appointments and clinics online and on the phone, Chief Operating Officer

1.7 Improve our hospital and community estates, including our critical care areas, Chief Financial Officer

Goal 2: An organisational culture that engages with our staff to develop them and transform services

2.1 Deliver our financial plan and contribute to the wider north west London financial plan, Chief Financial Officer

2.2 Work together with our partners to reduce waste and increase efficiency, Chief Financial Officer

2.3 Reduce inequalities in the workplace and improve our staff's working lives, Director of Human Resources and Organisational Development

2.4 Increase the proportion of our staff receiving the Covid-19 vaccine to 90 per cent, Director of Human Resources and Organisational Development

2.5 Have more than 60 per cent of staff complete the national staff survey, Director of Human Resources and Organisational Development

2.6 Create a respectful and inclusive culture through our HEART values and a new behaviour framework, Director of Human Resources and Organisational Development

2.7 Develop and nurture compassionate leaders and increase black, Asian and minority ethnic staff representation at senior levels across all services, Director of Human Resources and Organisational Development

2.8 Learn from new collaborative clinical service reviews with clinical colleagues and patients, Chief Medical Officer

2.9 Implement a transformation programme that trains and empowers our staff to think and act differently, to improve patient care, staff experience and reduce waste, Director of Strategy

Goal 3: A sustainable organisation that builds partnerships with purpose

3.1 Create a sustainability strategy for use in future developments and supply chain contracts, to make sure our supplies are of a high standard, and arrive promptly and reliably, , Chief Financial Officer

3.2 Help our support and enabling services improve what they offer to the organisation, Chief Financial Officer

3.3 Align our strategy and work with the north west London Integrated Care System, Director of Strategy

3.4 Work more closely with The Hillingdon Hospitals NHS Foundation Trust, Director of Strategy

3.5 Create more effective patient pathways across services and across the wider NHS in north west London, including with our local primary care networks, Chief Medical Officer

3.6 Improve our working relationships with other acute, community and mental health organisations, Chief Operating Officer

3.7 Work with councils, patient groups, residents, third sector and charitable organisations, and politicians to support our local communities, Director of Strategy

3.8 Build confidence in our organisation, improve our relationships with our stakeholders, and improve the way we communicate with our audiences, Director of Corporate Affairs

Our services

Lessons learned from the first Covid-19 wave (March to May 2020) and the second wave (September 2020 to April 2021), along with investments and changes introduced over the past year, have allowed us to resume our full range of services:

- Emergency and urgent care from A&Es at Ealing and Northwick Park hospitals
- Admissions for planned and urgent medical and surgical treatment
- Nationally commissioned specialist and highly complex care
- Critical care in dedicated units at Ealing and Northwick Park hospitals
- Non-admitted care through on-site, telephone and online clinics
- Diagnostic services
- Cancer screening and treatment
- Remote monitoring in the community and in virtual wards
- Maternity services
- A range of multi-disciplinary integrated community services in collaboration with other providers

Several new services were launched as part of the national pandemic response, including:

- Covid-19 vaccination for employees, health and social care partners and the wider public through mass-vaccination centres
- Post-Covid-19 clinics to assess and look after patients who were diagnosed with Covid at least three months previously and still have symptoms
- Rapid access antibody and antiviral treatment for people with Covid-19 who are at the highest risk of becoming seriously ill.

Our business model and environment

The pandemic accelerated the transition of community services into dedicated providers that had started several years earlier. At the beginning of the pandemic, we had put temporary management arrangements in place for our community services in Brent and Harrow; this led the way to a full transfer of these services to Central London Community Healthcare NHS Trust in August 2021.

We continue to play an active role in the development and delivery of integrated service models in our boroughs and across north west London. However, this change has further consolidated our position as a provider of acute and specialist services.

Alongside these developments, the North West London Integrated Care System (NWL ICS) has continued to gain influence as the main structure for strategic and operational planning, working with sector Chief Executives in advance of the NWL ICS becoming a statutory body.

Within the north west London system, acute providers have also established a wide array of collaborative working arrangements and a clinical advisory group to oversee the design and delivery of both the pandemic response and elective recovery. The arrangements put in place over the past two years are precursors to a future acute provider model.

We have cemented our relationship with The Hillingdon Hospitals NHS Foundation Trust through several joint appointments at executive director and senior management level, in addition to fully integrating our digital services.

Stringent Covid-19 infection control measures helped usher in a range of digitally enabled innovations and new ways of working. Online consultations, virtual wards and the use of remote monitoring technology have all increased substantially. One in four outpatient appointment appointments are now provided either online or by telephone.

Throughout the year preparations have continued for the implementation of a new electronic patient record system, which will bring benefits to both patients and clinicians.

Throughout the year we continued to work on several strategies. Our people strategy lays out our goals for wellbeing, leadership, learning, building our workforce capacity, and of course equity, diversity and inclusion (EDI). Our new EDI strategy sets out our commitments to achieve a long-term culture change for the benefit of our workforce, patients, and communities.

An endoscopy strategy was also approved together with a major business case that will see a £15m investment in new and upgraded facilities over the coming years.

In March 2022, our Board approved a comprehensive refresh of the Trust strategy, in recognition of the scale of changes that have happened in recent years. This work will take place in the first half of 2022-23 and will set out our vision and goals for the coming years. It will help us prioritise how we deploy our resources to achieve the greatest benefits for local people.

Our risks

Ten strategic risks received close and regular scrutiny at board level to check the adequacy of mitigating measures. Each has the potential to cause significant impacts to our Trust in one or more ways, including finance, regulation, quality, reputation, and people.
Strategic risks (SR)

- SR1 Failure to meet pre-Covid-19 levels of elective activity
- SR2 Patient safety associated with rising emergency admissions, impact on flow and unprecedented pressure across healthcare system
- SR3 Risk associated with the lack of a robust patient experience and engagement agenda
- SR4 Risk arising from challenges ensuring consistently good outcomes to a complex and high risk maternal population
- SR5 Risk to staff wellbeing and associated staff engagement
- SR6 Risk associated with decommissioning of specialist services
- SR7 Risk associated with development and delivery of sustainable financial and capital plan
- SR8 National issues associated with availability of trained staff
- SR9 NWL ICS leading strategic decision making impacting our service provision and configuration
- SR10 Impact of Covid-19 pandemic on services

In relation to SR4, our newly appointed leadership team in maternity services worked with colleagues on a wide range of improvements throughout the year. The CQC recognised the success of their efforts and upgraded the service's rating in December 2021. This remains our highest-rated strategic risk, while we continue our maternity improvement journey.

Elective service recovery (SR1) and the sustainability of our finances (SR7) are the next two most pressing risks as we move to living with Covid-19. As the earliest trust in the UK to experience the impact of the first two waves of Covid-19, and with some of the highest numbers of admissions recorded, we have been left with a backlog that is proportionately greater than most.

We have successfully mitigated recovery and financial risks through careful planning, backed up by a support framework that provide divisions with regular opportunities to raise recovery challenges, coupled with weekly forensic reviews of key aspects of our recovery programme. Routinely bringing together operational and corporate leadership teams in this way has enabled us to identify what support is needed and direct resources at problems.

We have made a considerable investment to increase the capacity of our transformation programme and the improvement expertise available to support front line teams in meeting their operational and financial goals.

Collaboration across north west London continues to mature, with relationships between partners deepening over the course of the past two years. Decisions across north west London are taken in an increasingly collegiate manner. This will be further strengthened as we move to a single sector plan in 2022-23.

Performance analysis

We strive to provide services that demonstrate continuous improvement, transformation, and personalised care.

During 2021-22, we provided:

- Emergency and urgent care for 281,888 patients
- Planned and emergency care admissions for 42,442 patients
- Critical care for our sickest patients
- Appointments for 583,673 outpatients
- A maternity service that delivered 3,260 babies.

Covid-19

We played a key role in London's response to Covid-19. The third wave (August to September 2021) and fourth wave (January 2022) brought with them numerous characteristics and impacts.

These included:

- lower acuity, with many patients admitted with incidental Covid-19 (around 45 per cent)
- staffing absence rates rising to 7 per cent (normally 4 per cent) due to the rapid spread of Omicron (wave 4) and requirements for isolation.

- vaccinations resulting in lower levels of admissions (199 at peak) and a high correlation between non-vaccinated and hospital admission for those with Covid-19
- the availability of new treatments.

Throughout this period, we:

- maintained elective surgery, diagnostic services, and outpatients, albeit some were provided at lower levels and via online appointments where appropriate and accessible to patients
- maintained a busy A&E, urgent treatment centres, Same Day Emergency Care units and virtual wards
- increased our critical care capacity to 36 beds across Ealing and Northwick Park hospitals, supporting and at times receiving mutual aid from partner acute sites in north west London
- conducted safety huddles to manage staffing pressures and some staff redeployment (specialist nurses) between wards and service areas to maintain safety and support our staff
- had good supplies of PPE, lateral flow tests, vaccines, flu jabs and staff wellbeing initiatives
- converted eight wards at Northwick Park and Ealing hospitals to red areas specifically catering for Covid-19 patients. This helped reduce the risk of hospital acquired infections.

Starting our elective recovery

We continued to deliver elective and outpatient services despite the ongoing waves of the pandemic, working in partnership with the North West London Integrated Care System (NWL ICS) to align recovery across all north west London providers.

Some of our key practices and achievements included:

- increasing digital solutions to clinic appointments to maintain the national requirement for more than 25 per cent of outpatient activity delivered virtually
- prioritising our admitted waiting lists to support waiting list management
- tracking activity against pre-Covid-19 baselines
- using mutual aid for admitted and non-admitted pathways to transfer waiting lists across the sector, where patients are clinically suitable and in agreement
- reducing long waiting patients, and monitoring any patients waiting over 52 and 104 weeks
- operating Central Middlesex Hospital as a non-Covid-19 site to maintain patient flow for our elective patients
- maximising capacity using independent sector partnerships for outpatient, diagnostics, and theatre capacity
- aligning our internal recovery plan to national benchmarking published via the Model Hospital (NHS Improvement).

Collaborative working

As the largest hospital trust in outer north west London, we continue to play a critical role in collaborative arrangements to balance pressures across the system. This includes taking critical care transfers and providing access to our elective surgery teams and diagnostic facilities, particularly for our colleagues at The Hillingdon Hospitals NHS Foundation Trust.

In return, we received support from our north west London hospital partners. Our gynaecology and St. Mark's services collaborated with colleagues from Chelsea and Westminster Hospitals Foundation Trust and Imperial College Healthcare NHS Trust to establish joint multidisciplinary teams. This allowed us to offer patients the choice of an earlier clinic or theatre appointment at a different hospital.

Over 20,000 additional treatments, including the equivalent of 20 extra surgical lists each week, were carried out through several collaborative arrangements established with several private sector organisations. This allowed us to make inroads into the backlog of patients built-up over successive waves of Covid-19.

A relentless focus on recovery

Throughout the year, we built on lessons learned over the course of the first year of the pandemic. Ongoing investment in our transformation programme was key to many of these improvements, supporting staff to make changes to benefit patient care and experience.

Careful planning enabled us to create safe and separate Covid-19 pathways within each of our three hospital sites. This meant we could flex our bed base up and down within hours to react quickly to surges in infection, while allowing us to protect and maintain normal services. This contrasts with the first two waves of the pandemic, when we had to temporarily stand down many of our non-urgent services.

The national vaccination roll-out helped keep the number and severity of new infections under control. New treatments also allowed us to achieve substantially better outcomes for the patients that had to be admitted. This reduced the length of hospital stays and the pressure on critical care, greatly increasing survival rates. The impact of these improvements was greatest on high-risk groups and our Black, Asian, and minority ethnic populations.

The extraordinary commitment of our staff coupled with the strong and sustained support of the NHS and government enabled us to concentrate our efforts on recovery by:

- returning most staff to their pre-Covid-19 roles
- clearing backlogs of patients who need planned care most urgently and who have been waiting longest

- working with our primary care partners to improve access and shorten delays for routine appointments and treatment
- increasing our critical care capacity to 36 beds, including 12 at Ealing Hospital, to provide resilience to future peaks in demand, particularly from Covid-19.

We were also able to return our attention to other service developments. Notably, our women and children team opened the new paediatric unit at Northwick Park Hospital in July. This brings together the paediatric ambulatory unit, day care beds and oncology service into a facility that will transform the experience for children and their families and carers.

Challenges

With the Delta and Omicron variants bringing two further waves of Covid-19, we monitored our situation closely on a day-to-day basis. Our Gold Command team and expanded site teams offered coordination seven days day a week, while a weekly recovery group provided oversight and helped divisions resolve issues facing the recovery effort.

Delta spread rapidly over the summer of 2021, affecting mainly children and unvaccinated adults. Our admissions reached 120 beds. While this remained well below the 500 or greater admissions we had seen previously, it was still enough to require the reopening of additional Covid-19 wards and the redeployment of staff.

We maintained elective services but were forced to prioritise the most urgent cases and cancer treatment. Inevitably, some of the progress we had made in reducing the number of patients with the very longest waits was lost.

The more transmissible Omicron variant peaked over the New Year and did not require us to activate emergency measures for critical care, although admissions reached 200 beds. High levels of staff absence due to self-isolation requirements represented our main challenge.

We also experienced a surge in A&E attendances that started over the summer of 2021, with ambulance arrivals and walk-in attendance regularly breaking records at both Northwick Park and Ealing hospitals. We introduced changes to our emergency pathway that both helped us deal with this challenge and saw us regularly become one of the best performing trusts in the NHS against emergency care targets. Our same day emergency care service continues to work successfully and has been extremely important in managing patient flow effectively.

Improving access to services

We have continued to improve our services to increase access, including expanding the same day emergency care service at the Ealing and Northwick Park hospitals. We continue to send patients to this service directly from A&E if they will benefit from this service. staff safe.

Our operational performance

Table 1: Performance appraisal against national standards

Standard	Expectation	Results 2020-21	Results 2020-21(%)	Results 2021-22	Results 2021-22(%)
Emergency access: 4 hours	Number of patients attending our Emergency Departments (EDs) treated, admitted, or discharged within four hours	215,337 of 234,434 arrivals	91.9%	272,948 of 334,028 arrivals	81.7%
Ambulance handovers: 30 mins	Number of patients waiting under 30 minutes from time of arrival to handover between ambulance crew and ED	53,134 from 54,591 conveyances	97.3%	51,278 from 57,190 conveyances	89.7%
Ambulance handovers: >60 mins	Number of patients waiting more than 60 minutes from time of arrival to handover between ambulance crew and ED	490 from 54,591 conveyances	0.9%	2,207 from 57,190 conveyances	3.9%
Cancer urgent referrals: 2 weeks	93 per cent of our patients to be seen in two weeks following an urgent referral from their GP	21,889 of 23,176 urgent referrals	94.4%	27,437 of 31,025 urgent referrals	88.4%
Cancer faster diagnosis: 28 days	75 per cent of patients to have confirmation of their cancer status within 28 days of an urgent referral			25,791 of 33,757 cancer pathways 76.4%	
Cancer diagnosis: 31 days	96 per cent of patients with a confirmed diagnosis to have a first treatment within 31 days of the decision to treat	2,838 of 2872 cancer pathways	98.8%	3,361 of 3,395 cancer pathways	99.0%
Cancer treatment: 62 days	85 per cent of patients receiving first treatment from the date of GP referral	1,637 of 1,965 cancer pathways	83.3%	1,759 of 2,225 cancer pathways	79.0%
Diagnostic waits: 6 weeks	99 per cent of patients should wait no longer than 6 weeks for a diagnostic test	8,344 of 8,676 diagnostic referrals at year-end	96.2%	9,496 of 9,897 diagnostic referrals at year-end	95.7%
Referral to treatment: 18 weeks	92 per cent of patients should wait no longer than 18 weeks from GP referral to treatment	29,330 of 41,304 open pathways at year-end	71.0%	38,153 of 56,347 open pathways at year-end	67.7%
Referral to treatment: 52 weeks	No patient should wait longer than 52 weeks for treatment from receipt of referral	1,918 of 41,304 open pathways at year-end		466 of 56,347 open pathways at year-end	

Financial summary

Our financial performance for the financial year 2021-22 was an adjusted surplus of £0.235m. The financial regime for NHS trusts over the last two financial years has been significantly different from previous years and this is reflected in the reported results.

The main reason for this was the change in the national financial arrangements for NHS trusts, put in place in 2020-21 to support the response to the pandemic. These new national financial arrangements provided for block and top-up funding which has resulted in the Trust delivering break-even financial positions in both 2020-21 and 2021-22.

The table below summarises our income and expenditure financial performance for the year. We made a retained deficit for the year of £0.235m. This retained deficit, however, includes certain income and expenses which the Department of Health and Social Care excludes for the purposes of measuring our financial performance for the year.

NHS trusts are required to account and report financial information in accordance with International Financial Reporting Standards. This requires trusts to revalue their land and buildings every year and in 2021-22, this resulted in a charge for impairment of £8.5m. This £8.5m impairment charge, together with net donated / grant income for assets of £9.1m and a charge of £1.14m for the reduction in inventories received from the Department of Health and Social Care (DHSC) group bodies for the coronavirus response, are excluded from the retained deficit for the year by the DHSC for the purposes of measuring the Trust's financial performance and its performance under the break-even duty resulting in an adjusted surplus for the year of £0.305m.

Table 2: financial summary

Summary of results	Year ended 2021-22 £000	Year ended 2020-21 £000
Income	864,880	835,032
Expenditure	-847,985	-822,195
Operating surplus	16,895	12,837
Net finance costs including dividends payable	-16,602	-14,523
Other gains	-528	-376
Deficit for the year	-235	-2,062
Donated / govt grant depreciation, donated asset income and impairments	540	3,434
Adjusted surplus re: statutory break-even duty	**305**	**1,372**

*Retained deficit - the retained surplus / (deficit) is the year-end position of the Trust calculated when income and expenditure are added together. Where income exceeds expenditure there is a surplus. A deficit arises where expenditure exceeds income. The retained surplus / (deficit) for the current financial year is added to the cumulative position from previous years.

NHS trusts are required to break-even taking one year with another. This is called the statutory break-even duty. Although we delivered an adjusted surplus in 2021-22, we have not met our break-even duty in relation to the rolling assessment period because of the deficits incurred in previous years which have not been recovered. The cumulative deficit is £325.63m, and the Trust has not met this duty.

Our adjusted surplus in the 2021-22 financial year was achieved after delivering £19.2m of financial efficiencies achieved mainly through improved control of expenditure and transformation projects.

Despite, and in some cases because of, the challenges of Covid-19, our clinical and operational teams have implemented new ways of working which have supported both improved care and better efficiency and productivity.

Examples include:

- a reduction in non-elective bed days (additional days in hospital for our patients) from the implementation of the same day emergency care model
- a reduced number of missed appointments by patients from the implementation of digital appointments in outpatients.

We will continue this improvement work to ensure identified opportunities are fully developed. Our transformation programme is a key component of our drive to secure financial and clinical sustainability goals for the organisation.

We continue to work closely in partnership with the North West London Integrated Care System (NWL ICS) and our future clinical and financial strategy continues to evolve in the context of working as an integral part of a wider system. The objective of the NWL ICS is to continue to improve the health and well-being of the local population with proactive models of care which will reduce the costs of meeting the care needs of the local population, enabling the system to move towards financial and clinical sustainability.

The leadership team is continuing to implement improvements to move towards in-year financial sustainability. The Trust is planning a small deficit in the 2022-23 financial year. Neither the Trust's recovery plan nor the system's recovery plans seek to address the cumulative deficit.

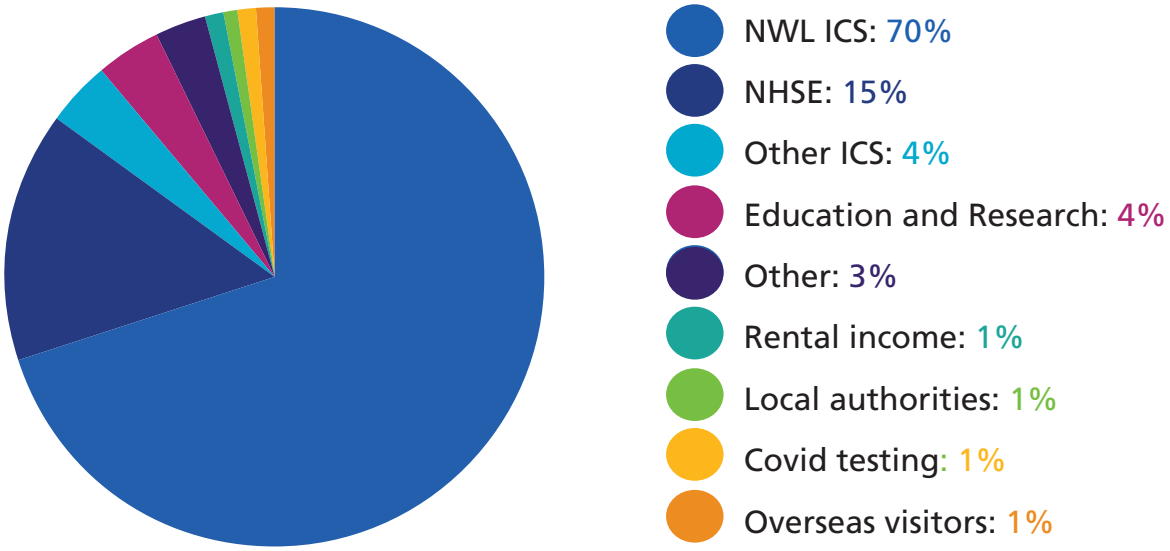
Income

Our income in 2021-22 was £864.880m compared to £835.032m in 2020-21. The income streams for NHS Trusts were simplified in 2020-21 as part of the response to the pandemic with the payment-by-results regime replaced by block contract payments. These block contract payments continued in 2021-22.

