The Hillingdon Hospitals NHS Foundation Trust

Annual Report and Accounts 2021/2022

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1. Performance Report

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

1.1 Foreword

The year covered by this annual report, 2021/22, was another unusual year for the Trust. We experienced continued disruption to several of our business as usual activities as a result of the ongoing Covid-19 pandemic. Clear learnings were taken from each wave of infection, and processes implemented to ensure we continued to deliver high quality care to the best of our ability.

The adaptability and resilience demonstrated by our workforce in response to these challenges has been remarkable and I would like to take a moment to acknowledge their extraordinary contribution to the safety of our local communities.

Despite these challenges, slow and steady progress was made against core objectives during the year. Appointments were made to a number of key senior posts, and the Trust also delivered a highly successful international nurse recruitment programme.

Other notable achievements during the year included: the implementation of Patient Initiated Follow Up (PIFU), with the Trust's performance used an exemplar for the region; introduction of the UK's first custom built electric ambulance; the opening of two new modular buildings, constructed as part of the Trust's decant programme; delivery of improvements to facilities in ICU, respiratory care, and paediatrics; several awards for our catering, facilities and sustainability services; and the successful decant of numerous departments in preparation for plans to build a new hospital on the Hillingdon site.

Throughout the pandemic the Trust has carried on caring for patients, delivering babies – 4,077 were born at Hillingdon Hospital - and treating 355,959 outpatients in our clinics.

The adaptability and resilience demonstrated by our workforce in response to challenges has been remarkable and we would like to take a moment to acknowledge their extraordinary contribution to the safety of our local communities.

Inevitably, some aspects of the Trust's performance have been impacted by the ongoing Covid-19 pandemic and the resulting pressures placed on NHS resources. We have found that necessary changes to patient pathways, pressures on staffing, and periods that

necessitated suspension of elective activity, have affected our ability to deliver against some objectives in the last financial year.

In particular, the necessary suspension of elective activity as part of the pandemic response has resulted in significantly reduced performance against the 18-week Referral to Treatment constitutional standard, which was at 59.7% for 2021/22 compared with 76.3% in 2019/20, and the cancer standard for two-week wait from referral for symptomatic breast patients, which was at 59.9% in 2021/22 compared with 90.8% in 2019/20.

However, year on year improvements have been seen in the number of patients waiting for treatment due to targeted activity to help reduce backlogs. The initial focus was on reducing the number of patients waiting over 104 weeks, which had been brought down to zero by end of March 2022, from a starting point of 58 patients as of September 2021. Elective recovery continues to be a priority for the Trust as we move into 2022/23.

Good progress has also been made against many of the issues raised during the Care Quality Commission's (CQC) last full inspection in 2018, and the specific licence conditions that were imposed by the CQC following their focused inspection in August 2020, were removed in October of 2021.

Following an assessment against the Strategic Oversight Framework (SOF), the Hillingdon Hospitals NHS Foundation Trust was placed into segment four of the regime in August 2021 and was given access to the NHS Recovery Support Programme. The NHS is working collaboratively with our Trust and partners across the North West London ICS to understand the root causes of the challenges we face, to deliver a mandatory package of support to the Trust and to oversee the implementation of a clear improvement plan that will enable us to exit the programme in a sustainable way.

In response to the significant risk posed by the continued deterioration of the Trust's estate, we have developed an ambitious plan to build a new hospital on the Hillingdon site, which is referenced later in this report. This forms part of the government's commitment to building 40 new hospitals by 2030 through the national New Hospital Programme.

Following ministerial approval of the Strategic Outline Case at the end of 2020, which identified the Preferred Way Forward for a new build hospital on the existing site, we have been working up our plans in detail over the past year to develop the Outline Business Case - the next stage in the process to secure the necessary funding and approval to proceed. This has involved extensive engagement with staff, patients and the public to inform the development of plans to provide a state-of-the-art hospital for the residents of Hillingdon and beyond, which will support the very best in the delivery of healthcare.

Despite the ongoing pressures of the Covid-19 pandemic, we look towards the future, particularly rebuilding our planned care capacity to meet the immediate need for elective recovery.

We are continuing to work towards building stronger collaborative relationships across the NW London sector, and particularly between neighbouring acute Trusts.

In 2021, it was agreed that four North West London acute Trusts – The Hillingdon Hospitals NHS Foundation Trust, Chelsea and Westminster NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust - would appoint a Chair-in-Common. This is a key next step in strengthening collaboration as we move towards becoming a formal Acute care collaborative in line with national NHS policy. While remaining separate organisations, we will seek to maximise our potential for joint working for the benefit of our local population, patients and staff.