This year's income includes £149m of top-up funding provided to all NHS trusts to pay for the impact of the pandemic and to safeguard cash flow.

The pie chart below shows that 70 per cent of our income came from our main commissioner, the North West London ICS, which was formed in 2021-22 from the consolidation of eight former CCGs. NHS England provided 15 per cent of our funding largely relating to the provision of specialist healthcare. Education and research made up 4 per cent of our revenue. Private patient income was £1.3m and this is included in the 'Other' category.

Table 3: income



Expenditure

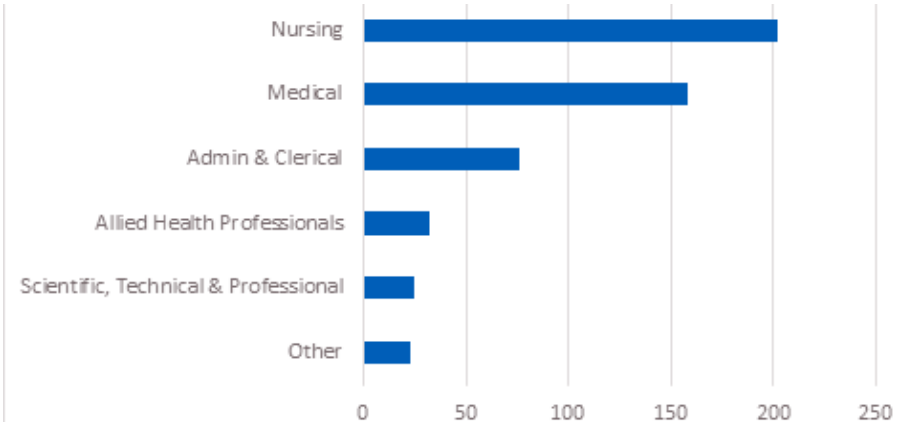
Our total operating expenditure for the year was £847.985m compared to £822.195m in 2020-21.

Pay expenditure

We spent £516.2m on pay in the year, of which 70 per cent was spent directly on medical and nursing staff. The chart below shows the total pay expenditure across all staff groups.

Table 4: pay expenditure

2021-22 £m



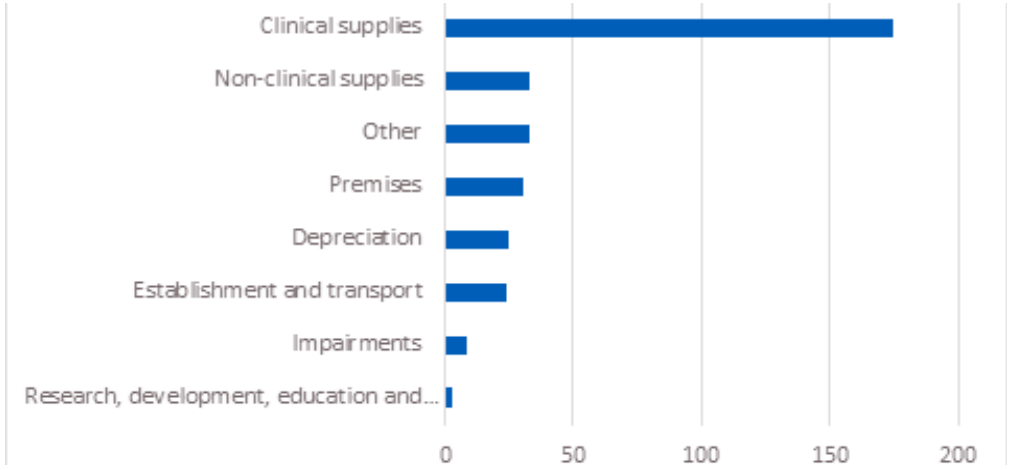
Non-pay expenditure

Non-pay expenditure was £331.8m and is illustrated in the chart below. The largest category of non-pay expenditure was on clinical supplies which support direct patient care on our wards and within our services.

Impairment charges in the year were £8.5m due to the revaluation of our land and buildings. This impairment charge is excluded from our adjusted surplus for the purposes of measuring our financial performance against the break-even duty.

Table 4: non pay expenditure

2021-22 £m



Capital investment 2021-22

We invested £55.7m in its equipment, estate, and IT infrastructure in 2021-22 which, although lower than last year, was still much higher than in previous years.

This investment enabled us to continue with our programme to digitise patient records, undertake significant investment in new energy saving plant and equipment, commission new imaging equipment and reconfigure inpatient wards to strengthen further our Covid-resilience capability.

The capital programme was financed by £35.7m of internally generated funds, £10.1m Public Dividend Capital (PDC) and a grant of £9.9m from the Public Sector Decarbonisation Fund (PSDF) towards the energy-savings investment.

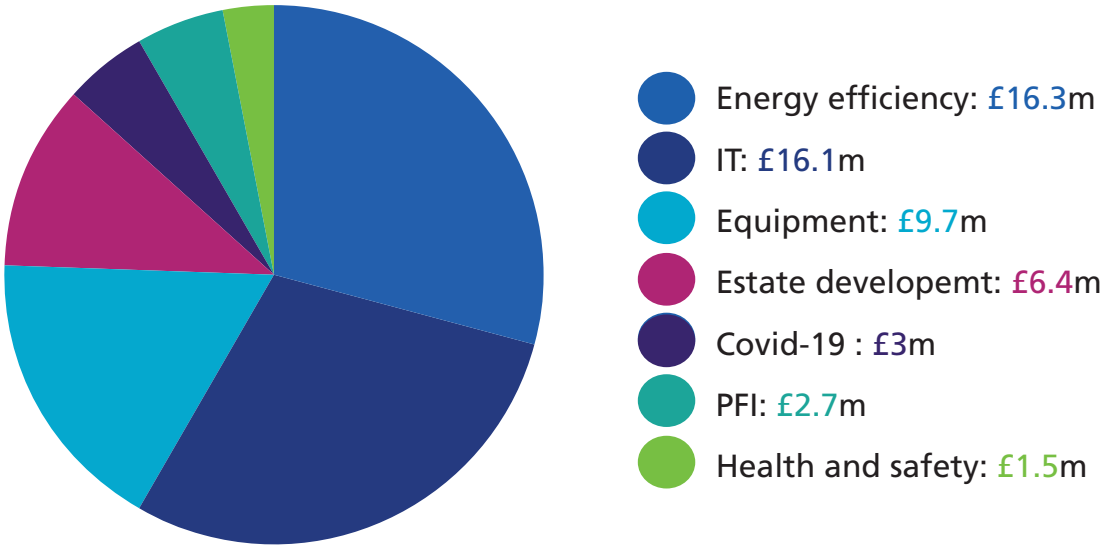
We maintained capital expenditure within the Capital Resource Limit (CRL) agreed with NHSI for the year.

The chart below shows how our capital was spent (addressing some of our key risks) and comprised the following larger schemes:

- Energy saving new plant and equipment which will reduce both energy costs and carbon emissions
- Estate works including ward re-configurations and infection control measures necessitated by the pandemic
- Health and safety works across the Trust sites, comprising fire safety, electrical infrastructure and water quality projects
- Investment in the Trust's IT and digital infrastructure to improve connectivity within Trust sites and digitise patient records
- Medical equipment including diagnostic equipment such as MRI scanners, X-ray rooms, ultra sound machines, mobile X-ray units, theatre equipment, and
- Investment in capital life cycle needs in the PFI buildings.

Table 6: capital investment

2021-22 £55.6m



Cash and liquidity

We ended the year with a healthy cash balance of £70m on 31 March 2022.

In 2021-22 the we maintained a strong cash position as a result mainly of the changes in funding arrangements for NHS Trusts continued by the DHSC. These changes involved the suspension of the Payment By Results funding arrangements and their replacement with a series of fixed sum block contracts. Therefore, the Trust did not require any deficit financing cash support in 2021-22.

During 2020-21 we received approximately £10.1m in public dividend capital funding for capital investment in imaging equipment, estate development and IT.

Our cash balance at the end of the year was £70m (2020-21: £8.1m) and we met our financial duty to manage its overall cash requirement within the External Financing Limit set by DHSC, and we met our financial duty to contain capital expenditure within the DHSC's Capital Resource Limit (CRL).

The Better Payment Practice Code (BPPC) requires us to aim to pay 95 per cent of undisputed invoices by the due date or within 30 days of the receipt of goods and services or a valid invoice, whichever is later. We paid 97.5 per cent by value of its non-NHS suppliers within 30 days compared to 96.1 per cent last year.

The table below shows our BPPC performance.

Table 7: Better payment practice code performance

	2021-22	2021-22	2020-21	2020-21
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	121,768	462,216	103,855	451,619
Total non-NHS trade invoices paid within target	112,599	450,600	91,090	434,041
Percentage of non-NHS trade invoices paid within target	92.5%	97.5%	87.7%	96.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,994	15,460	3,668	14,809
Total NHS trade invoices paid within target	2,684	14,638	3,080	14,123
Percentage of NHS trade invoices paid within target	89.6%	94.7%	84.0%	95.4%

Going concern

As in all previous years, we have prepared the financial statements on the basis that our Trust remains a going concern; that is, that it will continue to deliver clinical services as a major provider of healthcare in north west London for the foreseeable future.

Financial management

Our colleagues worked very hard to:

- continue to meet the challenges arising from Covid-19
- start the work on our elective recovery programme to reduce waiting lists,
- provide emergency care for the residents of Brent, Harrow and Ealing, and specialist services for patients from across London and the country.

Our managers continued to strive to manage the resources available to them in the most effective way, and to seek ways of improving working practices and processes to support effective financial management.

We are proud of the contribution all staff have made towards delivering this financial performance for 2021-22.

Jonathan Reid

Chief Financial Officer

Quality, transformation and improvement

Our CQC rating

We are registered with the Care Quality Commission (CQC), which has rated our Trust as requires improvement.

The CQC did not issue any enforcement notices during 2021-22.

The CQC published two reports in 2021-22:

- June 2021: report published on Northwick Park Hospital's
  - Emergency Department (ratings not considered during this inspection)
  - maternity services (rating went down to Inadequate)
- January 2022: report published on maternity services at Northwick Park Hospital (rating improved to Requires Improvement following extensive work on the service's maternity improvement plan).

In addition, the CQC undertook an inspection of surgery and medical care at both Ealing and Northwick Park hospitals in February and March 2022. The report following this inspection was published in May 2022.

Table 8: current CQC rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ealing Hospital	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Central Middlesex Hospital	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Northwick Park Hospital	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall Trust	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

In the coming year, we will continue to improve the quality of the care provided to patients by:

- responding to the recommendations made by the CQC
- identifying issues we need to overcome to provide outstanding care, and our plan to address them
- changing the way we work, not just to address the issues raised by the CQC, but to provide outstanding care for our patients no matter when or where they need our services.

Over the past year occasional concerns were raised directly with the CQC by patients, their relatives, or carers, which were then passed to us for a response. The main themes arising from from these concerns are discharge processes, communication, and documentation. In each instance we provide the CQC with a comprehensive response, including an action plan where relevant. We use these enquiries as an opportunity to continuously learn and improve. During 2022-23, we will continue to focus on working towards achieving a Good CQC rating.

Transformation

Our transformation programme trains and empowers staff to think and act differently, to improve patient care, staff experience and reduce waste.

Our Deputy Chief Executive provides executive level leadership, with the transformation team, clinical leads and collaborations driving improvements across our Trust.

Scaling up our ambitions

We have increased our ambitions for transformation, by learning from our experience through Covid-19 and how we can improve ways of working, adopt innovations, and bring people together more quickly. The challenges we face have grown and we need creativity and boldness to solve them.

Our transformation fellowships offer new leadership development roles open to anyone at our Trust as a twelve-month secondment.

There are seven roles, each of which works directly within one of our six clinical divisions or our corporate services division. We received 74 applications from every professional area, site and division, demonstrating real enthusiasm for the roles.

The first seven fellows began in April 2021 and included nurses, pharmacists, doctors, and therapists. They have led improvements, coordinated efforts, and supported training across our organisation.

Their projects have included:

- introducing new roles to support nurses, patients and carers on our wards
- expanding our recruitment and support for physician associates
- developing new nurse-led clinics
- innovations in ‘pre-habilitation’ to help prepare patients for complex surgery
- improvements to pathways and processes including in gynaecological cancers and radiology
- support with agile or remote working across LNWH.

We also created our Innovation Fund this year. Overseen by our transformation fellows, the fund offers one-off grants of up to £5,000 to help enact good ideas from our staff and allow them to happen more quickly. To-date, this has included:

- a new satellite pharmacy
- testing new staffing roles in our emergency department
- new tools to tackle pressure ulcers
- and musical therapy for people with dementia.

Innovations and achievements

Our strategic projects fall into cross-cutting workstreams, while each division has its locally led projects. These projects are coordinated by our Transformation Group, chaired by our Chief Executive Officer.

Across all our projects, we estimate that we have made:

- 855,000 differences across all our patient visits
- an average of four positive changes for each of our 8,500 staff.

Our clinical configuration workstream helps us provide better quality care and support new investments in our estate through the way we organise our services.

This year, we created proposals for new centres of excellence in breast and urology, which will:

- offer dedicated facilities
- allow us to introduce new care pathways, including one-stop clinics
- expand our capacity.

We received a £2m investment from NHS Improvement and the estate work began in March 2022. The centres will open to patients later this year.

Our improving flow programme has improved the way patients move through our services, from the front door of our emergency department to helping people go home when they are ready. The Trust-wide campaign Safer September improved how we follow best practice for emergency activity, including early senior review and agreeing expected discharge dates.

We established a single point of access in our Same Day Emergency Care Department so specialist nurses can access queries from GPs and others more quickly and effectively. This has freed up consultants to spend more time helping patients get home sooner. It has also allowed our Same Day Emergency Care service to continue to expand the number of patients it treats.

We are setting the standard for the rest of London, with other organisations visiting us to learn from our improvements. We partnered with Harrow Health and Totally (our urgent care provider) to make changes to how patients are greeted at our emergency department so they get expert advice more quickly and directed to more suitable support such as pharmacies when appropriate.

Along with our new virtual wards for heart failure and Covid-19, we are planning new services for respiratory conditions, diabetes and IBD which will launch in the new year.

Taken together, these changes have helped us become one of the best performing in London for length of stay, a measure of how quickly we help patients get back home. In January we were the top performing trust for cohorts of patients staying seven of more days.

Our elective care programme has focused on digital innovations in outpatients and surgery. These have included developing the care navigator tool, linking our GP partners with expert recommendations or a direct booking option for patients needing specialist help.

We have digitised medical records so that they can be accessed securely anywhere, anytime.

We have changed how we record pre-surgery assessments to help increase the capacity of the team. We launched a new online pre-operative self-assessment tool to help patients share information more easily and to help teams prioritise who needs extra support sooner. This will avoid last minute cancellations when patients are not ready for their surgery.

We are introducing a new digital platform that will allow us to see more patients more quickly. We are one of the first trusts in the country to adopt the Improving Elective Care Co-ordination for patients' software with our first clinicians improving how they schedule operating theatre lists with this tool from March.

In nearby Chelsea and Westminster Hospital, this software has helped reduce waiting lists and increase theatre utilisation. We have also partnered with Imperial College Hospital to develop a human factors quality and safety training for staff in operating theatres which will be expanded in 2022.

The elective care software is one example of collaborations with other partners in north west London.

We have:

- introduced new bank shift booking for nurses so they can work at any hospital in north west London, helping us reduce costs and provide more opportunities for our staff.
- established the community diagnostic centre at Ealing where three new MRIs were installed and are run in partnership with Imperial College London.
- collaborated with the other hospitals in north west London on transformation project tracking software to make easier to share and learn from each other's good ideas.
- supported the Wembley Vaccine Centre from opening in January to it closing in October by which time is had delivered over 145,000 vaccinations.

Innovations within our services

In addition to our workstreams, our services and divisions have demonstrated many examples of innovative improvements this year.

Table 9: innovations within services

Division	Project	Description
Emergency and Ambulatory Care	Rapid Flu Testing	Ability to offer routine flu tests with a turnaround time less than an hour at both sites.
Emergency and Ambulatory Care	Dickens Ward Pressure Ulcer Reduction Programme	Reduction of hospital stay related to treatment of pressure ulcers, death from complications associated with Hospital Acquired pressure ulcers, costs associated with treatment of pressure ulcers, negative patient experience associated with Hospital Acquired Pressure Ulcers.
Integrated Clinical Services	Physician Associates rollout	This project aimed to diversify our workforce to address historical workforce shortages, support the existing medical workforce, improve staff morale and help future proof our workforce.
Integrated Clinical Services	Learning from Excellence	This project involved setting up a Learning from Excellence award aimed at celebrating staff and giving our division an opportunity learn from excellence.
Integrated Medicines	Improving the process and quality of telephone communication with patients' relatives/NOK	Using EPRO to document critical conversations with relatives/NOK. This supported improved quality and consistency of conversations and follow up by ward MDT
Integrated Medicines	Investigations: Creation of a dashboard and improving flow related to use of investigations	Novel Dashboard design. Improved data usage and analytics to support clinicians with expediting investigations and improving patient flow
St Mark's	Fibroscan for nurse-led liver clinics	To enable a nurse-led one-stop liver clinic to save 480-720 consultant outpatient slots and 30-50 endoscopy slots per year.
St Mark's	Discharge waiting area for G2	To use a ward dining room as a discharge waiting area to reduce bed backlog without the need for additional staffing or space.
Surgery	Short notice cancellations – data visualisation	This improves the operational management for the schedulers to optimise their theatre bookings.
Surgery	Theatre safety – HOTT programme	This introduces a holistic approach to patient safety and team cultures to reduce likelihood of harm.
Women and Children	Using centralised cardiotocography software in obstetric suite	Continuous foetal monitoring in labour to detect and reduce the risks of foetal hypoxia and avoidable deaths. This will support decision making during labour and facilitates audit, clinical governance and improved quality of patient care
Women and Children	Paediatric integrated care	Breaking down barriers between primary and secondary care provision for children and young people, to focus on provision of right care, right place, right time.
Corporate	Digital Signatures	Digitalisation of the approval/sign-off process through software package. Removes need for manual signatures improving process completion times, accuracy and security.
Corporate	Dementia Activity Programme	Purchase of resources to support activities that engage Dementia patients and improve their experience and rehabilitation

Building our improvement network

We want to build a culture of improvement and innovation across our whole organisation. Alongside larger projects we encourage all our staff to identify and act on changes they believe would make tomorrow better than today.

We provide training to everyone on improvement skills, tools and methodologies. This includes one-day workshops called Improvement Leaders and a three-month project-based programme called Improvement Fellows.

Over the last year, we had 186 colleagues participate, with examples including improvements in pressure ulcer management, discharge processes for homeless patients, reducing do not attend rates, and improving job satisfaction for international nurses.

We have started building an improvement network that will help alumni of these training events to meet, share ideas and support further improvements.

Engaging with our patients and our communities

Patient and public engagement

In April 2021, the patient experience team launched a series of informal virtual engagement events to recruit local community representatives and patients to join our patient panel.

In September 2021, the panel was formally launched in an online event chaired by Chief Nurse Lisa Knight. Since then, the panel has established monthly meetings, and, through co-production methodology, renamed as the Patient and Carer Participation Group (PCPG). The group has elected a lay co-chair and deputy chair.

The PCPG has 90 participants representing our three local boroughs and local patient groups. We will continue to recruit and attract wider membership, with plans for participation in physical events in the community already in being planned.

Our communications team has helped to raise the profile of the group and create awareness locally, while group links closely with our transformation team to recruit patient representatives into projects. The group also invites an executive team guest speaker to every meeting to support effective engagement and listening.

The transformation leader training programme also welcomes group members to participate. This is supporting us to build mechanism of using patient and community feedback for strategic improvement. The three main themes emerging from this engagement are carers, discharge, and communication, which our patient experience team will work to improve by working with key professionals.

Significant outreach to community groups is ongoing, both to hear a wide range of diverse voices from our communities, and to address challenges with digital exclusion. Our partnership with the Patient Experience Collaborative is proving key to supporting us in this outreach.

Our patient experience team meets with Healthwatch representatives from our three boroughs, responds to issues raised by local communities, and facilitates partnerships and projects to act on identified priorities.

We are also working to create an adolescent and young adult group, in partnership with our Darzi Fellow for adolescent care. This will highlight the needs of our younger patient population and engage them in making improvements. This group also plans to support adolescent participants to gain experience that supports access to employment and further education.

Healthwatch are a valued contributor to our public and patient engagement, and representatives from Brent, Ealing, and Harrow have visited our maternity department, where they were joined by our Maternity Voices Partnership to discuss our maternity improvement plan and see our maternity department in action.

Our communications and patient experience teams attended the inaugural meeting of the Harrow Citizens Advisory Forum. This forum enables residents to engage in an ongoing dialogue with the Borough Based Partnership's leadership team and other relevant colleagues.

In November, staff from our maternity, patient engagement and communication teams attended a Romanian and Eastern European network event in November. This very productive group had expressed an interest in learning more about antenatal services and how to access them.

We also held an engagement event with the Harrow Association of Somali Volunteers (HASVO). Around 15 HASVO clients attended an online meeting to share their experiences of receiving care at our hospitals.

Listening to our diverse communities remains the cornerstone of patient engagement work, while also forming a vital role in supporting our Trust to fulfil our obligations as a local anchor institution.

Making our services accessible and friendly

At the time of writing, our website is the most accessible in the ICS, the second most accessible in the London, and within the top twenty provider NHS websites in the UK, as measured by SilkTide.

We are committed to making our website accessible. It is possible to navigate the site using just a keyboard, or speech recognition software, or screen readers. It is also possible to change

colours, contrast levels and fonts. We have also made information as simple as possible to understand.

We cannot guarantee all information in an older PDF format is fully accessible, so we use alternative formats wherever possible. Our website is partially compliant with the Web Content Accessibility Guidelines version 2.1 AA standard, and we are working to address the very few areas of non-compliance.

We can provide information in difference formats including large print, easy read, audio recording and braille. Where further help is required, our Patient Advice and Liaison Service provides support.

We continue to offer telephone or online outpatient appointments, which are popular with patients and clinicians. We deliver more telephone and online appointments than the national expectation.

We continue to provide automated check-in kiosks for patients attending hospital appointments and offer translations in more than 40 languages. Patient information leaflets can be translated, and our interpreting service is available on the phone and face-to-face.

Listening to our patients

Patient Advisory and Liaison Service (PALS)

PALS remained closed to walk-in appointments at the start of 2021 to safely manage infection prevention and control. However, it has continued to offer a telephone and email service throughout this period.

During quarter three, Ealing Hospital reintroduced a walk-in service, as it was safe for both staff and visitors. We are currently working on plans to re-introduce a walk-in service to Northwick Park Hospital in the first quarter of 2022-23. PALS has continued to offer a telephone and email service throughout this time.

During 2021-22, PALS received 3,326 enquiries. This is a slight decrease when benchmarking against 2019-20, when 3,598 PALS enquiries were recorded. This can be attributed to slightly lower activity levels, as well as staffing challenges during quarter two and quarter three, when the team were sometimes operating at 50 percent capacity.

Of the 3,282 enquiries received, 663 were resolved immediately. A further 2,151 were referred to the relevant department to be resolved.

Other outcomes included providing general advice, as well as giving advice on how to make a formal complaint. Overall PALS contacts represented 0.31 per cent of our Trust's activity.

Common themes

Of the 3,326 contacts the following table breaks down the common themes arising from the enquiries the team received along with a comparison of the two previous years.

Table 9: PALS contacts by theme

Frequency ranking	2019-20	2020-21	2021-22
1	Communication (36.26%)	Communication (27%)	Appointments (26%)
2	Appointments / outpatients (33.58%)	Appointments (22%)	Communication (25%)
3	Clinical treatment (8.46%)	Signposting (10.3%)	Signposting (9%)
4	Admissions and discharges (4.96%)	Clinical treatment (4%)	
5	Staff values and behaviour (2.08%)	Loss of property (3.75%)	Clinical treatment (3%)

More than half the enquiries we received this year related to appointments and communications. Further breakdown shows that 37 per cent of appointment queries related to delays, while 15 per cent and 14 per cent were in relation to availability and cancellation respectively.
For communication, 39 per cent related to communication with the patient, while 31 per cent related to communication with a relative or carer.

Complaints

Response times

We aim to ensure that every person raising a concern receives a timely and good quality response that addresses their complaint. We responded to 80 per cent of complaints on time: this is a target we had not achieved before 2021-22.

During 2021-22, the patient relations team further strengthened the weekly complaints meetings process, which now occur with each division with a member of the divisional leadership as well as relevant staff responsible for each specialty.

The team have developed and provided complaints training to several staff across almost all divisions, in a programme that will continue into 2022-23.

This has assisted us in exceeding the 80 per cent target every month throughout 2021-22. The average number of complaints that we responded to in time was 88 per cent.

The number of complaints we received each month increased in 2021-22. However, it is difficult to benchmark against the previous year (2020-21) because of the impact of Covid-19.In 2019-20, we received an average of 79 complaints per month, while in 2021-22, this decreased to 70 per month. This means that 0.08 per cent of patients made a formal complaint in 2021-22, compared to 0.08 per cent of patients in 2019-20.

We categorise every complaint we receive by theme, reporting the results at a national level every quarter.

Table 10: complaints by theme

Frequency ranking	2019-20	2020-21	2021-22
1	Clinical treatment (29.88%)	Clinical treatment (29.75%)	Clinical treatment (29.5%)
2	Staff values and behaviour (13.3%)	Staff values and behaviour (17.02%)	Staff values and behaviour (16%)
3	Appointments: delays / cancellations (13.2%)	Communication (11.34%)	Appointments: delays / cancellations (15%)
4	Communication / information to patients (12.14%)	Patient's privacy, dignity and wellbeing (9.04%)	Communication / information to patients (14%)

Parliamentary and Health Service Ombudsman

The second stage of the complaints process is the Parliamentary and Health Service Ombudsman (PHSO). Should a complainant remain dissatisfied with the responses received from us, they can ask the PHSO to undertake an independent review of their complaint.

We received 11 enquiries in which the PHSO asked us to share documentation and records. We also received seven final reports from the PHSO where they had conducted an independent investigation in to complaints referred to them. Of these seven, five were partially upheld and two were not upheld.

Compliments

The patient relations team welcome and register compliments received from patients and r elatives and share them with the relevant teams.

In 2021-22, 140 compliments were registered with the PALS and patient relations teams.

Online reviews

The Trust received 43 reviews posted on Care Opinion in 2021-22.

A total of 64 per cent of reviews were positive in sentiment, and of these, 80 per cent related to a positive sentiment about the treatment and care that was provided.

Of the negative reviews, 39 per cent of these were around delays to appointments, treatments and procedures.

We have a benchmark of responding to 100 percent of reviews with a personalised response, and in November 2021 we received a positive commendation for being in the top ten of NHS Trusts for responsiveness.

Friends and Family Test

During 2021-22, 38,659 people gave us feedback using the Friends and Family Test (FFT). This is an increase from the previous year's 9,264 responses, and the number of responses has steadily recovered from the issues caused by Covid-19.

Transitioning to a new Friends and Family Test provider has allowed us to generate a fluent national submission each month. The new provider also offers the option of postcard, online, automated text message and voicemail collection.

In November 2021, we started collection for the new national hierarchy of long Covid. This collection includes two additional questions to better understand the experience of this patient group. At our November Trust Board, a story from one of our long Covid patients was facilitated to highlight the service, which is aligned to the national recommended model.

Of the total number of FFT responses, 97 per cent said they rated our services as positive. This exceeds our benchmark of 94 per cent and shows an increase on the 94 per cent achieved last year. This offers a good indication that staff have taken on board and are living the Trust's HEART values.

Table 11: Friends and Family Test responses and positive scores

	Responses	Positive
A&E	3,420	97.15%
Outpatient	18,325	97.80%
Inpatient	14,076	97.98%
Maternity	928	97.85%
Community	2451	96.25%
Long Covid	51	98.46%

Improving our environment

Adapting our hospitals

During the last financial year, we have worked to strengthen the infrastructure and appearance across each of our hospital sites.

We have been working with patients, carers, clinicians, operational managers, and key stakeholders both inside and outside our Trust to understand more about what improvements we need to make and the capital and infrastructure investments which will make our hospitals fit for both current and future needs of our patients, staff, and communities.

We have made a strong start on developing a local site-specific strategy for each of our three main sites.

At Central Middlesex Hospital we have made significant investment both in building the capacity for our St. Mark's clinical teams and support staff to support the green pathway (Covid-19-free area) in place over the last year, but also in considering the right configuration for endoscopy and ophthalmology – two key services for our local population.

We have also started to review site support, including the provision of better facilities for staff working on the site.

We have continued to explore and develop how we might strengthen and support the provision of orthopaedic services across north west London in a centre of excellence, and we are consulting with key stakeholders and the public on how we can best use the excellent facilities at this site.

At Ealing Hospital, we have made material investment in the infrastructure of the site, as well as working with partners to articulate how community diagnostics can be provided on the site and investing in new diagnostic equipment and upgrades to ward areas.

We have agreed to fund and have made the initial expenditure on a new cardiac catheter laboratory, while two new MRI scanners were made available on the site in partnership with the North West London Imaging and Diagnostic Network.

At Northwick Park Hospital, we have completed a new multi-story car park and a new combined heat and power generation facility. We have also invested additional funding across many of the ward areas and have made material investments in radiology and diagnostics.

We have been able to consider how best to secure additional capital to invest on each site, which will be supported by the strategy work we are undertaking in 2022-23.

Our five-year capital investment plan is now agreed by the Trust Board, and will be refreshed again in late 2022-23, in partnership with the North West London Integrated Care System and the acute provider collaborative.

Delivering improvement projects

We have increased investment in medical equipment at all our sites, with significant investment to reduce our backlog and in key infrastructure, including fire and water safety.

This sits alongside the investments we're making in digital infrastructure, including Wi-Fi and our new electronic patient records system, to modernise the way in which we support our patients and our staff.

We have also agreed a green plan, helping in the delivery of the national net zero targets for the NHS.

We have developed the plan in partnership with the North West London Integrated Care System Green Plan group and have set out a series of important workstreams to reduce carbon emissions and support new ways of working and delivering patient care, which are more sustainable and reduce the impact on the environment.

We have also been working closely with partner organisations on the role of the Trust as an anchor institution in north west London.

We have a key role in supporting local economic development, local employment, and education. We also have a role in addressing some of the key health inequalities across north west London and within the individual places and boroughs around our hospitals. We recognise the importance of playing our part and explicitly articulating how we will do this and what benefits this will bring to our local population.

Research and development

A research-positive culture

The role of research and development department at our Trust has never been stronger or demonstrated more definitively than during the pandemic. Our contribution to the pandemic, both through delivering landmark vaccine studies, research into the epidemiology of the pandemic and the impact of Covid-19 on different patient groups has been exemplary and of national and international consequence. Research and development are a core enabler of our clinical strategy and bedrock of improving the health of our communities.

Performance

In 2021-22 we continued the robust recovery of our non-Covid-19 research areas and our contribution to further Covid-19 trials, now facilitated by our state-of-the-art clinical research facility.

We have recruited 3,868 patients into 108 national portfolio studies, 40 of which were observational studies.

We opened 17 new commercial studies in 2021-22, with 125 participants recruited into them.

This year we continued to make strong contributions to defeating the pandemic with the vaccine booster studies, providing evidence for additional vaccination boosts.

We have recruited 4,000 patients into 104 national portfolio studies, 40 of which were observational studies.

The total number of participants surpasses our pre-pandemic performance but is lower than 2020-21 levels. This is because in 2020-21 we had the AstraZeneca Covid-19 trial, which on its own had 2,000 patients.

We opened 17 new commercial studies in 2021-22, with 125 participants recruited into them. We continued to make strong contributions to defeating the pandemic, with vaccine booster studies and provided evidence for additional vaccination boosts.

We were able to open 83 per cent of studies within 40 days; in 58 per cent of studies we recruited the first patient within 30 days.

This year's objectives were to restart and recruit to managed recovery studies, which were paused due to the pandemic and identified as a priority to resume nationally.

Some 70 per cent of our non-commercial managed recovery studies met this target and 50 per cent of our commercial studies, against a national target of 80 per cent.

Completed participant experience surveys was also identified as a priority and we completed 204 surveys against an ambition of 316.

Principal investigators

We currently have approximately 180 principal investigators, of whom five are nurses. In addition, with the move of St. Mark's Hospital to Central Middlesex Hospital and the growth of research active specialties there, our research teams have delivered more studies across sites than ever before. There were 45 service evaluations opened this financial year.

Highlights this year

We recruited the first patient in Europe to the Ophthalmology THR-149 study, which is investigating alternative treatment for patients with diabetic macular oedema resistant to standard care.

We were also the top recruiting site in the UK to an ophthalmology study investigating

cutting-edge treatment for patients with branch retinal vein occlusion, a potentially blinding disease.

We have recruited 180 patients so far to a crucial study looking to determine whether testing pregnant women for Group B streptococcus reduces the risk of infection to new born babies.

Our large and well curated sickle cell disease database enabled us to secure a commercial study investigating a new treatment for sickle cell disease in the United Kingdom. This is particularly noteworthy as there are currently only two drugs approved for sickle cell in the UK and a recent parliamentary working group highlighted sickle cell disease as a neglected disease with a call for further research and education to improve outcomes.

In addition, staff at our clinical research facility have successfully delivered six studies, recruited 332 patients, and developed a healthy pipeline of Covid-19 and non-Covid-19 studies awaiting set-up.

Our clinical research facility staff were acknowledged and thanked nationally for meeting all national targets for recruitment and delivery of Covid-19 vaccine studies.

Our researchers have also contributed significant evidence to scientific literature, evidenced by high citations.

Dr Pedro Machado, a consultant rheumatologist at Northwick Park Hospital, wrote a paper on the characteristics associated with hospitalisation for Covid-19 in people with rheumatic disease, which has been cited over 347 times this year.

Our Emergency Department's Dr Matthew Walton produced a paper on mental health care for medical staff and affiliated healthcare workers during Covid-19 pandemic which has been cited over 219 times to-date.

We have an active nursing, midwives and allied health professionals research group (NMAHP) which promotes the embedding of research as part of the core activities across this group of professionals, who form a significant proportion of our frontline workforce.

It is our goal to increase the proportion of principal and chief investigators from this group. The inaugural NMAHP research awards were held in June 2021 with significant engagement.

The National Institute for Health and Care Research asks all trusts to collect information from patients and services users about their experience of taking part in NHS research through the Participant Research Experience Survey (PRES).

In 2021-22, we increased research participant engagement with PRES. Of the 204 PRES responses, 97 per cent felt they were treated with courtesy and respect and 83 per cent agreed they would consider taking part in research again.

We are committed to ensuring our research studies include participants from all segments of our community and believe our diversity is one of our strengths.

In one example, Dr Ashley Whittington, Infectious Diseases Consultant and CRF Clinical Lead, presented our Covid-19 recruitment data, demonstrating that the diversity of recruited participants matches that in our community.

We are refreshing our patient and public involvement strategy to ensure we have representation from hard to reach and under-served groups, and that our groups include participants with lived experience from each disease area.

We provide support to both non-commercial and commercial sponsors and researchers to ensure research studies are designed and delivered with patients at the heart. This is a bold ambition which aligns with our values of equality and respect for all.

Demystifying research

New research ground rounds are helping us to embed clinical research as a key part of our Trust's culture. Internal and external researchers can learn about research, present their work, and seek input and collaboration from their peers and audience each month.

We also have a monthly research column in the staff newsletter.

Looking to the future

As our portfolio recovers and grows beyond the pandemic, we have begun the process of reviewing our set-up, delivery processes and staffing structures with the goal of streamlining our processes and achieving better alignment with the clinical divisions.

Our aim is to have structures that enable faster set-up times and attract more high-quality commercial trials that address the needs of our local population. We will lead and deliver impactful non-commercial research with excellence and establish a reputation as the go-to trust for excellent and efficient delivery of high quality and inclusive clinical trials.

Our main challenge in 2022-23 will be providing robust research infrastructure at all three hospitals to support the large number of studies already in set-up, and the expected increase in studies as we recover from the pandemic and embed the research engagement initiatives we have devised.

We plan to run an increasing number of studies through the clinical research facility, maximising our resources.

Our people

Health and wellbeing

In response to the Covid-19 pandemic, we invested significantly in wellbeing, implementing new systems and processes to support our staff in a proactive and preventative approach.

When the Omicron variant was detected in November 2021, we launched a surge plan, putting our team on standby to support those who were unwell or required support. This meant that our staff could access resources more easily and focus on their recovery.

Despite our hospitals including one of the busiest in London, our staff engagement levels were consistent across our three sites and remained comparable with similarly sized trusts. Unsurprisingly, however, morale suffered most amongst those staff working in Covid-19 specific wards.

We directed resources to the recovery of those staff who were most affected, learning from previous Covid-19 waves to embed a compassionate approach across all our divisions.

We also worked closely with other NHS organisations across the North West London Integrated Care System, sharing resources and working collaboratively. This included providing staff with access to the NHS Keeping Well Service.

In the past year we have undertaken a range of wellbeing interventions, including:

- creating health and wellbeing roles to provide direct support to staff on busy wards
- helplines, apps and self-help resources
- support for staff psychological and physical wellbeing
- treatment based and prevention focused interventions
- food and drink for staff working on the frontline
- requiring Covid-19 personal risk assessments for all colleauges
- dedicated coaching support and guidance for line managers, leaders and teams
- team coaching and service interventions to support emotional labour of care health and wellbeing education and awareness
- health promotion through routine lunch and learn sessions
- regular surveys and solicited feedback from staff to ensure services are meeting their imme diate and long-term needs
- offering dedicated access to health and wellbeing services (including counselling and financial advice) for our staff and their families through our employee assistance programme.

As a result, we have:

- improved staff experience and perceptions, with a 29 per cent point increase in positive responses to the related question in the 2021 staff survey
- delivered significant improvements in staff wellbeing through increased access to physical, emotional and psychological interventions
- increased support for managers and promoted a culture of wellbeing, through the launch of a wellbeing conversations guide and management training
- delivered routine themed wellbeing awareness sessions for our staff
- started the co-creation of a health and wellbeing strategy to deliver the future vision of staff wellbeing
- secured funding to embed and deliver the future of the health and wellbeing service.

These improvements were reflected in our 2021 annual staff survey scores, which showed statistically significant improvement in staff responses to health and wellbeing when compared with benchmarked organisations and the previous year.

This improvement validates our ongoing investment in staff and wellbeing.

Next steps

We continue to adopt an evidence-based approach to supporting the health and wellbeing needs of our staff.

Our annual staff survey and ongoing pulse surveys offer ongoing important insight which shapes our new health and wellbeing strategy. This work is also informed by what we have learnt during the pandemic.

We will continue with a more preventative health and wellbeing approach to create a positive workplace that keeps our people safe and retains and attracts the best staff.

We are proud of progress in this area and the recognition received through a national award. We are also conscious that a variety of factors such as workload, job quality, autonomy, people management, and behaviour are all key elements for increasing staff wellbeing. Over the next year we will continue to work to create healthy cultures of working to support recruitment, staff retention and patient care.

Equity, diversity and inclusion

Our diverse workforce positively enriches the care we provide to our patients and our local communities. In 2021, we launched our first equity, diversity and inclusion (EDI) strategy, setting out a vision for inclusion over the next three years. This plan for an inclusive future was co-created with our staff and is owned by them.

During this reporting period there were several improvements in key equality, diversity and inclusion areas. Highlights include:

- A 3 percentage point increase from the previous year in staff from Black, Asian and minority ethnic backgrounds – now at 65 per cent
- a 5.1 percentage point increase from the previous year in Trust board members from Black, Asian, and minority ethnic backgrounds
- Similar levels of reporting of bullying by peers from White staff compared to Black, Asian and minority ethnic colleagues (30.9 per cent of white staff compared with 32.8 percent of staff from Black, Asian, and minority ethnic backgrounds).

Some 31.9 per cent of our disabled staff were satisfied with the extent to which we valued their work. This was a 0.4 percentage point increase compared to previous year. There was a 6.3 percentage point increase in staff who said we had made adequate adjustments to enable them to carry out their work. This figure now stands at 66 per cent.

We also saw improvements in the number of disabled staff at agenda for change (AfC) band 8c to9 (including very senior managers), with 8.1 per cent declaring a disability compared to 4 per cent the previous year.

Conversely, there was a reduction in the number disabled staff who say they believe that the organisation provides equal opportunities for career progression or promotion (46.5 per cent). We also self-assessed our gender pay gap performance, reporting at 22 per cent, largely widened by the hourly pay of our consultant medical workforce.