Matthew Swindells was appointed to the position in January 2022 and took up the post on 1 April 2022. May we take this opportunity to thank Lord Amyas Morse for his service as Chair of the Trust until 31 March 2022 and wish him well for the future.

Matthew Swindells — Trust Chair

Patricia Wright — Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

21st June 2022

1.2 Overview of performance

1.2.1 Purpose, Activities and History of the Trust

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

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

The Trust typically provides a range of clinical services to over half a million patients a year. Activity returned to close to 2019/20 levels during the year despite the ongoing impact of the Covid-19 pandemic. Figures are included in section 1.4.2 of this report.

As an NHS Foundation Trust, the Trust has a Council of 25 Governors and 6110 public members. It employs approximately 3200 permanent staff, making it one of Hillingdon's largest employers. The Board of Directors, led by Chairman, Lord Amyas Morse during 2021/22, comprises seven non-Executive (including the Chairman) and six executive directors (including the Chief Executive).

1.2.2 Our Vision

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

Vision

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

Mission

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

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

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

The Trust's objectives for 2021//22 were framed around six plus one * key delivery areas:

Quality - We will deliver consistent high quality care

2021/22 priorities:

- Improving our regulatory compliance
- Ensuring safe Maternity care
- Delivering our Quality priorities

Workforce - A great place to work

2021/22 priorities:

- **Belonging -** *Our NHS People Promise – "We each have a voice that counts, we are compassionate and inclusive, and we are recognised and rewarded"*
- **Looking after ourselves -** *Our NHS People Promise – "We are safe and healthy"*
- **Growing our workforce -** *Our NHS People Promise – "We are a team"*

- **New ways of working & delivering care -** *Our NHS People Promise – "We work flexibly, and we are always learning"*

Performance - We will deliver the right care at the right time for our patients

2021/22 priorities:

- Improve performance against the constitutional performance standards:
    - Emergency and urgent care
    - Planned care
    - Cancer care
    - Diagnostics.

Money - We will live within our means

2021/22 priorities:

- Delivering our 2021/22 Finance Plan
- Develop and enhance our finance capacity and capability
- Manage capital programme within Capital Resource Limits (CRL)
- Manage in year cash flow
- Financial Recovery Support Programme

Well led - We will empower our people to deliver

2021/22 priorities:

- Creating a culture of excellence
- Embed our sustainable governance systems
- Embed our new divisional structure
- Develop a strong performance culture

Partnership working - We will develop sustainable models of care centred around our patients

2021/22 priorities:

- We will actively contribute to the development of the North West London Integrated care system
- Developing the acute provider collaborative
- Hillingdon Health and Care Partners - work with HHCP to improve integrated care for our local population
- As part of North West London Pathology continue to improve our pathology services

- Deliver improvements in care through advances in education and research with our university partners.

***Hospital Redevelopment**

2021/22 priorities:

- Working in partnership with our local population and stakeholders, regional and national leads in finalising plans for our new Hillingdon Hospital
- Delivering the finance and economic case in the Hillingdon Hospital Redevelopment Strategic Outline Case (SOC) and Outline Business Case (OBC)
- Deliver year one of the Trust's Transformation and Innovation Strategy

During the year, the Covid-19 pandemic impacted the delivery of a number of these objectives and several areas were reprioritised as the impact of the pandemic unfolded. Although not all objectives were achieved by year-end, there was good progress across all areas.

1.2.1 Our Values

Our Cares values underpin everything we do at our Trust. They have helped to deliver high-quality care and unite our staff and services at both our hospitals and our clinics throughout London.

Our values are firmly embedded in our organisational culture and continue to demonstrate the standard of care and experience our patients and members of the public should expect from all of our staff and services.

Communication: Recognising the importance of listening and communicating in practice.

Attitude: Striving to understand others' needs, responding with care, compassion and professionalism.

Responsibility: Taking responsibility for consistently delivering excellence and being open in all that we do.

Equity: Recognising that people are different and value everyone equally.

Safety: Viewing patient, staff and visitor safety as a priority.