Building a culture of inclusion

Since July 2020, we have rolled out several interventions to embed equality and diversity in the organisation. These have included more inclusive and visible recruitment processes, introduction of positive action development, and involvement in the White Allies programme.

We continue work to transition to a more inclusive board through inclusive workshops to further develop senior leadership. This includes recruitment of three non-executive directors from Black, Asian, and minority ethnic backgrounds to provide inclusive board succession, creating balance and greater diversity of thought in our governance and decision making.

We also established the Independent Staff Insight Group (ISIG). ISIG bringing together staff and senior leaders to drive more inclusive board-level decisions through a range of perspectives and diverse lenses. It includes representation from our staff networks, including our BME network, our LGBTQI+ network, our disability inclusion network, and our women's network.

Over its relatively short existence so far, ISIG has provided rigour and insight to the our vision. It has developed a work plan to take forward its key priorities and continues to elevate its profile in the organisation.

Our staff survey results

In the 2021 staff survey, we scored positively in 92 out of 117 questions. This ranked us 37 out of the 60 acute trusts and community care organisations in England.

The 2021 survey responses were mapped against the seven elements of the NHS people promise and the two themes of staff engagement and morale. There were also questions on staff experience during the Covid-19 pandemic.

Our scores on bullying, harassment and abuse were amongst the most improved. They showed a reduction in incidents with patients and other members of the public, as well as with managers.

There was also a reduction in the number of staff reporting physical violence from patients, service users, their relatives or other members of the public.

More staff said they meet with colleagues to discuss the team's effectiveness, and more staff now feel we act fairly. Scores on career progression also saw an improvement.

In several areas we scored better than the national average. Amongst the best scores here were those relating to appraisals, with staff citing clear objectives and help to improve how they do their job.

Against the national average, more of our colleagues say they often or always look forward to work. Fewer staff said they felt frustrated at work, or experienced conflicting demands.

Our response rate in 2021

Of our 7,769 eligible staff, 4,643 (61 per cent) participated in the online staff survey. This was our highest participation rate to date, and compares well with 2020, when 53 per cent of staff participated. Uptake increased across all occupational groups and divisions.

Our staff engagement

The staff survey has a distinct NHS engagement measure, which is broadly linked to staff experiences of working locally, their involvement and what they think and feel about care.

Table 12: staff survey scores

	Description	National average	LNWH 2020	LNWH 2021
Motivation	• I look forward to going to work • I am enthusiastic about my job • Time passes quickly when I am working	7.0	7.6	7.3
Involvement	• There are frequent opportunities for me to show initiative in my role • I am able to make suggestions to improve the work of my team/department • I am able to make improvements happen in my area of work	6.8	6.6	6.7
Advocacy	• Care of patients/service users is my organisation's top priority • I would recommend my organisation as a place to work • If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	6.8	6.8	6.6
Overall staff engagement score		6.9	7.0	6.9

Staff engagement activities in 2021-22

Recovery with HEART and Allyship sessions

Allyship is a training program that empowers colleagues to take meaningful action as allies. These sessions focus on race, disability, and staff wellbeing.

Recovery with HEART events primarily targeted managers and drew more than 700 participants, including executive members. Feedback from the sessions indicated that they were thought provoking, reflective and impactful.

Listening events with a focus on issues affecting staff from Black, Asian, and minority ethnic backgrounds

We continue to hold monthly listening events on topical issues with actions taken forward as appropriate. This interaction has enabled our leadership team to be more visible and alive to the issues that staff experience and that affect them daily. These meetings are inclusive and are open to all staff members including allies.

Strengthening staff networks

We support our staff networks and have commissioned work to improve partnership working, better resource networks, increase their membership and strengthen their governance processes and operation.

Our senior leaders, including our Chief Executive, continue to meet regularly with the networks, while executive diversity leads have been their strong advocates and champions.

In 2021, we launched our Healthcare Support Worker and Admin Clerical Group for staff at AfC bands 2-4 roles, to hear their voices more effectively, better support them at work and address their development needs.

Combating bullying and harassment

Our staff continue to tell us that their experiences of working at our Trust do not always align with our culture represented by our HEART values. Responses indicate that more staff are experiencing bullying and harassment, but that fewer of them are reporting it (4 per cent).

This is disappointing, as between 2016 to 2020, around one third of the staff members who completed the survey reported that they had experienced bullying and harassment from managers and colleagues.

This year, the numbers of staff responding to questions relating to bullying or abuse from managers, colleagues or patients remain higher than the average for comparable NHS organisations.

Over the last five years, staff with disabilities, those from Black, Asian and minority ethnic backgrounds, LGBTQI+ colleagues have told us that they are more likely to be bullied, harassed, and abused than other staff.

We have identified specific areas where this theme stands out as a priority, and it will be the subject of focussed action in the coming year. Addressing bullying and harassment will also be a prominent topic in our staff survey corporate action plan, as well as our Workforce Disability Equality Standard and Workforce Race Equality Standard plans.

Areas we need to improve

Although our staff tell us they are more motivated and engaged, they also tell us there is still a lot to do to improve their working lives.

In the coming year we will focus on:

- ensuring that we have enough staff for people to do their jobs properly
- improving staff satisfaction with recognition for their good work
- supporting staff to be enthusiastic about their job
- ensuring that staff don't have to work additional paid hours per week
- demonstrating that the Trust values good work
- encouraging staff not to leave the Trust
- combating from patients, service users, their relatives or other members of the public
- working to demonstrate fair processes around career progression
- helping staff feel safe to speak up about anything that concerns them
- making improvements so that staff would be happy with our standard of care if their friend or relative needed treatment here.

We are particularly focussed on improving workload, career progression and speaking up. At a divisional and service level, we have developed action plans which are focussed on local issues, identifying interventions to address specific priorities for individual areas.

An anchor organisation

As an anchor institution, we strive to contribute to the local communities we serve beyond providing healthcare, positively impacting on the wider factors that make people healthy. In this spirit, we continue to work with local schools and colleges to deliver educational and career opportunities.

We have worked with several third sector organisations to support placements for refugees living in London to requalify to secure employment at our Trust. This work also included providing work experience programmes remotely at the peak of the pandemic by working closely with partners organisations in the north west London sector.

During this period, we offered online events and webinars on NHS careers, such as nursing, allied health professions, and medicine.

Project SEARCH

We actively support the Project SEARCH Supported Internship programme. The programme supports young people with special educational needs and intellectual disabilities (SEND) such

as autism and other developmental conditions to learn the skills needed to achieve sustainable paid employment through learning in the workplace.

This programme is centred on strong partnership working with our local community to support young people to successfully seek employment. The partnership includes Harrow College and Uxbridge College, Harrow Council, West London Alliance, and Kaleidoscope Sabre.This successful programme has enabled us to access the enriching and diverse talents of our interns with 60 per cent of our interns gaining paid employment in the Trust. The programme has an overall success rate of 65-73 per cent of interns gaining paid employment.

Growing the nursing workforce of the future

Growing our nursing workforce is vital to delivering our goals and objectives.

We have developed a new working relationship with Kingston University and accepted direct entry adult nursing students from the September 2021 cohort. Direct entry students are those that have applied through the UCAS route and are funding their own university tuition. They are university students and not Trust employees.

We also recruited 15 apprentice nursing associates, while new university partners have introduced the opportunity to receive direct entry trainee nursing associates from students that live within north west London. This further supports our ambition to provide healthcare opportunities for people living in our communities, as well as creating a robust pathway of training places for pre-registration learners using the apprentice and direct entry models.

It is important that we continue to increase the number of pre-registration clinical placements, particularly in small service areas such as paediatrics. This will support the essential experience of paediatric nursing and nursing associate students. This requires specific and focused work with the paediatric teams to explore evolving virtual technologies and alternative placement models tested during the Covid 19 pandemic, when clinical placement opportunities were limited.

Post-registration development

Between 2019 and 2021, our provision of continuing professional development opportunities increased by 33 per cent. This increase occurred despite a pause in non-essential training programmes while we focused on upskilling our staff to care for very sick patients and create safe environments for care.

Now that non-essential training has been reinstated, staff continue to access a range of academic programmes to support their development needs, including apprenticeships for both clinical and non-clinical staff. During this period, we introduced three new apprenticeships.

Nurse preceptorships

We updated our preceptorship strategy to include newly qualified, international and return to practice midwives. We offered preceptorships to 104 newly qualified nurses in three cohorts and are currently planning to expand our offer to a fourth cohort, to include newly qualified midwives.

Other in-house development includes career clinics for staff in bands 2-6 which saw attendance levels increased by 77 per cent.

Restorative supervision

Restorative supervision is psychological support to help staff cope, especially in managing difficult or stressful situations, and we have offered it to healthcare professionals over the last two years. This support proved vital during the peak of the pandemic and continues to be in demand.

At the start of the pandemic, we offered restorative clinical supervision to a small number of nursing staff, but developed a wider programme due to increased demand. This programme was expanded to include in-house supervisor training by experienced supervisors and trainers.

We run nine restorative clinical supervisors, with an additional 11 trained professional nursing advocates (PNAs) and six professional midwifery advocates (PMAs), who work collaboratively with the restorative clinical supervision team to increase the pool of supervisors within the organisation.

Since April 2020, 72 members of staff have received restorative clinical supervision and this number is likely to go up as the number of supervisors increases through both in-house training and the national PNA and PMA programmes.

Voluntary services and our LNWH Charity

Voluntary services

Our volunteer service strives to meet the needs of our patients by service users by involving volunteers, while simultaneously offering our volunteers a rewarding experience.

Registered volunteers continue to participate in a range of projects and roles, offering their valuable time and skills to support staff and enhance the experience of patients.

This year has brought challenges for everyone following the impact of Covid-19.

Sadly, we saw the loss of our longest serving volunteer, Audrey Alpe, who achieved an extraordinary 48 years of volunteering. She won our Volunteer of the Year award in 2016 and was presented with a Gold Lifetime award of 45 years' service in 2018.

We have worked on recovering our programmes by phasing in our volunteer roles, while concentrating on areas that would have the most impact on patients and staff.

We maintained contact with volunteers throughout the year, with well received quarterly newsletters and online forums. We recognised the contribution of volunteers during Volunteers' Week and International Volunteer Day by sending out long service awards and publishing volunteer stories through social media platforms. We also teamed up with our colleagues in LNWH Charity and health and wellbeing teams to celebrate the NHS 73rd anniversary, making the Big 5 Tea Event a roaring success.

Our League of Friends volunteer, Beryl Carr, turned 100 this year. She was visited by friends, hospital staff, and even the national media, including the Telegraph, BBC London, and ITV. We successfully secured funds from NHS England and NHS Improvement's winter pressures programme to develop two new projects.

These new programmes of care will see us collaborate with internal and external partners with a focus on aligning volunteering interventions with clinical outcomes in palliative care and youth mental health. We anticipate that they will not only provide more impactful volunteering but also enhance the volunteering experience, as well as facilitating both the return of volunteers and the recruitment of new volunteers.

The service participates in the North West London Integrated Care System Volunteering Group, which looks at implementing cross-sector volunteering programmes, while exploring ways to tackle health inequalities in our communities.

The volunteer team regularly meets with strategic leads at NHS England and NHS Improvement and participates in the Future NHS Collaboration Platform. We look forward to actively recruiting new volunteers, as well as reinstating vital services such as voluntary cars and breastfeeding peer support.

LNWH Charity

Ealing Hospital faith rooms

To compliment the recent refurbishment of the faith rooms at Ealing Hospital, LNWH Charity provided the funding for a new an altar table, decorative lectern, credence table and a St Cuthbert's professional chair.

Rainbow unit

Rainbow ward accommodates children and young people from birth to 16 years who need elective day care procedures, investigations, diagnostic testing or who have cancer. LNWH Charity funded the design, decoration, and installation of colourful wall illustrations. This work has helped children feel more comfortable when they are having a procedure or coming to the unit for a short stay.

The first stage recovery areas in theatres are just about to be redecorated and the design has a theme that is common to all areas which will create an environment for the looked after children to have a relaxed and child friendly space.

Virgin Pulse Go Challenge

The LNWH Charity supported our 2021 Virgin Pulse Go Challenge as part of our staff health and wellbeing initiative and provided £18,000 in funding.

The Virgin Pulse Go Challenge is a virtual global wellbeing event, in which staff can challenge friends and colleagues to get moving through a fun team challenge to take the most steps or burn the most calories.

A total of 962 colleauges set off on the challenge which began in May 2021 and concluded in July 2021.

The Virgin Pulse Go Challenge survey established the following:

- Over half of the staff taking part took more active breaks after participating
- Over a third felt less stressed, more productive and energized after taking part.
- 71 per cent of the staff who participated are more active after taking part in the challenge.
- 87 per cent of the staff who participated improved at least one nutritional habit after participating.

For 2022-23, the Charity has committed £25,000 towards the Virgin Pulse Go Challenge 2022, which began in May 2022.

Cancer unit

LNWH Charity part funded health and wellbeing videos for patients with cancer to watch at the end of treatment. The video replaces the pre-Covid-19 pandemic face-to-face events which we ran every month and allows patients to access the same information remotely.

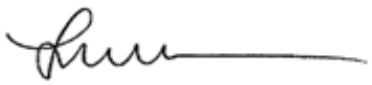
Dementia care

In October 2021, the charity organised our first ever virtual half marathon, with more than 30 members of staff participating. Fundraising resulted in more than £3,500 for the reminiscence room for dementia services at Northwick Park Hospital.

The charity has also partnered with the Griffin Institute, St Mark's Foundation, Hillingdon Hospital Charities, and Red Lion Pouch Support to host the London Bridges Walk in June this year. Participants completing the walk on the Charity's behalf will be raising funds for dementia services across LNWH.

This year, LNWH Charity will also be reintroducing the public lottery, raising additional funds to further improve the hospital environment for patients and staff.

Signature to the performance report:



Pippa Nightingale MBE
Chief Executive

The **Accountability Report**

Corporate Governance Report

The Directors' Report

1 The Trust board is accountable, through the chair, to NHS Improvement (NHSI) and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively as a unitary board, and individually, to act with a view to promoting the success of the organisation. It has overall responsibility for ensuring delivery of safe and effective services in accordance with legislation and the principles of the NHS Constitution.

2 The members of the Trust board possess a broad range of skills. The executive directors are recruited by the board with a process overseen by the appointments and remuneration committee. The non-executive recruitment is overseen by NHSI who have a specific role in appointing and supporting NHS trust chairs and non-executives. These are public appointments made using powers delegated by the Secretary of State for Health.

3 In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust board directors have been assessed as being fit and proper persons to be directors of the Trust.

4 The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for executive directors, by the chief executive; for non- executive directors and the chief executive by the chairman; and for the chairman, by self- assessment with sign-off by NHS Improvement.

5 During the year there have been several changes to board members

Executive director appointments 2021-22

- Chief Executive Officer Pippa Nightingale joined the board on 14 February 2022, replacing Chris Bown who left the board on 31 March 2022.
- Chief Medical Officer Dr Jon Baker joined the board on 1 September 2021 on an interim basis and substantively in March 2022.
- Director of Estates and Facilities Mark Trumper left the board on 31 January 2022.

- Chief Operating Officer James Walters joined the board on 13 March 2022, replacing Ellis Pullinger who left the board on 27 March 2022
- Acting Director of HR and Organisational Development Phil Spivey joined the board on 6 June, replacing Claire Gore, who left the board on 5 June.

Chair appointment

- Lord Amyas Morse left the board on 31 March 2022 and was replaced by Matthew Swindells who joined the Board as Chair in common (North West London Acute Collaborative, incorporating LNWH, Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS) on 1 April 2022.

Our board throughout the year and as of 22 June 2022

Chair

Matthew Swindells (from 1 April 2022)

Lord Amyas Morse (until 31 March 2022)

Chief Executive Officer

Pippa Nightingale MBE (from 14 February 2022)

Chris Bown (until 13 February 2022)

Non-Executive Directors

- Janet Rubin (Vice Chair)
- Professor Desmond Johnson
- Dr Vineta Bhalla
- Andrew van Doorn
- Neville Manuel
- David Moss
- Dr Syed Mohinuddin

Associate Non-Executive Directors

- Kingsley Peter
- Huda As'ad

Executive Directors

- Simon Crawford, Deputy Chief Executive Officer and Director of Strategy
- Dr Martin Kuper, Chief Medical Officer (until 31 August 2021)
- Dr Jon Baker, Chief Medical Officer (interim from 1 September 2021, substantive from 29 March 2022)
- Lisa Knight MBE, Chief Nurse
- Ellis Pullinger, Interim Chief Operating Officer (until 27 March 2022)
- James Walter, Chief Operating Officer (from 28 March 2022)
- Jonathan Reid, Chief Financial Officer
- Claire Gore, Director of HR and Organisational Development (until 5 June 2022)
- Phil Spivey, Acting Director of HR and Organisational Development (from 6 June 2022)
- Mark Trumper, Director of Estates and Facilities (until 31 January 2022)
- David Searle, Director of Corporate Affairs

Declarations of interest

Trust board members are required to declare any interests. The register is available on the Trust's website (www.lnwh.nhs.uk).

Personal data related incidents

This is described in more detail in the Annual Governance Statement (see page 69).

Board and board committee meetings register of attendance

Table 14: Attendance of board and board committee members at Trust board meetings and board Committee meetings for the period 1 April 2021 to 31 March 2022

Name	Position	Trust Board Meeting	Appointments and Remuneration Committee	Audit Committee	Charitable Funds Committee	Finance and Performance Committee	Quality & Safety	People, Equality & Inclusion
		6*	4	7	4	10	6	6
Lord Amyas Morse	Chairman	6	3					
Professor David Taube	Non-Executive Director	1/1	1/1				1/1	
Professor Desmond Johnston	Non-Executive Director	6		3				
Mrs Janet Rubin	Non-Executive Director	6	4			9		6
Dr Vineta Bhalla	Non-Executive Director	5			1/1	1/3	6	
Mr Andrew van Doorn	Non-Executive Director	6		7	3			6
Mr David Moss	Non-Executive Director	5		7	3/3		6	6
Mr Neville Manuel	Non-Executive Director	5		6	3	8		
Dr Syed Mohinuddin	Non-Executive Director	6	3/3			6/7	5/5	
Huda As'ad	Associate Non-Executive Director	4						
Kingsley Peters	Associate Non-Executive Director	5						
Mr Chris Bown	Interim Chief Executive Officer	5/5				6/8		
Mrs Pippa Nightingale	Chief Executive Officer	1/1						
Mr Simon Crawford	Deputy Chief Executive	6			4		4	4
Dr Martin Kuper	Chief Medical Officer	3/3				3/4	2/2	2/3
Dr Jon Baker	Interim Chief Medical Officer	3/3				5/6	4/4	0/3
Mr Ellis Pullinger	Interim Chief Operating Officer	4/5				8/9	4/5	
Mr James Walters	Chief Operating Officer	1/1				1/1	0/1	

Mr Jonathan Reid	Chief Financial Officer	5			3	9		
Mrs Lisa Knight	Chief Nurse	5					5	1/6
Mr David Searle	Director of Corporate Affairs	6						
Ms Claire Gore	Director of HR and Organisational Development	6			4			6
Mr Mark Trumper	Director of Estates and Facilities	4/5						

* There was a total of 6 Trust Board meetings scheduled with public agendas. In addition to this, the Board also met in private on 7 occasions throughout the year.

Directors' statement in respect of the annual accounts

The directors have been responsible for preparing this annual report and the associated financial accounts and each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken all the steps that he or she ought to have taken to make himself or herself aware of any such information and to establish that the auditors are aware of it.

Statement of directors' responsibilities

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

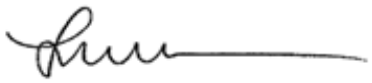
- apply on consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure

that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors 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 trust's performance, business model and strategy.



Pippa Nightingale MBE
Chief Executive

Jonathan Reid
Chief Financial Officer

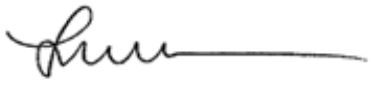
Statement of the Chief Executive's responsibilities

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the 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 my letter of appointment as an Accountable Officer.



Pippa Nightingale MBE

Chief Executive

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable 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 London North West University Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in London Northwest University Healthcare NHS Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board approved Risk management policy contains a risk strategy statement and leadership arrangements for managing risk. This document is further supported by the Trust's strategic goals, objectives, and a range of policies and procedures including the Risk assessment standard operating procedure and Incident reporting and investigation policy. These documents define the management of risk including the responsibilities of executive directors and all staff employed by the organisation, including sub-contractors, interim and agency staff. Through terms and conditions of their employment, and health and safety regulations, all staff have a responsibility for ensuring their working practices are safe and they do not introduce risk to patient safety or their colleagues.

While ultimate accountability for risk management rests with the Board, responsibility is devolved to Board committees. Each Board Committee has a responsibility for effective risk management, and this is reflected in the Terms of Reference. While the Risk and Compliance Group confirm and challenge process to review all risks over the course of the year,

accountability for the risk management process and, and to ensure the trust has control, measures in place, is that of the Audit Committee.

Systems are in place to support risk management and patient safety which includes statutory and mandatory training, ongoing training on risk awareness and specific risk training for risk owners.

As Chief Executive, all executive directors report to me and the executive team is held to account for its performance through regular meetings with me and individual annual performance reviews. Some key aspects of executive portfolios have specific non-executive oversight as indicated in the table below.

Table 14: accountable roles

Role	Executive lead	Non-executive director lead
Counter Fraud	Chief Financial Officer	Andrew Van Doorn
Doctors in Difficulty	Chief Medical Officer	Professor Des Johnston
Emergency Planning	Chief Operating Officer	David Moss
End of Life	Chief Medical Officer	Dr Syed Mohinuddin
Equality and Diversity	Chief Nurse: Patients Director of HR & OD: Staff	Janet Rubin
Guardian of Safe Working	Chief Medical Officer	Dr Vineta Bhalla
Health and Safety	Director of Estates and Facilities	David Moss
Learning from avoidable/ preventable deaths	Chief Medical Officer	Dr Syed Mohinuddin
Maternity Services	Chief Nurse	Dr Vineta Bhalla
Patient safety	Chief Medical Officer and ChiefNurse	Dr Vineta Bhalla
Safeguarding adults	Chief Nurse	Trust Chair
Safeguarding children	Chief Nurse	Trust Chair
Whistleblowing/ Freedom to Speak Up	Director of HR & OD	Janet Rubin

In January 2022 our Trust Board approved the recommendations of NHS England and Improvement in the guidance issued in December 2021: Enhancing board oversight: a new approach to non-executive director champion roles. The recommendations as applied to the Trust will be implemented in 2022-23.

The risk and control framework

The Trust's Board Governance structure supports the assessment and assurance processes related to the key elements of Quality Governance and compliance with the CQC's regulatory requirements. The relevant executive sub groups report to the Trust Executive Management Group to provide information and assurance. The executive sub groups' remit includes performance, strategy and transformation. The Trust's corporate and clinical divisions report into the executive sub groups.

Risk to data security is managed through the Information Governance and Cyber Security Group (IGCSG), which is chaired by the Deputy Chief Executive who is the Trust's Senior Information Risk Owner

Actions arising from in-year inspections and reviews form a wider Trust improvement plan; the progress of which is monitored through executive operational groups and non-executive led assurance committees. The trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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.

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Risk Management

The Risk management policy and procedure, containing a risk strategy statement, is intended to foster a positive risk management culture to aid identifying risks to the organisation. The policy details how risks are identified, evaluated, and controlled and enables logical and systematic

methods to manage and control existing and potential risks in a way that is understood by all staff. This permits the Trust to minimise losses and maximise opportunities. Proactive risk assessment is through analysis of risk assessments; sector-wide intelligence and activity, and audit, while intelligence is also gathered from thematic analysis of incidents complaints, claims, internal and external inspections.

Risk management is supported by the use of a risk management system which is accessible to all staff to identify and report potential risk. This is maintained according to the principles and framework of the NHS Resolution Safety and Learning Service, the Care Quality Commission's Fundamental Standards and is aligned with the Care Quality Commission's Key Lines of Enquiry

Risk to data security is managed through the Information Governance and Cyber Security Group (KLOE), including the Well-Led Framework. This approach contributes towards achieving the aims of a learning organisation.

This register contains all operational and strategic risks with inbuilt divisional and department/ward levels. Additionally, the Trust has a robust system of incident identification and reporting for shared learning and to enhance good practice. Where serious incidents are identified these, and related action plans, are monitored and reviewed by the Serious Incident Review Group (SIRG) and are reported to the Trust Board.

Top operational risks rated at 15 and above, scored using the standard 5 by 5 matrix for measuring consequence and likelihood. Scoring of a risk will determine the level of assurance scrutiny a risk is subjected to and from which governance meetings confirmation and challenge will happen – which includes Board sub-committees.

As the main operational group accountable for risk management, the Trust Executive Group (TEG) ensures:

- Risks and hazards to patients, staff, carers, contractors, and visitors are reduced to as low a level as possible creating a safety culture throughout the Trust.
- There is a risk management culture at all levels across the Trust,
- There is clear and deliverable provision of risk awareness and management-training
- Maintain compliance with statutory and mandatory requirements and with professional regulations.
- Work in partnership with the NHS Resolution's (NHSR) Safety and Learning Service and ensure that Trust policy is based upon the NHSR best practice guidance.

The Trust has identified its strategic risks, and these are monitored and managed through the Board Assurance framework (BAF).

The Trust risk appetite, or level of risk the organisation is prepared to accept or tolerate was established and approved by the Board in 2021 and is subject to periodic review. The riskappetite statement is included in the Risk Management Policy and Procedure and sets clear expectations for staff about the management of risk by creating a common language and understanding. All strategic risks are aligned to the Trust goals and these are identified on the next page.

Table 15: risks and owners

Risk Title	Risk Owner
Goal 1: We want to be recognised for excellent care quality and patient experience	
Failure to meet pre-COVID-19 levels of elective activity	Chief Operating Officer
Patient safety associated with rising emergency admissions, impact on flow and unprecedented pressure across healthcare system	Chief Operating Officer
Risk associated with the lack of a robust patient experience and engagement agenda	Chief Medical Officer
Impact of COVID-19 pandemic on services	Chief Operating Officer
Risk arising from challenges ensuring consistently good outcomes to a complex high risk maternal population	Chief Nursing Officer
Goal 2: We want to engage with our staff to transform services to be excellent consistently	
Risk to staff wellbeing and associated staff engagement	Director of HR & OD
National issues associated with availability of trained staff	Director of HR & OD
Goal 3: We want to be a sustainable organisation that plays a positive and externally facing role and is the first choice for patients, staff, and partners.	
Risk associated with decommissioning of Specialist Services	Deputy Chief Executive Officer
Risk associated with development and delivery of sustainable financial & capital plan	Chief Financial Officer
NWL ICS leading strategic decision-making impacting Trust service provision and configuration	Deputy Chief Executive Officer

Review of economy, efficiency, and effectiveness of the use of resources – economic and internal audit narrative.

The Trust Board continues to focus on delivering strengthening value for money – improving the overall use of resources by the Trust –with Executive responsibility sitting with the Chief Financial Officer. The Board receives assurance on the use of resources through the Finance and Performance Committee. Key measures which are used by the Trust include delivery of financial performance against plan and understanding of the underlying deficit, and analysis of excess costs included in the cost base for the Trust, although the Committee looks at all aspects of financial performance.

The Trust's external auditors have undertaken a formal review of the use of resources at the Trust for the second year – this review has been considered and reviewed by the Trust Finance and Performance Committee, Trust Audit Committee and Trust Executive Group. This report provides the Trust with assurance on the adequacy of the arrangements in place to ensure economy, efficiency and effectiveness in the use of resources – but also highlights the key areas where continued focus is required, and additional challenge would support the Trust in improving value for money. The draft review by KPMG for the 2021-22 financial year notes that the Trust continues to make progress in strengthening the arrangements, noting the improved arrangements for financial management and internal governance (categorising these as having 'no significant risks' in the risk assessment). The report also highlights that there remains a significant risk around financial sustainability in the light of ambiguity around future funding arrangements, and the scale of the financial challenge facing the Trust, given the demands on the service, including a material cost improvement programme. The external audit report sets out some key recommendations; the Trust has accepted these and is working to agree the appropriate approach to implementation.

During the year, the Trust refreshed again the analysis of the Drivers of the Deficit, improving its understanding of the key areas of excess cost – and supporting the development and direction of the Transformation Programme. At the same time, the Trust worked with the North West London Integrated Care System and the Acute Programme Board to review the North West London underlying deficit and to move towards the development of a shared Financial Recovery Plan. With the Trust, work continued to strengthen the financial management and costing arrangements across the organisation, to ensure improved use of resources in 2021-22 and in future years. The Trust identified 'excess costs' of circa £50m in 2021-22 and has a programme of work in train to reduce these over a two to three year timescale, although further work is needed to implement these plans. The requirement to improve use of resources through a reduction in costs and improved value for money remains a key priority for the Trust, reflected in our forward plans, our strategy and our detailed objectives.

Roles of Committees

The formal committees of the Board are as follows:

- Appointments and Remuneration Committee
- Audit Committee
- Charitable Funds Committee
- Finance and Performance Committee
- Quality and Safety Committee
- People, Equality and Inclusion Committee

Board committees are chaired by nominated non-executive directors. The executive groups which report to the TEG are chaired by nominated executive directors and report upwards to provide assurance to the Board committees. All Board committees have a programme of work for the year.

The range of mechanisms available to provide assurance that systems are robust and effective include utilising internal and external audit reports, peer review assessments, management reporting, clinical audit, and the Board Assurance Framework (BAF).

Appointments and Remuneration Committee

This committee oversees the process of appointment, remuneration, suspension, termination and succession planning for all executive directors and other very senior manager that report directly to the Chief Executive. The committee also considers the recommendations for awards under the Clinical Excellence Awards Scheme to the Advisory Committee on Clinical Excellence Awards.

Audit Committee

The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the clinical and non-clinical activities that support the achievement of the organisation's objectives. The committee primarily utilises the work of the internal and external auditors and other assurance functions. It seeks reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control together with indicators of their effectiveness.

The Committee has monitored the Board Assurance Framework (including the practice of deep dives into areas of focus) and the Risk Register.

The committee has effective relationships with other committees as part of its integrated approach. The Committee receives regular reports on the work and findings of the internal and

external auditors (including considering the appointment and performance of the external auditors making recommendations to the Board when appropriate) and Local Counter Fraud Services.

Charitable Funds Committee

The Trust Board acts as Trustee to the London North West Healthcare Charitable Fund and has established a Charitable Funds Committee with delegated authority to manage the charitable funds on its behalf. The committee provides oversight, scrutiny and challenge to all aspects of the activities of the fund associated with the Trust and encourages cooperation and optimisation of the use and application of resources wherever practical. The committee ensures that charitable funds are managed and invested in accordance with the Charities Act and with the LNWH Standing Financial Instructions (SFIs).

Finance and Performance Committee

This committee is responsible for providing assurance to the Board of the Trust's financial and operational performance, and to oversee the Trust's performance management and accountability arrangements to support delivery of Trust objectives. It evaluates the development of the Trust's financial and performance strategy to deliver the service objectives as set out in the Annual Plan and to ensure delivery of financial and performance targets through a comprehensive financial and performance management control framework.

The committee provides assurance to the Trust Board that the financial strategy, financial policies and efficiency plans effectively support the organisational strategy and undertakes, on behalf of the Trust Board, objective scrutiny of the Trust's annual financial plans, long-term financial strategy, investment policy, estates strategy and major investment decisions, including those relating to the Trust's estate and information technology. The committee also gives consideration to the workforce implications of its financial plans. The committee scrutinises the development of the Trust's contractual regime including contract portfolios and contracting processes.

Quality and Safety Committee

The primary purpose of the committee is to support the Board in the objective scrutiny and challenge of all aspects of clinical safety, quality, patient experience, clinical effectiveness and outcomes, health and safety, security and fire management, and information governance.

The committee works closely with the Finance and Performance Committee to ensure there is no detrimental impact on the quality and safety of services because of financial and operational performance-related decisions and to ensure that related risks are regularly reviewed, updated and escalated to the Audit Committee as appropriate to the risk rating. The role of the committee is to provide assurance to the Audit Committee concerning the effective oversight and scrutiny of Trust risks in line with the Risk Management Strategy and Policy.

People, Equality and Inclusion Committee

The committee ensures the Trust has a robust and strategic approach to the recruitment and retention of staff, organisational development and learning and development, and oversees the Equality and Diversity and Health and Wellbeing agendas on behalf of the Trust Board. The committee will also seek assurance on the management of the relationship with staff side through the Joint Negotiation and Consultation Committee, JNCC to the People and Organisational Development Group.

The committee oversees the Transformation Programme work stream where it relates to workforce matters.

Information governance

Data protection incidents deemed severe enough by their nature or because they involve a large number of subjects are reported to the Information Commissioner's Office (ICO) within 72 hours of discovery. The mechanism for doing this is normally through the Data security and protection toolkit (DSPT). During 2021-22, there were two incidents reported via the DSPT, one of which was reported to the ICO. The ICO have not taken any further action on this case. In the 2021-22 financial year we received communication from the ICO regarding two complaints raised by data subjects of the Trust. One compliant related to a request from a data subject made under the right to rectification. The other complaint was made about the Trust's handling of their personal data. Neither compliant was upheld by the ICO.

Data quality and governance

The Trust primarily manages data quality risk and issues through a dedicated Data Quality Management Group (DQMG). This group includes digital services teams alongside corporate and operational managers and is chaired by the Deputy Chief Information Officer for Business Intelligence and Application Management. DQMG reviews compliance with the Trust Data Quality Policy and in response to reported issues, initiates activities involving data cleansing, audit and feedback to clinical and non-clinical teams.

DQMG is responsible for oversight of a rolling data quality assurance programme ensuring key elements of information reporting including data assurance, presentation and validation are delivered within national guidance and standards. DQMG reports through to the Information Governance and Cyber Security Group (IGCSG) chaired by the Deputy Chief Executive acting as the Trust's Senior Information Risk Owner.

DQMG links with other data management programmes including clinical coding, patient pathway management, and patient record data migration. The Trust routinely improves data quality through a regular programme of audit of its clinical coded data in line with data security standards. The Clinical Coding department also works closely with clinicians to ensure

the accuracy of coded data through regular and ad hoc joint reviews and through an education programme. Operational data quality is managed through various channels including the planned care board and there are a number of operational data quality reports designed to facilitate the validation of 18-week referral to treatment time (RTT) and cancer pathways through audit, review and education of both clinical and non-clinical teams. Data cleansing of patient records ahead of the planned migration to the Cerner EPR is managed by the Cerner programme team in close partnership with the Data Quality Team at the Trust.

Review of effectiveness

As Accountable 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 trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Quality and Safety Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has received summaries of the work of its committees during the year and a year-end summary. It receives the Board Assurance Framework monitors actions to address gaps in control and gaps in assurance and has also developed the Trust's risk appetite statement to inform the risk management strategy and policy.

The Audit Committee receives and reviews both internal and external audit reports and progress against actions, as well as updates from the local counter fraud specialist and the Trust executive team. For the period 2021-22 the Trust was assessed by the LCFS as having achieved a composite rating of 'green' overall for organisational compliance (accountable individual, senior engagement, strategy, risk assessment, policy and response plan, annual action plan, outcome-based metrics, reporting routes, report identified loss, trained investigators, access to training and gifts & hospitality). The LCFS carried out work against the functional standards requirements for governance and counter fraud bribery and corruption practices in line with an agreed programme – and these were reported to the Trust Audit Committee.

The Head of Internal Audit has provided me with an opinion for the 2021-22 financial year on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed during the year. The basis for forming their opinion is as follows:

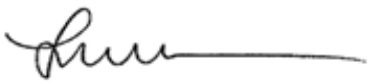
- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

- An assessment of the range of individual opinions arising from risk based audit assignments contained within internal audit risk based plans that have been reported throughout the year;
- This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- Any reliance that is being placed upon third party assurances.

The Head of Internal Audit opinion provides moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. Moderate assurance is the second highest assurance rating.

Conclusion

In conclusion, as Accountable Officer, my review of the effectiveness of the system of internal control has identified no significant control issues.



Pippa Nightingale MBE

Chief Executive
May 2022

Remuneration and staff report

Remuneration policy

The purpose of the pay policy is to:

- support the recruitment, retention and motivation of talented and high performing leaders
- secure value for money for the Trust and its stakeholders.

The remuneration package will normally consist of salary and pension contribution. There will be no other element unless specifically approved by the Remuneration Committee. The committee will set and review the level of salary to ensure it is competitive and fair for the role, taking account of:

- information about the market rate for jobs of similar type in NHS trusts of broadly comparable size and challenge
- evidence of recruitment difficulty and retention risk
- assessment of the contribution and track record of the individual.

This salary setting and review will be informed by market data from the NHS (and other sources where relevant), and every third year by independent external advice.

The committee will seek advice and recommendations from the Chief Executive on the salary of directors and other Very Senior Managers (VSMs). The Chief Executive will have no role in setting her/his own salary.

There is no standard provision for performance related pay. However, the committee reserves the right to award bonus payments for exceptional achievement.

The expense payments (taxable) relates to reimbursement of mileage costs at the applicable NHS mileage rate which is in excess of the HMRC rate per mile.

No additional benefits will become receivable by the individuals listed in the event that they retire early.

There will also be regular and annual reviews of performance against plans and agreed objectives. In the case of directors, these will be conducted by the Chief Executive, informed by discussion with the committee. In the case of the Chief Executive, the reviews will be led by the Chair of the Trust, informed by discussion with the committee and other stakeholders. For Very Senior Managers (VSMs), these will be held by the appropriate executive director.

Remuneration Report

for Year Ended 31st March 2022 (Unaudited)

			A	B	C	D	E	F
			Salary	Expense Payments (taxable)*	Performance pay and bonuses	Long term performance pay and bonuses	All pension - related benefits	TOTAL
			(bands of £5000)	(nearest £100)	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
			£000	£	£000	£000	£000	£000
Executive directors								
Bown	Chris	Chief Executive (to 31/03/22)	220-225	2,600	15-20		Notes 1 and 3	240-245
Nightingale MBE	Philippa	Chief Executive (from 14/02/22)	25-30				Notes 2 and 3	25-30
Reid	Jonathan	Chief Financial Officer	180-185				Notes 1 and 4	180-185
Pullinger	Ellis	Chief Operating Officer (to 13/03/22)	155-160				47.5-50	200-205
Walters	James	Chief Operating Officer (from 14/03/22)	5-10				Note 5	5-10
Knight MBE	Lisa	Chief Nurse	155-160				55-57.5	215-220
Kuper	Martin	Chief Medical Officer (to 31/08/21)	80-85		20-25		Note 1	105-110
Baker	Jon	Interim Chief Medical Officer (from 01/09/21)	140-145		0-5		Note 6	140-145
Gore	Claire	Director of Human Resources and Organisational Development	170-175				72.5-75	245-250

Crawford	Simon	Director of Strategy and Deputy Chief Executive Officer	195-200				Note 1	195-200
Searle	David	Director of Corporate Affairs	85-90				Notes 1 and 7	85-90
Trumper	Mark	Director of Estates and Facilities (left 31/01/22)	120-125		15-20		Note 1	135-140
Non-executive Directors								
Morse	Lord Amyas	Chairman	45-50	0	0	0	Note 8	45-50
Rubin	Janet	Non-Executive Director	15-20					15-20
Van Doorn	Andrew	Non-Executive Director	10-15					10-15
Bhalla	Vinetta	Non-Executive Director	10-15					10-15
Moss	David	Non-Executive Director	10-15					10-15
Manuel	Neville	Non-Executive Director	10-15					10-15
Johnston	Desmond	Non-Executive Director	0	0	0	0	0	0
Taube	David	Non-Executive Director	1-5					1-5
Mohinuddin	Dr Syed	Non-Executive Director (from 01/07/21. Associated Non-Executive Director to 30/06/21).	10-15					10-15
As'ad	Huda	Associate Non-Executive Director	10-15					10-15
Peter	Kingsley	Associate Non-Executive Director	10-15					10-15

Note 1: The following directors chose not to be covered by the pension arrangements during the reporting year:- Chris Bown; Jonathan Reid; Simon Crawford and; David Searle.
The following directors chose not to be covered by the pension arrangements during the reporting year up to the date that they left:- Martin Kuper and; Mark Trumper.
Note 2: No pension disclosure was requested for Philippa Nightingale MBE as her start date was after the deadline for requesting this from NHS Pensions (NHSP).
Note 3: There was an overlap between Philippa Nightingale MBE commencing as Chief Executive on 14/02/2022 and Chris Brown ending as Chief Executive on 31/03/2022.
Note 4: Current year pension disclosure received from NHSP for Jonathan Reid was marked as N/A. Accordingly no annual movements have been disclosed as these will be negative.
Note 5: No pension disclosure was requested for James Walters as his start date was after the deadline for requesting this from NHSP.
Note 6: Previous year pension amounts received from NHSP for Jon Baker were marked as N/A. Accordingly no annual movements have been disclosed as these are misleading.
Note 7: From April 2021 to July 2021 David Searle held the position of Director of Corporate Affairs of the Trust. From August 2021 his directorship extended to cover Hillingdon Hospitals NHS Foundation Trust. His total salary for all of the current year for both directorships fell in the £135,000 - £140,000 salary banding, of which banding of £85,000 to £90,000 is attributable to the Trust.
Note 8: From April 2021 Lord Morse held the position of Chair both of the Trust and Hillingdon Hospitals NHS Foundation Trust. His total salary for all of the current year for both directorships fell in the £85,000 - £90,000 salary banding, of which banding of £45,000 to £50,000 is attributable to the Trust. Note 9: Simon Crawford's salary includes payment of approx. £9,183 as payment in lieu for annual leave not taken and Claire Gore's salary includes £4,095 payment in lieu for annual leave not taken.