1.3 Key issues and Risks for the Trust

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

The Trust identified the following as the most significant potential risks to achieving our objectives in 2021/22:

1.3.1 Principal Risks

Strategic Objective 1	**Quality – We will deliver consistent high quality care**
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor high quality care which results in consistent achievement of all relevant national and local quality standards: 1a failure to deliver safe care 1b failure to deliver good patient outcomes 1c failure to delivery good patient experience
Strategic Objective 2	**Workforce – A great place to work**
Risk	Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Great place to work' in a competitive labour market
Strategic Objective 3	**Performance – We will deliver the right care at the right time for our patients**

Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to deliver consistent achievement of all relevant national performance and regulatory standards
Strategic Objective 4	**Money - We will live within our means**
Risk	Failure to maintain the financial sustainability of the Trust and the services it provides
Strategic Objective 5	**Well Led – We will empower our people to deliver**
Risk	Failure to embed effective corporate and clinical governance systems and structures.
Strategic Objective 6	**Quality – estates related in support of quality - We will deliver consistent high quality care**
Risk	Failure to maintain safe estate in a sustainable way to support the delivery of high quality, efficient care in the short and medium term in line with the planned opening of the new hospital in 2025

1.3.2 Key issues for the Trust

The following were identified as key issues for the Trust in 2021/22:

1. Responding to and recovering from the Covid-19 pandemic	The Covid-19 pandemic has been the most serious public health issue in a generation, resulting in extraordinary demand for critical and medical treatment in hospitals. The Trust has responded to the pandemic in accordance with national and local guidelines, and has successfully implemented its internal incident procedures, using a gold, silver, and bronze command and control structure. Restoration of elective and other business as usual service has been a key focus over 2021/22 and this will continue into the next year with an increased focus on reducing elective waiting times and management of the pandemic as “business as usual”.

2. Performance against Constitutional Standards	A key objective for the Trust was to recover delivery against all constitutional standards that were significantly impacted by the Covid-19 pandemic. This was not achieved in 2021-22. Emergency Department activity returned to pre-pandemic levels by year end, with the additional challenge of segregated pathways continuing. This, along with bed base challenges within the Trust and sickness related to Covid-19 has contributed to a reduced recovery trajectory, particularly in relation to type 1, emergency performance. The Trust focus was on elective recovery and treating the backlog of patients waiting on RTT and Cancer Pathways. As a result the constitutional standards have not been met but there has been a significant reduction in patients waiting over 52 weeks and over 62 days on RTT and Cancer pathways since the beginning of the year
3. Regulatory action by the CQC – section 31 and section 29a notices	The CQC inspected the Trust, following an outbreak of Covid-19 amongst staff in August 2020 and September 2020. Following these inspections, the Trust received a Notice of Decision (where a condition(s) are applied to the Trust for non-compliance with its licence to operate) under Section 31 and Section 29a of the Health and Social Care Act 2008 following the August and September 2020 CQC inspections respectively. The Trust took a robust project management approach to monitor the concerns raised by the CQC and made significant improvements in the issues that were identified. The CQC carried out a further unannounced inspection in May 2021 to follow up on the enforcement notices. The outcomes of this inspection were generally positive. Following the successful application made by the Trust to the CQC to remove the conditions imposed on the Trust's registration in the Section 31 notice in August 2021, the CQC sent a 'notice of decision' in October 2021, confirming that the conditions imposed on the Trust's registration had been removed. The CQC issued the Trust an updated registration certificate on 29th October 2021.
5. Delivering high quality patient care	Challenges remain with regard to recruiting adequate substantive medical staff, in particular at consultant level in

with medical recruitment challenges and increased patient acuity	a number of medical specialities including the Emergency Department and Acute Medicine. The Trust has been successful in recruiting at consultant level in a number of medical specialities including Care of the Elderly and Endocrinology. Mutual aid from Chelsea and Westminster Foundation Trust has resulted in West Middlesex Acute Medical Unit (AMU) consultants providing 8 PA sessions per week to the AMU in support of new substantive appointments and to support junior doctor training. For 2022/23, the Trust will embark on a program to recruit Medical Support Workers -overseas doctors not yet licensed- to help with routine medical tasks. Services will also be looking at use of Physician Associates to help support Medical Staff with work intensity and tasks particularly in the Unplanned Care Division. The Trust is also collaborating with Acute Trusts across the NWL Integrated Care System (ICS) in a Medical Staffing Improvement Programme with sector-wide approaches to Local Employed doctors training programmes, International Medical Recruitment, Bank and Agency usage and tariffs, and developing the Certificate of Eligibility for Specialist Registration (CESR) programme in hard to recruit specialities.
6. Poor condition of our estate	The level of backlog maintenance required to maintain safe and effective buildings continues to be a significant issue for the Trust. A condition survey completed in August 2021 concluded that the total cost to address the backlog was £189m for the total occupied estate. During the period of 2019/20 to 2020/21 the Trust received emergency capital funding of £16.5M to address 'business as usual' estate statutory compliance matters, and subsequently undertook major infrastructure work in 2021/22 on the following priority areas: ● Fire Compliance – Tower Wards and Podium ● Legionella & Water Quality ● Heating and hot water ● Lifts