Prior Year Remuneration Report

for Year Ended 31st March 2021 (Audited)

			A	B	C	D	E	F
			Salary	Expense Payments (taxable)*	Performance pay and bonuses	Long term performance pay and bonuses	All pension - related benefits	TOTAL
			(bands of £5000)	(nearest £100)	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
			£000	£	£000	£000	£000	£000
Executive directors								
Bown	Chris	Chief Executive (from 30/03/20)	230-235	1,000	10-15			240-245
Reid	Jonathan	Chief Financial Officer (from 01/04/20)	180-185				87.5-90	270-275
Pullinger	Ellis	Chief Operating Officer (from 01/04/20)	160-165		5-10		17.5-20	180-185
Knight MBE	Lisa	Chief Nurse	160-165		5-10		125-127.5	290-295
Kuper	Martin	Chief Medical Officer	205-210		25-30			235-240
Gore	Claire	Director of Human Resources and Organisational Development	160-165		10-15		37.5-40	210-215
Crawford	Simon	Director of Strategy and Deputy Chief Executive Officer	180-185					180-185
Searle	David	Director of Corporate Affairs	125-130					125-130

Trumper	Mark	Director of Estates and Facilities	150-155		15-20			165-170
Non-executive Directors								
Morse	Lord Amyas	Chairman	30-35					30-35
Rubin	Janet	Non-Executive Director	10-15					10-15
Van Doorn	Andrew	Non-Executive Director	10-15					10-15
Bhalla	Vinetta	Non-Executive Director	10-15					10-15
Moss	David	Non-Executive Director	10-15					10-15
Manuel	Neville	Non-Executive Director	10-15					10-15
Johnston	Desmond	Non-Executive Director	5-10					5-10
Taube	David	Non-Executive Director	10-15					10-15
As'ad	Huda	Associate Non-Executive Director (from 01/02/21)	0-5					0-5
Peter	Kingsley	Associate Non-Executive Director (from 01/02/21)	0-5					0-5
Mohinuddin	Dr Syed	Associate Non-Executive Director (from 01/02/21)	0-5					0-5

The figures for 2020/21 were obtained from the NHS Pensions Agency before the 2020/21 1.03% pay award for staff had been implemented and therefore the pension benefits disclosed above do not include the effect of this pay award.

Pension Report

for Year Ended 31st March 2022 (Unaudited)

			Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31st March 2022	Lump sum at age 60 related to accrued pension at 31st March 2022	Cash Equivalent Transfer Value at 31st March 2022	Cash Equivalent Transfer Value at 31st March 2021	Real Increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
			(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				
			£000	£000	£000	£000	£000	£000	£000	£000
Executive directors										
Bown	Chris	Chief Executive (to 31/03/22).	0	0	0	0	0	0	0	0
Nightingale	Philippa	Chief Executive (from 14/02/22). Note 1.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Reid	Jonathan	Chief Financial Officer (from 01/04/20). Note 2.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pullinger	Ellis	Chief Operating Officer (to 13/03/22)	2.5-5	0-2.5	40-45	65-70	663	602	36	0
Walters	James	Chief Operating Officer (from 14/03/22). Note 3.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Knight MBE	Lisa	Chief Nurse	2.5-5	0-2.5	70-75	155-160	1,384	1,291	64	0
Kuper	Martin	Chief Medical Officer (to 31/08/21)	0	0	0	0	0	0	0	0
Gore	Claire	Director of Human Resources and Organisational Development	2.5-5	0	15-20	0	281	209	56	0

Crawford	Simon	Director of Strategy and Deputy Chief Executive Officer	0	0	0	0	0	0	0	0
Searle	David	Director of Corporate Affairs	0	0	0	0	0	0	0	0
Trumper	Mark	Director of Estates and Facilities	0	0	0	0	0	0	0	0
Baker	Jon	Interim Chief Medical Officer (from 01/09/21). Note 4.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

As non-executive members do not receive pensionable remuneration, there is no disclosure in respect of pensions.

The following directors chose not to be covered by the pension arrangements during the reporting year:- Chris Bown; Jonathan Reid; Simon Crawford and; David Searle.
The following directors chose not to be covered by the pension arrangements during the reporting year up to the date that they left:- Martin Kuper and; Mark Trumper.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement.

(This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Note 1: No pension disclosure was requested for Philippa Nightingale as her start date was after the deadline for requesting this from NHSP.
Note 2: Current year pension disclosure received from NHSP for Jonathan Reid was marked as N/A. Accordingly no annual movements have been disclosed as these will be negative.
Note 3: No pension disclosure was requested for James Walters as his start date was after the deadline for requesting this from NHS Pensions (NHSP).
Note 4: Previous year pension amounts received from NHSP for Jon Baker were marked as N/A. Accordingly no annual movements have been disclosed as these are misleading.

Prior Year Pension Report

Pension report for year ended
31 March 2021 (Audited)

			Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31st March 2021	Lump sum at age 60 related to accrued pension at 31st March 2021	Cash Equivalent Transfer Value at 31st March 2021	Cash Equivalent Transfer Value at 31st March 2020	Real Increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
			(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				
			£000	£000	£000	£000	£000	£000	£000	£000
Executive directors										
Bown	Chris	Chief Executive (from 30/03/20)	0	0	0	0	0	0	0	0
Reid	Jonathan	Chief Financial Officer (from 01/04/20)	5 - 7.5	5 - 7.5	30 - 35	45 - 50	480	384	65	0
Pullinger	Ellis	Chief Operating Officer (from 01/04/20)	0 - 2.5	0	35 - 40	60 - 65	602	560	11	0
Knight MBE	Lisa	Chief Nurse	5 - 7.5	10 - 12.5	65 - 70	150 - 155	1,291	1,125	126	0

Kuper	Martin	Chief Medical Officer	0	0	0	0	0	1,280	0	0
Gore	Claire	Director of Human Resources and Organisational Development	2.5 - 5	0	10 - 15	0	209	160	24	0
Crawford	Simon	Director of Strategy and Deputy Chief Executive Officer	0	0	0	0	0	0	0	0
Searle	David	Director of Corporate Affairs	0	0	0	0	0	0	0	0
Trumper	Mark	Director of Estates and Facilities	0	0	0	0	0	0	0	0

The figures for 2020/21 were obtained from the NHS Pensions Agency before the 2020/21 1.03% pay award for staff had been implemented and therefore the pension benefits disclosed above do not include the effect of this pay award.

As non-executive members do not receive pensionable remuneration, there is no disclosure in respect of pensions.

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

Fair pay disclosure

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration in their organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in London North West Healthcare in the financial year 2021-22 was £240-245k (£240k-£245k in 2020-21). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay ratio information table

(Subject to audit)

2021-22			
Total remuneration (£)	26,447	36,066	50,682
Salary component of total remuneration (£)	26,447	36,066	50,682
Pay ratio information	9.17	6.72	4.78
2020-21	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	25,676	34,354	47,693
Salary component of total remuneration (£)	25,676	34,354	47,693
Pay ratio information	9.44	7.06	5.08

Remuneration	Highest paid director £	Average of workforce £
2022 Salary & allowances	226,736	42,033
2021 Salary & allowances	231,441	44,008
Percentage Change	-2.03%	-4.49%

2022 Performance pay & bonuses	16,557	-
2021 Performance pay & bonuses	11,000	-
Percentage Change	50.52%	

All the pay ratios tabled above, other than the highest paid director's performance pay and bonus, have slightly decreased to a similar extent between the financial years' 2020-21 to 2021-22. The only change to the composition of the workforce in the financial year 2021-22 was the TUPE transfer of 490 staff in July 2021, in relation to the transfer of the community services.

In 2021-22, two (2020-21: two) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £247 to £254,632 (2020-21 £585 to £251,065).

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

Fair pay disclosure

2021/22 (Unaudited)

	2021/22
Band of Highest Paid Director Remuneration (£'000)	240-245
Median Total £	£36,076.36
Ratio	6.81

Reporting bodies are required to disclose the relationship between the salary of the most highly-paid individual in their organisation and the median earnings of the organisation's workforce.

The banded remuneration of the highest paid director in London North West Healthcare in the financial year 2021-22 was 240-245 (240-245 in 2020/21). This was 6.81 (7.06 in 2020/21) times the median salary of the workforce, which was £36,076.36 (£34,353.95 in 2020/21).

In 2021-22 two employees received remuneration in excess of the highest paid director.

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

Fair pay disclosure

2021/22 (Audited)

	2020/21
Band of Highest Paid Director Remuneration (£'000)	240-245
Median Total £	£34,353.95
Ratio	7.06
Reporting bodies are required to disclose the relationship between the salary of the most highly-paid individual in their organisation and the median earnings of the organisation's workforce.	
The banded remuneration of the highest paid director in London North West Healthcare in the financial year 2020-21 was 240k-245 (250-255 in 2019/20). This was 7.06 (7.08 in 2019/20) times the median salary of the workforce, which was 30-35 (35-40 in 2019/20).	
In 2020-21 two employees received remuneration in excess of the highest paid director.	
Total remuneration includes salary, non consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.	

Staff costs

2021/22 (Unaudited)

	Perm anent £000	Other £000	Total £000
Salaries and wages	399,898	-	**399,898**
Social security costs	45,032	-	**45,032**
Apprenticeship levy	2,020	-	**2,020**
Employer's contributions to NHS pension scheme	60,814	-	**60,814**
Pension cost - other	44	-	**44**
Other post employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	29	-	**29**
Temporary staff	-	17,395	**17,395**
Total gross staff costs	**507,837**	**17,395**	**525,232**
Recoveries in respect of seconded staff	(3,731)	-	(3,731)
Total staff costs	**504,106**	**17,395**	**521,501**
Of which			
Costs capitalised as part of assets	1,508	3,764	**5,272**

Average number of employees

(WTE bases) 2021/22 (Unaduited)

	Permanent Number	Other Number	Total Number
Medical and dental	1,376	168	**1,544**
Ambulance staff	-	-	**-**
Administration and estates	1,542	197	**1,739**
Healthcare assistants and other support staff	1,233	226	**1,459**
Nursing, midwifery and health visiting staff	2,556	426	**2,982**
Nursing, midwifery and health visiting learners	1	-	**1**
Scientific, therapeutic and technical staff	790	45	**835**
Healthcare science staff	22	-	**22**
Social care staff	-	-	**-**
Other	-	-	**-**
Total average numbers	**7,520**	**1,062**	**8,582**
Of which:			
Number of employees (WTE) engaged on capital projects	-	-	-

Staff composition 2021/22	No	%
Female	6,074	74.20%
Male	2,110	25.80%

Board composition 2021/22	No	%
Female	6	33.30%
Male	12	66.70%

Staff turnover	%
Turnover 21/22	12.2%

Staff costs

2021/22 (Audited)

	Permanent £000	Other £000	Total £000
Salaries and wages	411,261	-	**411,261**
Social security costs	43,079	-	**43,079**
Apprenticeship levy	1,944	-	**1,944**
Employer's contributions to NHS pension scheme	60,886	-	**60,886**
Pension cost - other	39	-	**39**
Other post employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	130	-	**130**
Temporary staff	-	8,863	**8,863**
Total gross staff costs	**517,339**	**8,863**	**526,202**
Recoveries in respect of seconded staff	-	(3,942)	**(3,942)**
Total staff costs	**517,339**	**4,921**	**522,260**
Of which			
Costs capitalised as part of assets	535	288	**823**

Average number of employees (WTE basis) 2020/21 (Audited)

	Permanent Number	Other Number	Total Number
Medical and dental	1,336	163	**1,499**
Ambulance staff	-	-	**-**
Administration and estates	1,559	140	**1,699**
Healthcare assistants and other support staff	1,248	197	**1,445**
Nursing, midwifery, and health visiting staff	2,647	377	**3,024**
Nursing, midwifery, and health visiting learners	3	-	**3**
Scientific, therapeutic, and technical staff	873	41	**914**
Healthcare science staff	18	-	**18**
Social care staff	-	-	**-**
Other	-	-	**-**
Total average numbers	**7,684**	**918**	**8,602**
Of which:			
Number of employees (WTE) engaged on capital projects	-	-	-

Staff composition 2020/21	No	%
Female	6,417	74.80%
Male	2,167	25.20%

Board composition 2020/21	No	%
Female	5	23.80%
Male	16	76.20%

Staff turnover	%
Turnover 20/21	9.91%

Exit packages

2021/22 (Unaudited)

	Number of compulsory redundancies Number	Cost of compulsory redundancies £	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £
Exit package cost band (incl. any special payment element)								
<£10,000	1	9,214	5	18,615	6	27,829		
£10,000 - £25,000	1	15,669			1	15,669		
£25,001 - 50,000	1	49,516			1	49,516		
£50,001 - £100,000								
£100,000 - £150,000	2	236,164			2	236,164		
Totals	**5**	**310,563**	**5**	**18,615**	**10**	**329,178**	**-**	**-**

Analysis of Other Departures

2021/22 (Unaudited)

	Number of Other departures	Total value of Other departures £
Voluntary redundancies incl. early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	5	18,615
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval		
Totals	**5**	**18,615**

Exit packages

2020/21 (Audited)

	Number of compulsory redundancies Number	Cost of compulsory redundancies £	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £
Exit package cost band (incl. any special payment element)								
<£10,000			5	17,999	5	17,999		
£10,000 - £25,000	1	35,207			1	35,207		
£25,001 - 50,000	2	151,295	4	266,107	6	417,402		
£50,001 - £100,000	1	128,900			1	128,900		
Totals	**4**	**315,412**	**12**	**330,821**	**16**	**646,223**	**-**	**-**

Analysis of Other Departures

2020/21 (Audited)

	Agreements Number	Total value of agreements £
Voluntary redundancies incl. early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	4	266,107
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	8	64,714
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
Totals	**12**	**330,821**

Sickness absence data

Sickness absence data may be accessed via the following link for NHS Digital publications:

Read more about NHS Sickness Absence Rates at digital.nhs.uk >

Staff policies

Staff policies for Equality, Diversity and Inclusion, Disability in Employment and Sickness Absence are in place and have been applied during the financial year:

- for giving full and fair consideration to applications for employment by the Trust made by disabled persons, having regard to their particular aptitudes and abilities
- for continuing the employment of, and for arranging appropriate training for, employees of the Trust who have become disabled persons during the period when they were employed by the Trust
- otherwise for the training, career development and promotion of disabled persons employed by the Trust.

Table of figures

Glossary of terms

A

A&E: Accident and Emergency

AHP: Allied Health Professional - One of several professional healthcare roles in the NHS which are not nursing, doctor or pharmacist roles.

B

BAF: Board Assurance Framework - brings together in one place all the relevant information on the risks to the board's strategic objectives.

C

CCG: Clinical Commissioning Group - NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CEO: Chief Executive

Commissioning: Commissioning is the process of planning, agreeing and monitoring services. This can range from assessing the health needs of a population, to designing patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

CMH: Central Middlesex Hospital

CRF: Clinical Research Facility - a purpose- built environment for volunteers and patients taking part in early-phase clinical trials and other experimental medicine research projects.

E

ED: Emergency Department – also known as Accident and Emergency (A & E).

H

Healthwatch: the independent champion for people who use health and social care services. There is a local Healthwatch in every area of England.

I

ICU: intensive care unit

ICS: Integrated care system: new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

L

LNWH: London North West University Healthcare NHS Trust

LTC: Long-term conditions: defined as a condition that cannot, be cured but can be controlled by medication and other therapies.

N

NED: Non-Executive Director.

NHSI: NHS Improvement - responsible for overseeing NHS trusts, NHS foundation trusts and independent providers.

NICE: National Institute for Health and Care ¬Excellence - working to improve outcomes for people using the NHS and other public health and social care services.

NPH: Northwick Park Hospital

O

Ockenden Report: Emerging findings and recommendations from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust

P

PALS: Patient Advice and Liaison Service - offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.

PPE: personal protective equipment such as goggles and masks.

R

R&D: Research

S

SDEC: Same Day Emergency Care - one of the many ways the NHS is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.

Independent auditor's report and annual accounts

Independent Auditor's Report to the board of Directors of London North West University Healthcare NHS Trust

Report on the audit of the financial statements

Opinion

We have audited the financial statements of London North West University Healthcare NHS Trust ("the Trust") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion, except for the possible effects solely on the comparative information for the year ended 31 March 2021 of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included.

Basis for qualified opinion

We were appointed as auditors of the Trust on 1 September 2020 and, therefore, we were unable to observe the counting of the physical inventory as at 31 March 2020. With respect to inventory having a carrying amount of £11.356m as at 31 March 2020 the audit evidence available to us in support of this balance was limited and we were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities by using other audit procedures. Any adjustments would have a consequential effect on the Trust's income and expenditure for the year ended 31 March 2021. The audit opinion on the Trust's financial statements for the years ended 31 March 2020 and 31 March 2021 were qualified with regard to a similar limitation.

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

Going concern

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

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

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

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

- Enquiring of management, the Audit Committee and internal audit as to the Trust's highlevel policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve statutory break-even duties and control totals delegated to the Trust by NHS Improvement.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries.

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

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year and deferred income at year end not being significant. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual income, expenditure and cash account combinations and other high risk criteria.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Identifying income and expenditure invoices recognised in the period 1 March 2021 to 31 May 2021, to assess whether the income and expenditure is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties by agreeing to the supporting evidence such as invoice description, goods received note and cash transaction per the bank statement.
- Agreeing a sample of year end accruals to relevant supporting documents and evidence, including invoices received after year end.

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

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

from inspection of the Trust's regulatory correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

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

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

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

The Trust is subject to laws and regulations that directly affect the financial statements including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

We are also required to make a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 if we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

As outlined in the section of this report dealing with other legal and regulatory matters, we made a Section 30 referral to the Secretary of State on 13 May 2022.

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

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

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

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

Other information in the Annual Report

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

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

- we have not identified material misstatements in the other information;
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and
- In our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on pages 64 and 65, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 66 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website:

Read more about our auditors responsibilities at frc.org.uk >

Report on other legal and regulatory matters

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

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

We have nothing to report in this respect.

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

As explained in the statement set out on page 66, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied 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 have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

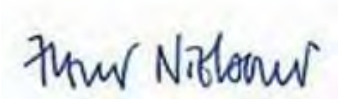
On 13 May 2022 we wrote to the Secretary of State in accordance with Section 30(1)(a) of the Local Audit and Accountability Act 2014 in respect of the Trust's breach of its "breakeven duty" as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 and taking into account the Department of Health and Social Care's Guidance on Breakeven Duty and Provisions. At the date of our referral the Trust's reported financial position at 31 March 2022 was a cumulative deficit of £325.6m.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Board of Directors of London North West University Healthcare NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of completion of the audit

We certify that we have completed the audit of the accounts of London North West University Healthcare NHS Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Fleur Nieboer
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL
22 June 2022

London North West University Healthcare NHS Trust

Annual accounts for the year ended 31 March 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	785,541	705,086
Other operating income	4	79,252	129,946
Operating expenses	6, 8	(847,985)	(822,195)
Operating surplus from continuing operations		**16,808**	**12,837**
Finance income	11	87	-
Finance expenses	12	(6,070)	(6,227)
PDC dividends payable		(10,532)	(8,296)
Net finance costs		**(16,515)**	**(14,523)**
Other gains / (losses)	13	(528)	(376)
Deficit for the year from continuing operations		**(235)**	**(2,062)**
Deficit for the year		**(235)**	**(2,062)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(997)	(12,224)
Revaluations	18	14,027	1,283
Total comprehensive income / (expense) for the period		**12,795**	**(13,003)**

Explanatory note - Adjusted financial performance for Department of Health and Social Care (DHSC) purposes

The Trust made a retained deficit for the year of £235k. For the purposes of measuring the Trust's financial performance and its performance under the break-even duty as defined by the Department of Health and Social Care, the Trust made an adjusted surplus for the year of £305k. For 2020/21 the equivalent adjusted surplus was £1.372m. This is explained fully in the financxial summary section of the Annual Report. This explanatory note does not form part of the Statement of Comprehensive Income and represents a note to the accounts.