	● A range of projects to support decarbonisation through a Salix Grant (Salix provides interest-free Government funding to the public sector to improve energy efficiency, reduce carbon emissions and lower energy bills.) An Estate's Risk Register is in place, which is regularly monitored through Trust governance processes, with risks escalated to the Board Assurance Framework as required. Under the Department of Health and Social Care's (DHSC) 'Health Infrastructure Plan' the Trust is seeking funding for a new hospital build. Our Strategic Outline Case (SOC), which was approved by the DHSC and NHSEI Joint Investment Committee in late 2020, evaluated a range of options. Based on a comprehensive assessment of options, a full redevelopment of Hillingdon Hospital on the current site was identified as the preferred way forward.
7. The scale of investment required to improve the Trust's fragile estate infrastructure	The Trust is required to comply with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises, which covers issues around failure to maintain the estate. To support the Trust in meeting this requirement, the condition of key building systems is assessed by a five-yearly survey, and is risk assessed and rated against available capital. The annual capital investment available for the estate is targeted at addressing specific extreme risks, and has enabled risk reduction. However, the available funds are insufficient to keep pace with the scale of backlog maintenance and the Trust continues to have high-risk estates issues on its Risk Register and on the Board Assurance Framework (BAF).
8. Effectiveness of the financial control system or inability to achieve the financial plan	The Trust has reported a deficit of £11.5m in its financial statements, adjusted to a deficit of £6.0m after the effect of impairments, grants and donations. The Trust's reported financial performance of a £6.0m deficit is a marginal improvement on 2020/21, when it reported an adjusted deficit of £6.4m. As with the prior year, the Trust has received significant additional funding to deliver this position. The underlying financial performance and sustainability of the Trust remains a major challenge and requires further improvement in 2022/23.

	On 9th August 2021, the Trust received notification of being placed in the System Oversight Framework Level 4 (SOF4) regime and the Recovery Support Programme with a particular focus on finance. In response, the Trust has developed a plan that outlines twelve programmes of work that aim to deliver against the exit criteria from SOF4, agreed with NHSEI. Further detail can be found in section 2.7 of this report.

1.4 Performance against objectives

Despite the considerable disruption caused by the Covid-19 pandemic, The Trust has made good progress in delivering against several of its key objectives during 2021/22.

Quality - We will deliver consistent high quality care

Objective	Summary of Performance
Improving our regulatory compliance	Following the successful application made by the Trust to the CQC to remove the conditions imposed on Trust's registration in the Section 31 notice in August 2021, the CQC sent a 'notice of decision' in October 2021, confirming that the conditions imposed on Trust's registration had been removed. The CQC issued the Trust with an updated registration certificate on 29th October 2021. As part of longer term Quality Improvement strategy the Trust has established the Hillingdon Care Quality Programme (HCQP) to provide a proactive management approach to quality improvement in the Trust. The HCQP includes work to meet the CQC's standards and requirements, but also oversees other relevant quality issues and work streams that feed into the programme. A more detailed account can be found in sections 1.6 of this report
Ensuring safe Maternity care	The interim Ockenden Report (published December 2020) identified 7 immediate and essential actions for Trusts, and work remains ongoing in the maternity unit to ensure these are in place. The final report was published in March 2022 and the Trust will respond to the additional findings alongside any findings from other investigations into Maternity care in 22/23. The Maternity Clinical Negligence Scheme for Trusts (CNST) Year 4 published in August 2021 was paused in December 2021 for a minimum of 3 months due to the pandemic. However, the Trust has

	continued to work toward maintaining compliance with the 10 CNST safety actions and to meet any new requirements identified for Year 4.
Delivering our Quality priorities	The Trusts Quality Priorities for 2021/22 were: • Improve the experience of patient discharge • Deliver high quality patient experience • Prevention and management of VTE • Patients whose clinical condition may be deteriorating Progress has been made in all four current Quality Priority areas for 2021/22 further information can be found in section 1.4.1 and the Trusts Quality Account Report for 2021/22.