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	15	26,230	23,009
Property, plant and equipment	16	474,062	442,918
Receivables	20	2,173	1,723
Total non-current assets		**502,465**	**467,650**
Current assets			
Inventories	19	8,131	11,705
Receivables	20	23,945	57,485
Cash and cash equivalents	21	70,435	8,094
Total current assets		**102,511**	**77,284**
Current liabilities			
Trade and other payables	22	(122,431)	(86,100)
Borrowings	24	(2,328)	(2,086)
Provisions	27	(1,179)	(2,091)
Other liabilities	23	(12,273)	(9,160)
Total current liabilities		**(138,211)**	**(99,437)**
Total assets less current liabilities		**466,765**	**445,497**
Non-current liabilities			
Trade and other payables	22	-	-
Borrowings	24	(45,109)	(47,181)
Other financial liabilities	23	-	-
Provisions	27	(7,641)	(7,201)
Other liabilities	23	-	-
Total non-current liabilities		**(52,750)**	**(54,382)**
Total assets employed		**414,015**	**391,115**
Financed by			
Public dividend capital		783,842	773,737
Revaluation reserve		30,258	17,228
Income and expenditure reserve		(400,085)	(399,850)
Total taxpayers' equity		**414,015**	**391,115**

The notes on pages 122 to 163 form part of these accounts.

Name	Philippa Nightingale	Jonathan Reid
Position	Chief Executive Officer	Chief Financial Officer
Date	22nd June 2022	22nd June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**773,737**	**17,228**	**(399,850)**	**391,115**
Surplus/(deficit) for the year	-	-	(235)	**(235)**
Impairments	-	(997)	-	**(997)**
Revaluations	-	14,027	-	**14,027**
Public dividend capital received	10,105	-	-	**10,105**
Taxpayers' and others' equity at 31 March 2022	**783,842**	**30,258**	**(400,085)**	**414,015**

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	**376,255**	**28,169**	**(397,788)**	**6,636**
Surplus/(deficit) for the year	-	-	(2,062)	**(2,062)**
Impairments	-	(12,224)	-	**(12,224)**
Revaluations	-	1,283	-	**1,283**
Public dividend capital received*	397,482	-	-	**397,482**
Taxpayers' and others' equity at 31 March 2021	**773,737**	**17,228**	**(399,850)**	**391,115**

*In 2020/21 the Trust received £339.7m PDC capital from the Department of Health and Social Care as part of a national exercise to convert NHS Trusts' interim working capital loans and interim capital loans outstanding as at 31 March 2020 to PDC capital. In addition during the year the Trust received £57.9m PDC capital to finance capital investment in the year.

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		16,808	12,837
Non-cash income and expense:			
Depreciation and amortisation	6.1	25,215	22,938
Net impairments	7	8,501	5,902
Income recognised in respect of capital donations	4	(9,942)	(1,866)
(Increase) / decrease in receivables and other assets		31,867	(2,482)
(Increase) / decrease in inventories		3,574	(349)
Increase in payables and other liabilities		36,372	10,402
Increase / (decrease) in provisions		(374)	2,225
Net cash flows from operating activities		**112,021**	**49,607**
Cash flows from investing activities			
Interest received		87	-
Purchase and sale of financial assets / investments		134	-
Purchase of intangible assets		(6,977)	(12,765)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(45,663)	(71,302)
Receipt of cash donations to purchase assets		12	116
Net cash flows (used in) investing activities		**(52,407)**	**(83,951)**
Cash flows from financing activities			
Public dividend capital received		10,105	397,482
Movement on loans from DHSC		(136)	(339,854)
Other capital receipts		9,930	-
Capital element of finance lease rental payments		(223)	(201)
Capital element of PFI, LIFT and other service concession payments		(1,473)	(1,526)
Interest on loans		(17)	(1,308)
Interest paid on finance lease liabilities		(32)	(49)
Interest paid on PFI, LIFT and other service concession obligations		(6,118)	(6,238)
PDC dividend (paid) / refunded		(9,309)	(9,595)
Net cash flows from financing activities		**2,727**	**38,711**
Increase in cash and cash equivalents		**62,341**	**4,367**
Cash and cash equivalents at 1 April - brought forward		**8,094**	**3,727**
Cash and cash equivalents at 31 March	21	**70,435**	**8,094**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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 2021/22 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 financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. For the financial year commencing 1 April 2022, the Trust's plan is for a deficit of £6.6m on income and expenditure after meeting a planned efficiency requirement of £30m. This planned deficit is driven by specific increased costs, particularly utility costs, which are not being met by inflationary uplifts in contract income. The four Acute Trusts in North West London have adopted a common approach to this financial risk, which will be kept under review in the coming year. This plan is subject to local approval by the North West London Sector Integrated Care System and national approval by NHS England and Improvement (NHSE&I). In the event the Trust's income and expenditure performance is worse than plan, the Trust may require deficit financing for the financial year 2022/23. NHSE&I has supported the Trust's applications for cash deficit support in 2017/18, 2018/19 and 2019/20 and therefore the Board of Directors anticipates that NHSE&I would continue to support the Trust's application for deficit financing support in 2022/23 subject to the normal application approval process.

In the 2020/21 financial year and again during 2021/22 the Trust, in common with other acute NHS Trusts, suspended elective patient activity at certain times in order to increase clinical capacity for the treatment of patients with the Covid-19 coronavirus. The financial impact of the pandemic on the Trust's financial position continued throughout 2021/22 and the DHSC continued the temporary funding arrangements for NHS Trusts first introduced in 2020 in 2021/22 to address this financial impact. These temporary funding arrangements involved the suspension of the Payment By Results (PbR) tariff regime and its replacement with a system of block contract payments from local CCGs. These block contract payments from local commissioners were supplemented with top-up income payments from a local commissioner in 2021/22.

At the time these financial statements were prepared the DHSC had confirmed that the temporary funding arrangements - the block contract payments from local and the top-up payments - would be subject to some change in 2022/23 with a higher proportion of income subject to clinical operational performance.

As directed by the 2021/22 Department of Health and Social Care Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. Therefore the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 was completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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.

The timing of payment for goods/services provided by the Trust is dependent on the satisfaction of performance obligations and also credit terms and therefore debtor contract balances at year end will reflect this timing difference between the provision of goods/services and payment for them.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a 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 also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.
In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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

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

Where the Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from NHS education and training contracts

The Trust receives revenue from Health Education England for the provision of education and training services for medical, dental and nursing trainees. This income is credited to the accounting period in which the corresponding expenditure on these services is charged in accordance with the matching principle.

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, notification has been received from the Department of Work and Pension's Compensation Recovery Unit, the Trust has completed the NHS2 form and has 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, currently at 23.76%. Last year's expected credit losses rate was 22.43%.

Revenue grants and other contributions to expenditure

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

Provider sustainability fund (PSF), Financial recovery fund (FRF) and Elective Recovery Fund (ERF)

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

Note 1.4 Other forms of income

Sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Grants and donations

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

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.
Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full valuation every four years and an accounting valuation every year.

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement
Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties 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 meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

The Trust engaged Cushman and Wakefield, an external independent body who are RICS qualified practitioners, to carry out a full 5 year revaluation of the Trust's land and buildings including dwellings in 2019/20 and commissioned them to undertake an annual 'desk-top' valuation for 2021/22. The total valuation of the Trust's land and buildings including dwellings as at 31st March 2022 is £393.3m (31st March 2021: £363.7m).

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition. The criteria in IFRS 15 are set out below:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.
The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.
The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income. An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract. The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	60
Dwellings	42	42
Plant & machinery	5	15
Information technology	5	10
Furniture & fittings	5	15

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

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

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. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met.

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

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	5	10

Note 1.9 Inventories

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

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 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 1.11 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. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

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 were reviewed as at 31st March 2022 for expected credit losses. Non NHS receivables are adjusted for credit losses based on amounts due greater than 90 days. Other receivables, such as Overseas Visitors Income, are assessed each year end to determine the level of credit losses attributable.

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 1.12 Leases

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

The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.13 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 from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	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 from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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 27.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, 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 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.
A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.16 Value added tax

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

Note 1.17 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 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 1.19 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 1.20 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 1.21 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS or local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net [gain / loss] corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

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

In 2021/22 the Trust transferred all remaining adult and paediatric community services to Central London Community Healthcare NHS Trust and Central and North West London NHS Foundation Trust. The annual income attributable to these services was approx £34.9m. The effective date for the transfer of services was 1st August 2021.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.23 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 without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The 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:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	2,787
Additional lease obligations recognised for existing operating leases	-
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**2,787**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(833)
Additional finance costs on lease liabilities	(21)
Lease rentals no longer charged to operating expenditure	853
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(1)**
Estimated increase in capital additions for new leases commencing in 2022/23	**250**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

Note 1.24 Critical judgements in applying accounting policies

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

Non-material

Following Treasury's agreement to apply IFRS 10 to NHS Charities from 1 April 2013, London North West University Healthcare has established that as the Trust is the corporate Trustee of the London North West Healthcare Charitable Fund, charity number 1083634, it effectively has the power to exercise control so as to obtain economic benefits.

Total income received by the Charity during the period 1st April 2021 to 31st March 2022 was £0.67m which is less than 0.1% of London North West University Healthcare NHS Trust's income. There were no substantive legacies or grant income received during this period.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need to be satisfied if the information is not material and is reiterated in the DHSC Group Accounting Manual 2021/22.

In line with IAS 1, the London North West Charitable Funds are *not* consolidated into London North West University Healthcare Trust accounts on the grounds of materiality.

Material

Assets relating to land and buildings were subject to a formal valuation as at 31st March 2020, completed on an "alternate modern equivalent asset" basis. An existing use value alternative was used which assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service provision as the existing asset. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area than the existing asset which reflects the challenges healthcare providers face when utilising historical NHS Estate). Under the Trust's alternative modern equivalent asset valuation, the modern alternative hospitals are of the same service potential and in the same locations but on a smaller physical footprint to serve the catchment area of population. The Trust commissioned a 'desktop' valuation of its land and buildings as at 31st March 2022 updating the last formal valuation carried out as at 31st March 2020. The results of the 'desktop' valuation are included in these accounts.

The methodology adopted meets the requirements of International Accounting Standards (IAS) 16; Property, Plant and Equipment and does not deviate from the principles therein.

The Trust has used this valuation in its 202/22 accounts. The impact of the assessment of the Trust's estate is an overall increase in the valuation as at 31st March 2022 and will result in a depreciation profile that is a more accurate reflection of the useful economic life of the land and buildings.

Note 1.25 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:

Land and buildings.

The freehold and lease hold properties comprising the Trust operation estate were valued at 31 March 2022 by an external valuer, Cushman & Wakefield, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS valuation - Global Standard (July 2017 edition), the international valuation standard and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM) and the DHSC Group Accounting Manual. The valuation of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in-use properties reported on an Existing Use Value basis.

The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercised his professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation.

A reduction in the estimated values would result in reductions to the Revaluation Reserve and / or a loss recorded as appropriate in the Statement of Comprehensive Income. Conversely, an increase in estimated valuations would result in an increase to the Revaluation Reserve and / or reversals of previous negative revaluations to the Statement of Comprehensive Income.

Note 1.26 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the liofe of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 2 Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations, as all policies, procedures and governance arrangements are Trust-wide. As an NHS Trust, all services are subject to the same regulatory environment and standards. Accordingly, the Trust operates as one segment.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Block contract / system envelope income	734,700	653,432
High cost drugs income from commissioners (excluding pass-through costs)	5,626	1,981
Other NHS clinical income	2,151	14,637
Private patient income	1,330	947
Elective recovery fund	7,709	-
Additional pension contribution central funding*	18,559	18,523
Other clinical income	15,466	15,566
Total income from activities	**785,541**	**705,086**

*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.The cost of the additional employer contributions in 2021/22 was £18.559m and the corresponding income from NHS England of £18.559m have both been recognised in these accounts.

In 2021/22 the Trust transferred all remaining adult and paediatric community services to Central London Community Healthcare NHS Trust and Central and North West London NHS Foundation Trust. The annual income attributable to these services was approx £34.9m. The effectve date for the transfer of services was 1st August 2021.

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	132,080	139,836
Clinical commissioning groups	635,253	547,718
Department of Health and Social Care	-	-
Other NHS providers	1,410	1,018
NHS other	-	-
Local authorities	9,183	9,884
Non-NHS: private patients	1,330	947
Non-NHS: overseas patients (chargeable to patient)	4,716	4,198
Injury cost recovery scheme	316	509
Non NHS: other	1,253	976
Total income from activities	**785,541**	**705,086**
Of which:		
Related to continuing operations	785,541	705,086
Related to discontinued operations	-	-

Income from patient care activities includes non-recurring funding of £14.2m (2020/21: £25.8m) from NHS England and Clinical Commissioning Groups (CCGs) towards both the costs and the loss of elective income incurred by the Trust as a result of the Covid-19 pandemic.

Income from patient care activities also includes £18.559m income from NHS England in respect of the additional pensions contributions paid on the Trust's behalf and included in staff costs within Operating expenses.

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

	2021/22	2020/21
	£000	£000
Income recognised this year	4,716	4,198
Cash payments received in-year	1,184	766
Amounts added to provision for impairment of receivables	-	2,054
Amounts written off in-year	1,082	955

Note 4 Other operating income	**2021/22**			**2020/21**		
	Contract income	**Non-contract income**	**Total**	**Contract income**	**Non-contract income**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Research and development	3,680	-	**3,680**	3,025	-	**3,025**
Education and training	28,302	-	**28,302**	26,594	-	**26,594**
Non-patient care services to other bodies	2,612		**2,612**	2,912		**2,912**
Reimbursement and top up funding	9,428		**9,428**	72,095		**72,095**
Income in respect of employee benefits accounted on a gross basis	-		**-**	-		**-**
Receipt of capital grants and donations		9,942	**9,942**		1,866	**1,866**
Charitable and other contributions to expenditure		2,341	**2,341**		8,575	**8,575**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**
Rental revenue from operating leases		12,314	**12,314**		11,637	**11,637**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income	10,633	-	**10,633**	3,242	-	**3,242**
Total other operating income	**54,655**	**24,597**	**79,252**	**107,868**	**22,078**	**129,946**
Of which:						
Related to continuing operations			79,252			129,946
Related to discontinued operations			-			-

Receipt of capital grants and donations in 2021/22 includes £9.93m received from the Public Sector Decarbonisation Scheme for the installation of energy saving plant and equipment.

Other income includes funding for various projects in addition to income for corporate and estate services provided to third party organisations.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue (charged) / recognised in the reporting period that was included in within contract liabilities at the previous period end	(3,113)	1,629
Revenue (charged) / recognised from performance obligations satisfied (or partially satisfied) in previous periods		

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	11,386	3,144
Purchase of social care	-	-
Staff and executive directors costs	516,200	519,940
Remuneration of non-executive directors	170	162
Supplies and services - clinical (excluding drugs costs)	92,468	82,292
Supplies and services - general	33,355	34,114
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	70,271	64,067
Inventories written down	547	679
Consultancy costs	170	-
Establishment	7,761	6,779
Premises	30,413	26,966
Transport (including patient travel)	10,478	9,430
Depreciation on property, plant and equipment	21,528	19,672
Amortisation on intangible assets	3,687	3,266
Net impairments	8,501	5,902
Movement in credit loss allowance: contract receivables / contract assets	4,494	3,932
Audit services- statutory audit	100	86
Other auditor remuneration (external auditor only)	15	15
Internal audit costs	80	75
Clinical negligence	22,267	18,474
Legal fees	481	387
Insurance	516	544
Research and development	722	739
Education and training	2,390	1,936
Rentals under operating leases	4,308	4,406
Early retirements	-	-
Redundancy	29	1,397
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,839	1,794
Car parking & security	1,239	1,632
Hospitality	127	52
Losses, ex gratia & special payments	-	132
Other	2,443	10,181
Total	**847,985**	**822,195**
Of which:		
Related to continuing operations	847,985	822,195
Related to discontinued operations	-	-

Other expenditure in 2021/22 includes £1.9m on IT systems and £0.5m on interpreting services. Other expenditure in 2020/21 includes expenditure on IT systems £4.8m, professional fees and project management £4.1m and subscriptions £1.1m.

Note 6.2 Other auditor remuneration

There was no remuneration paid to the external auditor for non-audit services.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £166k (2020/21: £151k).

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Other	8,501	5,902
Total net impairments charged to operating surplus / deficit	**8,501**	**5,902**
Impairments charged to the revaluation reserve	997	12,224
Total net impairments	**9,498**	**18,126**

The details of the valuation of the Trust's land, buildings and dwellings as at 31 March 2022 are provided in Note 18.

Note 8 Employee benefits

	2021/22	2020/21
	Total	Total
	£000	£000
Salaries and wages	399,898	411,261
Social security costs	45,032	43,079
Apprenticeship levy	2,020	1,944
Employer's contributions to NHS pensions	60,814	60,886
Pension cost - other	44	39
Termination benefits	29	130
Temporary staff (including agency)	17,395	8,863
Total gross staff costs	**525,232**	**526,202**
Recoveries in respect of seconded staff	(3,731)	(3,942)
Total staff costs	**521,501**	**522,260**
Of which		
Costs capitalised as part of assets	5,272	823

Note 8.1 Retirements due to ill-health

During 2021/22 there were 4 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £238k (0k in 2020/21).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Other pension schemes: National Employment Savings Scheme (NEST)

In accordance with pensions auto-enrolment legislation, the Trust automatically enrols employees who do not qualify for the NHS Pensions scheme into the National Employment Savings Trust (NEST). The Trust makes a contribution of 3% of employee pensionable pay into the NEST scheme and the employee makes a contribution of 4% of pensionable pay. This cost is included in operating expenses. The government contributes the equivalent of 1% of qualifying earnings to the scheme.

Note 10 Operating leases

Note 10.1 London North West University Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where London North West University Healthcare NHS Trust is the lessor.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	12,314	11,637
Total	**12,314**	**11,637**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	12,314	11,637
- later than one year and not later than five years;	5,745	-
- later than five years.	2,122	-
Total	**20,181**	**11,637**

Note 10.2 London North West University Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where London North West University Healthcare NHS Trust is the lessee.

London North West University Healthcare NHS Trust has entered operating leases as lessee for land, buildings, equipment, cars and printers for various lease terms.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	4,308	4,406
Total	**4,308**	**4,406**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	6,927	4,389
- later than one year and not later than five years;	3,591	6,006
- later than five years.	27	1
Total	**10,545**	**10,396**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	87	-
Total finance income	**87**	**-**

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	17	22
Finance leases	32	49
Main finance costs on PFI and LIFT schemes obligations	3,357	3,461
Contingent finance costs on PFI and LIFT scheme obligations	2,762	2,776
Total interest expense	**6,168**	**6,308**
Unwinding of discount on provisions	(98)	(81)
Other finance costs	-	-
Total finance costs	**6,070**	**6,227**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22	2020/21
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	133	-
Losses on disposal of assets	(661)	(376)
Total gains / (losses) on disposal of assets	**(528)**	**(376)**
Total other gains / (losses)	**(528)**	**(376)**

The Trust disposed of costs previously capitalised within Assets Under Construction totalling £661k in 2021/22 and £376k in 2020/21.

Note 14 Discontinued operations

London North West University Healthcare NHS Trust had no discontinued operations in 2021/22.

Note 15.1 Intangible assets - 2021/22

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**34,606**	**9,649**	**44,255**
Transfers by absorption	-	-	**-**
Additions	161	6,816	**6,977**
Reclassifications	(2,611)	(676)	**(3,287)**
Valuation / gross cost at 31 March 2022	**32,156**	**15,789**	**47,945**
Amortisation at 1 April 2021 - brought forward	**21,246**	**-**	**21,246**
Provided during the year	3,687	-	**3,687**
Reclassifications	(3,218)	-	**(3,218)**
Amortisation at 31 March 2022	**21,715**	**-**	**21,715**
Net book value at 31 March 2022	**10,441**	**15,789**	**26,230**
Net book value at 1 April 2021	**13,360**	**9,649**	**23,009**

Note 15.2 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**32,101**	**1,505**	**33,606**
Additions	3,116	9,649	**12,765**
Reclassifications	(611)	(1,505)	**(2,116)**
Valuation / gross cost at 31 March 2021	**34,606**	**9,649**	**44,255**
Amortisation at 1 April 2020 - as previously stated	**17,980**	**-**	**17,980**
Prior period adjustments	-	-	**-**
Amortisation at 1 April 2020 - restated	**17,980**	**-**	**17,980**
Provided during the year	3,266	-	**3,266**
Amortisation at 31 March 2021	**21,246**	**-**	**21,246**
Net book value at 31 March 2021	**13,360**	**9,649**	**23,009**
Net book value at 1 April 2020	**14,121**	**1,505**	**15,626**

Note 16.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**31,068**	**327,626**	**4,962**	**29,131**	**128,834**	**70,383**	**5,726**	**597,730**
Additions	-	17,337	-	27,850	3,104	251	193	**48,735**
Impairments	-	(18,974)	(234)	-	-	-	-	**(19,208)**
Revaluations	2,911	10,564	552	-	-	-	-	**14,027**
Reclassifications	-	17,456	-	(24,238)	5,972	(2,587)	30	**(3,367)**
Disposals / derecognition	-	-	-	(661)	-	-	-	**(661)**
Valuation/gross cost at 31 March 2022	**33,979**	**354,009**	**5,280**	**32,082**	**137,910**	**68,047**	**5,949**	**637,256**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**96,697**	**52,926**	**5,189**	**154,812**
Provided during the year	-	9,592	118	-	7,176	4,475	167	**21,528**
Impairments	-	(9,592)	(118)	-	-	-	-	**(9,710)**
Reclassifications	-	-	-	-	-	(3,436)	-	**(3,436)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**103,873**	**53,965**	**5,356**	**163,194**
Net book value at 31 March 2022	**33,979**	**354,009**	**5,280**	**32,082**	**34,037**	**14,082**	**593**	**474,062**
Net book value at 1 April 2021	**31,068**	**327,626**	**4,962**	**29,131**	**32,137**	**17,457**	**537**	**442,918**

The details of the valuation of the Trust's land, buildings and dwellings as at 31 March 2022 are provided in Note 18.

Note 16.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**31,068**	**335,329**	**4,865**	**5,170**	**116,633**	**57,771**	**5,614**	**556,450**
Additions	-	16,155	-	28,965	12,201	8,498	112	**65,931**
Impairments	-	(27,569)	(105)	-	-	-	-	**(27,674)**
Revaluations	-	1,081	202	-	-	-	-	**1,283**
Reclassifications	-	2,630	-	(4,628)	-	4,114	-	**2,116**
Disposals / derecognition	-	-	-	(376)	-	-	-	**(376)**
Valuation/gross cost at 31 March 2021	**31,068**	**327,626**	**4,962**	**29,131**	**128,834**	**70,383**	**5,726**	**597,730**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**-**	**-**	**-**	**90,396**	**49,369**	**4,923**	**144,688**
Provided during the year	-	9,432	116	-	6,301	3,557	266	**19,672**
Impairments	-	(9,432)	(116)	-	-	-	-	**(9,548)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**96,697**	**52,926**	**5,189**	**154,812**
Net book value at 31 March 2021	**31,068**	**327,626**	**4,962**	**29,131**	**32,137**	**17,457**	**537**	**442,918**
Net book value at 1 April 2020	**31,068**	**335,329**	**4,865**	**5,170**	**26,237**	**8,402**	**691**	**411,762**

Note 16.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	33,979	278,244	5,280	22,152	32,368	13,959	533	**386,515**
Finance leased	-	-	-	-	99	-	-	**99**
On-SoFP PFI contracts and other service concession arrangements	-	63,802	-	-	-	-	-	**63,802**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	11,963	-	9,930	1,570	123	60	**23,646**
NBV total at 31 March 2022	**33,979**	**354,009**	**5,280**	**32,082**	**34,037**	**14,082**	**593**	**474,062**

Note 16.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	31,068	243,690	4,962	29,131	30,062	17,213	464	**356,590**
Finance leased	-	-	-	-	198	-	-	**198**
On-SoFP PFI contracts and other service concession arrangements	-	71,432	-	-	-	-	-	**71,432**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	12,504	-	-	1,877	244	73	**14,698**
NBV total at 31 March 2021	**31,068**	**327,626**	**4,962**	**29,131**	**32,137**	**17,457**	**537**	**442,918**

Note 17 Donations of property, plant and equipment

In 2021/22 the Trust received a £12k donation from the London North West Healthcare Charity to purchase an item of medical equipment which is accounted as a donated asset in accordance with the accounting treatment prescribed by DHSC. This value is included in Other non contract operating income (Note 4). This income is removed from the financial performance for the year to arrive at the adjusted retained deficit.

Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued at 31 March 2022 by the Trust's appointed valuers, Cushman and Wakefield, applying the Modern Equivalent Valuation methodology for the valuation. The total value of Land, Buildings and Dwellings as at 31st March 2022 per the valuation is £393.3m.

In 2021/22 the Trust commissioned an independent valuer, Cushman and Wakefield, to undertake a desktop valuation of the Trust's land and buildings. The overall impact of the revaluation is to increase the value of land and buildings as at 31st March 2022 by £4.5m, comprising an upward revaluation of £14m for land and some buildings which is credited to the revaluation reserve and an impairment in respect of a reduction of other buildings of £9.5m. The impairment relates to necessary capital expenditure to renew infrastructure and re-configure and improve clinical facilities including enhancing capacity for the treatment of Covid-19 patients which does not result in a commensurate increase in the buildings' values under the applicable valuation methodology. For buildings where the balance on the revaluation reserve is sufficient to offset the impairment, £1m of the impairment has been charged to the revaluation reserve. For buildings where the balance of the revaluation reserve is not sufficient to offset the impairment, £8.5m has been charged to operating expenses within the Statement of Comprehensive Income (SoCI). This impairment charge of £8.5m in operating expenses is excluded by the Department of Health and Social Care when measuring the Trust's financial performance and therefore it is removed from the adjusted financial performance in the explanatory note below the Statement of Comprehensive Income.

Within the total values as at 31st March 2022, £34m related to land valued at open market value and £5.3m related to dwellings valued at open market value.

The fair value of Buildings excluding Dwellings as at 31st March 2022 is £354m.

The valuation was undertaken by surveyors who were suitably experienced and qualified members of the Royal Institute of Chartered Surveyors.

The valuation was carried out in accordance with the RICS Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury.

Note 19 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	4,296	4,684
Consumables	3,695	6,937
Energy	140	84
Total inventories	**8,131**	**11,705**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £76,242k (2020/21: £70,584k). Write-down of inventories recognised as expenses for the year were £547k (2020/21: £679k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £2,341k of items purchased by DHSC (2020/21: £8,575k).

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

Note 20.1 Receivables

	31 March 2022	31 March 2021
	£000	£000
Current		
Contract receivables	28,165	35,476
Allowance for impaired contract receivables / assets	(15,413)	(12,150)
Prepayments (non-PFI)	5,895	27,166
PDC dividend receivable	970	2,193
VAT receivable	4,328	4,800
Total current receivables	**23,945**	**57,485**
Non-current		
Other receivables	2,173	1,723
Total non-current receivables	**2,173**	**1,723**
Of which receivable from NHS and DHSC group bodies:		
Current	14,453	23,045
Non-current	2,173	1,723

In March 2021 the Trust made prepayments for 2021/22 PAYE to HM Revenue and Customs of approx. £21.3m and these are included in the Prepayments (non-PFI) comparative total above. In March 2022 the Trust did not make any prepayments to HM Revenue and Customs.

Note 20.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**12,150**	**9,264**
New allowances arising	4,494	3,932
Utilisation of allowances (write offs)	(1,231)	(1,046)
Allowances as at 31 Mar 2022	**15,413**	**12,150**

Note 20.3 Exposure to credit risk

The Trust has low exposure to credit risk because the majority of the Trust's revenue comes from contracts with other public sector bodies. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**8,094**	**3,727**
Net change in year	62,341	4,367
At 31 March	**70,435**	**8,094**
Broken down into:		
Cash at commercial banks and in hand	107	45
Cash with the Government Banking Service	70,328	8,049
Total cash and cash equivalents as in SoFP	**70,435**	**8,094**
Total cash and cash equivalents as in SoCF	**70,435**	**8,094**

Note 21.2 Third party assets held by the Trust

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

	31 March 2022	31 March 2021
	£000	£000
Bank balances	4	4
Total third party assets	**4**	**4**

Note 22.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	33,761	22,058
Capital payables	10,259	7,187
Accruals	46,079	26,050
Receipts in advance and payments on account	285	268
Social security costs	6,606	175
Other payables	25,441	30,362
Total current trade and other payables	**122,431**	**86,100**
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	10,377	11,322
Non-current	-	-

Note 22.2 Early retirements in NHS payables above

There are no early retirements included in NHS payables above.

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	12,273	9,160
Total other current liabilities	**12,273**	**9,160**
Total other non-current liabilities	**-**	**-**

Note 24.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	136	136
Obligations under finance leases	254	477
Obligations under PFI, LIFT or other service concession contracts	1,938	1,473
Total current borrowings	**2,328**	**2,086**
Non-current		
Loans from DHSC	321	457
Obligations under PFI, LIFT or other service concession contracts	44,788	46,724
Total non-current borrowings	**45,109**	**47,181**

Note 24.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**593**	**477**	**48,197**	**49,267**
Cash movements:				
Financing cash flows - payments and receipts of principal	(136)	(223)	(1,473)	**(1,832)**
Financing cash flows - payments of interest	(17)	(32)	(3,355)	**(3,404)**
Non-cash movements:				
Application of effective interest rate	17	32	3,357	**3,406**
Carrying value at 31 March 2022	**457**	**254**	**46,726**	**47,437**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**341,733**	**678**	**49,724**	**392,135**
Cash movements:				
Financing cash flows - payments and receipts of principal	(339,854)	(201)	(1,526)	**(341,581)**
Financing cash flows - payments of interest	(1,308)	(49)	(3,462)	**(4,819)**
Non-cash movements:				
Application of effective interest rate	22	49	3,461	**3,532**
Carrying value at 31 March 2021	**593**	**477**	**48,197**	**49,267**

On 3 April 2020, NHS England and Improvement announced that all DH interim revenue and DH interim capital loans of NHS Trusts outstanding as at 31 March 2020 will be repaid and the equivalent amount issued to the Trust as Public Dividend Capital (PDC) in 2020/21. Public Dividend Capital represents the Secretary of State's equity in the Trust and is not repayable. Therefore all the Trust's DH interim revenue and DH interim capital loans which totalled £339.7m as at 31 March 2020 were repaid and replaced by £339.7m of newly issued Public Dividend Capital in August 2020.

Note 25 Other financial liabilities

The Trust has no Other financial liabilities.

Note 26 Finance leases

Note 26.1 London North West University Healthcare NHS Trust as a lessor

The Trust has no finance leases in which it is the lessor.

Note 26.2 London North West University Healthcare NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**267**	**522**
of which liabilities are due:		
- not later than one year;	267	255
- later than one year and not later than five years;	-	267
- later than five years.	-	-
Finance charges allocated to future periods	(13)	(45)
Net lease liabilities	**254**	**477**
of which payable:		
- not later than one year;	254	477
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as expense in the period	-	-

The finance leases relate mainly to leases of clinical equipment.

Note 27.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2021	**608**	**5,169**	**499**	**658**	**406**	**1,952**	**9,292**
Transfers by absorption	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	**-**
Arising during the year	51	358	96	-	393	2,174	**3,072**
Utilised during the year	(96)	(219)	-	-	(206)	-	**(521)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	**-**
Reversed unused	(1)	-	(342)	(658)	(200)	(1,724)	**(2,925)**
Unwinding of discount	(10)	(88)	-	-	-	-	**(98)**
At 31 March 2022	**552**	**5,220**	**253**	**-**	**393**	**2,402**	**8,820**
Expected timing of cash flows:							
- not later than one year;	79	225	253	-	393	229	**1,179**
- later than one year and not later than five years;	321	917	-	-	-	-	**1,238**
- later than five years.	152	4,078	-	-	-	2,173	**6,403**
Total	**552**	**5,220**	**253**	**-**	**393**	**2,402**	**8,820**

The Pensions early departure cost relates to pension payments for staff retiring early through ill health. These figures are provided by the NHS Pensions Authority. The discount rate for pensions relating to other staff is -1.3% in line with HM Treasury and Department of Health guidelines. Settlements of these claims are determined using statistics provided by The Office of National Statistics (ONS).

Legal Claims refer to Public and employers liability claims and also provisions in relation to ongoing employment cases. The value of these claims will be subject to the relevant judgements or subsequent settlements made by employment tribunals.

The redundancy provision relates to potential management redundancies.

Note 27.2 Clinical negligence liabilities

At 31 March 2022, £529,541k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London North West University Healthcare NHS Trust (31 March 2021: £324,779k).

Note 28 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(34)	(42)
Gross value of contingent liabilities	**(34)**	**(42)**
Net value of contingent liabilities	**(34)**	**(42)**
Net value of contingent assets	**-**	**-**

Note 29 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	8,570	6,706
Total	**8,570**	**6,706**

Note 30 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

Note 31 On-SoFP PFI, LIFT or other service concession arrangements

Under the PFI contract, which ends on 16 March 2036, the Trust's PFI provider ByCentral Limited has constructed the Brent Emergency Care and Diagnostic (BECaD) building on the site of Central Middlesex Hospital and provides facilities management for existing and new premises for the duration of the contract. At the conclusion of the contract, ownership of the asset will revert to the Trust. Under IFRIC 12, the asset is treated as an asset of the Trust and is included in the Statement of Financial Position.

Note 31.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2022	31 March 2021
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**74,359**	**79,189**
Of which liabilities are due		
- not later than one year;	5,182	4,830
- later than one year and not later than five years;	21,078	21,111
- later than five years.	48,099	53,248
Finance charges allocated to future periods	(27,633)	(30,992)
Net PFI, LIFT or other service concession arrangement obligation	**46,726**	**48,197**
- not later than one year;	1,938	1,473
- later than one year and not later than five years;	9,677	9,062
- later than five years.	35,111	37,662

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022	31 March 2021
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**105,388**	**112,057**
Of which payments are due:		
- not later than one year;	7,067	6,669
- later than one year and not later than five years;	29,101	28,939
- later than five years.	69,220	76,449

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**12,164**	**11,999**
Consisting of:		
- Interest charge	3,357	3,461
- Repayment of balance sheet obligation	1,473	1,526
- Service element and other charges to operating expenditure	1,839	1,794
- Capital lifecycle maintenance	2,733	2,442
- Contingent rent	2,762	2,776
Total amount paid to service concession operator	**12,164**	**11,999**

Note 32 Financial instruments

Note 32.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Trust has a continuing service provider relationship with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, and therefore the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. For the financial year commencing 1 April 2021, the Trust has submitted a plan to NHS England and Improvement for a deficit of £415m, after receiving planned Provider Sustainability Funding (PSF) of £40m. The plan requires additional cash support through PDC revenue financing.

Note 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	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	12,740	-	-	**12,740**
Cash and cash equivalents	70,435	-	-	**70,435**
Total at 31 March 2022	**83,175**	**-**	**-**	**83,175**

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	25,049	-	-	**25,049**
Cash and cash equivalents	8,094	-	-	**8,094**
Total at 31 March 2021	**33,143**	**-**	**-**	**33,143**

Note 32.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	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	457	-	**457**
Obligations under finance leases	254	-	**254**
Obligations under PFI, LIFT and other service concession contracts	46,726	-	**46,726**
Trade and other payables excluding non financial liabilities	113,181	-	**113,181**
Total at 31 March 2022	**160,618**	**-**	**160,618**

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	593	-	**593**
Obligations under finance leases	477	-	**477**
Obligations under PFI, LIFT and other service concession contracts	48,197	-	**48,197**
Trade and other payables excluding non financial liabilities	67,755	-	**67,755**
Total at 31 March 2021	**117,022**	**-**	**117,022**

Note 32.4 Maturity of financial liabilities

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

	31 March 2022	31 March 2021
	£000	£000
In one year or less	119,021	21,323
In more than one year but not more than five years	21,400	42,761
In more than five years	48,099	83,977
Total	**188,520**	**148,061**

Note 32.5 Fair values of financial assets and liabilities

Financial assets and financial liabilities are held at amortised cost. The difference between carrying value and fair value is immaterial.

Note 33 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	273	1,185	176	1,054
Stores losses and damage to property	112	646	13	679
Total losses	**385**	**1,831**	**189**	**1,733**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	100
Ex-gratia payments	52	284	44	32
Total special payments	**52**	**284**	**45**	**132**
Total losses and special payments	**437**	**2,115**	**234**	**1,865**
Compensation payments received		-		-

The bad debts and claims abandoned relates to debts recognised in previous financial years which have been written off as they were considered non-recoverable following the conclusion of recovery processes. The Trust had set aside provisions in these previous financial years for these debts before writing them off in 2021/22.

Note 34 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with London North West University Healthcare NHS Trust.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year the Trust has had a significant number of material transactions with the DHSC, and with other entities for which the DHSC is regarded as the parent Department.

The significant transactions were with NHS North West London CCG, Health Education England and NHS England.

The Hillingdon Hospital NHS Foundation Trust

The Chairman of the Trust, Lord Amyas Morse, was also Chairman of the The Hillingdon Hospitals NHS Foundation Trust during the 2021/22 financial year. The Trust accounted for income and expenditure with The Hillingdon Hospitals NHS Foundation Trust in 2021/22 and therefore it is disclosed as a related party. In 2021/22 the Trust accounted for expenditure of £163k and income of £1,055k with The Hillingdon Hospitals NHS Foundation Trust and the balances at year end were as follows:

	31st March 2022 £000
Debtor - amounts owed by The Hillingdon Hospitals NHS Foundation Trust	742
Creditor - amounts owed to The Hillingdon Hospitals NHS Foundation Trust	-544

London North West Healthcare Charity

Members of the Trust board are also Trustees are also of the London North West Healthcare Charity. The Trust received revenue of £126k in the year from the London North West Healthcare Charity in 2021/22. The amounts due or to be paid at the end of the financial year are as follows:

	31st March 2022 £000
Debtor - amounts owed by London North West Healthcare Charity	0
Creditor - amounts owed to London North West Healthcare Charity	-7

Imperial College Health Partners (ICHP)

The Deputy Chief Executive of the Trust, Simon Crawford, is a member of the Audit Committee of Imperial College Health Partners (ICHP). The Trust made payments for services to ICHP totalling £281k in 2021/22.

Brunel University

A Non-Executive Director of the Trust, Dr Vineta Bhalla, is vice chair of Brunel University. The Trust made payments for services to Brunel University totalling £1k in 2021/22.

Deloitte LLP

A Non-Executive Director of the Trust, Dr Vineta Bhalla, is a clinical lead for Deloitte LLP. The Trust made payments for services to Deloitte LLP totalling £42k in 2021/22.

Note 35 Events after the reporting date

The Trust is negotiating the transfer of five properties to West London NHS Trust. The total net book value of the properties is £19.7m comprising £6.8m for the land and £12.9m for the buildings. The objective of the transfer is to align the ownership of the properties with the responsibility of the clinical services provided in the properties in accordance with the strategy of the North West London Integrated Care System. The estimated annual income of the properties is approx. £3m. The Trust is in discussions with West London NHS Trust and the North West London Integrated Care system to ensure the net revenue impact of the transfer is neutral. The proposed effective date for the transfer of services is 1st April 2022.

Note 36 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	121,768	462,216	103,855	451,619
Total non-NHS trade invoices paid within target	112,599	450,600	91,090	434,041
Percentage of non-NHS trade invoices paid within target	92.5%	97.5%	87.7%	96.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,994	15,460	3,668	14,809
Total NHS trade invoices paid within target	2,684	14,638	3,080	14,123
Percentage of NHS trade invoices paid within target	89.6%	94.7%	84.0%	95.4%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 37 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2021/22 £000	2020/21 £000
Cash flow financing	(44,138)	51,534
Finance leases taken out in year	-	-
Other capital receipts	(9,930)	
External financing requirement	**(54,068)**	**51,534**
External financing limit (EFL)	(54,068)	51,535
Under / (over) spend against EFL	**-**	**1**

Note 38 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	55,712	78,696
Less: Disposals	(661)	(376)
Less: Donated and granted capital additions	(9,942)	(1,866)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**45,109**	**76,454**
Capital Resource Limit	45,358	76,638
Under / (over) spend against CRL	**249**	**184**

Note 39 Breakeven duty financial performance

	2021/22 £000	2020/21 £000
Adjusted financial performance surplus (control total basis)	305	1,372
Breakeven duty financial performance surplus	**305**	**1,372**

Note 40 Breakeven duty rolling assessment

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(88,245)	(61,098)	(38,597)	(20,998)	(93,429)	1,372	305
Breakeven duty cumulative position	(113,180)	(174,278)	(212,875)	(233,873)	(327,302)	(325,930)	(325,625)
Operating income	666,125	681,059	701,443	729,022	703,256	835,032	864,793
Cumulative breakeven position as a percentage of operating income	(17.0%)	(25.6%)	(30.3%)	(32.1%)	(46.5%)	(39.0%)	(37.7%)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, London North West University Healthcare NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

Although the Trust earned an adjusted surplus in 2021/22 it has not met its breakeven duty in relation to the rolling assesment period because of the deficits incurred in previous years.

The Trust is a full member of NHS North West London and is working in partnership with the wider Integrated Care System - the Trust's clinical and financial strategy for the future should be seen in the context of working as an integral part of a wider system, rather than as an isolated and unsustainable organisation. The NWL ICS is determined to improve the health and well-being of the local population through a proactive model of care which will reduce the costs of meeting the care needs of the local population, enabling the system to move towards financial as well as clinical sustainability.

In 2019, the Trust commissioned a review of the 'Drivers of the Deficit.' This was updated in 2020, and helps drive the actions that the Trust is taking in partnership to move towards in-year financial sustainability. The Trust achieved small surpluses in 2020/21 and in 2021/22. Recovery of the cumulative deficit is not covered by the Trust or the existing system recovery plans however, the Trust is working with the NWL Acute Collaborative and the Integrated Care System to develop a system deficit recovery plan, and remains committed to achieving financial and clinical sustainability.

Annual Report
2021-22