Workforce - A great place to work

Objective	Summary of Performance
Belonging	In 2021/22 The Trust appointed a Diversity and Inclusion Lead. We commenced implementation of our Equality, Diversity and Inclusion (EDI) action plan, re-energised our Staff networks and reviewed the Trust approach to recognition. We have also launched a new management development programme and commenced opportunities for agile working as the hospital redevelopment progresses.
Looking after ourselves	In 2021/22 we launched our Health & Wellbeing (H&W) Programme, appointed a H&W Guardian, introduced H&W conversations with line managers and ensured staff have individual risk assessments in response to Covid 19. We have also commenced the process of introducing the principles of Just Culture throughout our disciplinary, grievance and performance management processes.
Growing our workforce	The Trust has made significant progress in reducing vacancy rates. This has been particularly impacted by a very successful international nurse recruitment campaign, with 109 nurses arriving during 2021/22. Our international recruitment has supplemented our ongoing local recruitment drives,

	guaranteed job offer schemes for student nurses and development of rotational posts for our Allied Health Professionals to improve recruitment and retention. The Trust has also commenced the development of a Health Care Support Worker apprenticeship programme, and is working with the North West London ICS to commence a system approach to international recruitment of Allied Health Professionals. Challenges remain with regard to recruiting adequate substantive staff, in particular at consultant level in a number of medical specialities including the Emergency Department, Acute Medicine, Care of the Elderly and Endocrinology. The Trust is working to refresh the workforce strategy with targeted work against these specialities. The Trust has seen some early success including a recent appointment into Endocrinology and applicants for our Acute Medicine advert. The Trust has collaborated with Acute Trusts in the ICS to look at a sector wide approach, including joint consultant appointments for some of the difficult to recruit specialities and cross Trust working for highly specialised services such as paediatrics, orthopaedics, and haematology. In addition we have joined with our partners across North West London in the launch of a collaborative Bank model.
New ways of working & delivering care	In 2021/22 we have developed our workforce plan for the redevelopment of the new hospital. We have worked with clinical, operational and digital colleagues to think innovatively about the service we will need for the future and the new roles and digital technologies that will support this.

Performance - We will deliver the right care at the right time for our patients

Objective	Summary of Performance
Improve performance against the constitutional performance standards	Over 2021/22 the Trust did not consistently meet the constitutional performance standards. All constitutional standards were significantly impacted by the ongoing challenges of the Covid-19 pandemic, either due to segregation of pathways, additional infection control and prevention measures or due to not having enough capacity to manage demand. A more detailed breakdown is provided in section 1.4.3

Money - We will live within our means

Objective	Summary of Performance
Delivering our 2021/22 Finance Plan	The Trust's reported financial performance of a £6.0m deficit is a marginal improvement on 2020/21, when it reported an adjusted deficit of £6.4m. As with the prior year, the Trust has received significant additional funding to deliver this position. The underlying financial performance and sustainability of the Trust remains a major challenge and requires further improvement in 2022/23. As part of the Recovery Support Programme objectives the Trust was set a plan to deliver break even for the second half of the year and this was achieved.
Develop and enhance our finance capacity and capability	The Trust has strengthened its arrangements through development of training packages for budget holders. Additional resourcing in the finance team, supported by the Recovery Support Programme, was put in place whilst a full review of the finance capacity and capability is undertaken.
Manage capital programme within Capital Resource Limits (CRL)	A full review of capital process was carried out and the findings and recommendations have been implemented. The Trust has managed its capital programme within the allocated budget in 2021/22.
Manage in year cash flow	The cash flow forecasting processes have been strengthened and the Trust had sufficient cash throughout the year and did not need to seek any emergency cash.

Financial Recovery Support Programme	On 9th August 2021, the Trust received notification of being placed in the System Oversight Framework Level 4 (SOF4) regime and the Recovery Support Programme with a particular focus on finance. In response, the Trust has developed a plan that outlines twelve programmes of work that aim to deliver against the exit criteria from SOF4, agreed with NHSEI.

Well led - We will empower our people to deliver

Objective	Summary of Performance
Creating a culture of excellence	A number of Staff recognition proposals were developed in 2021/22, including relaunch of Long Service awards, monthly CARES awards and plans to hold a staff recognition event linked in with 'I am the Change' launch – all proposals underpinned by the Trust People Promise (in particular 'We are recognised and rewarded') and reinforce the CARES values. The Trust updated and approved a number of strategies in 2021/22 including the Estates, People and Digital Strategy.
Embed our sustainable governance systems	The Trusts commissioned its internal auditors to review its 'Board Governance' arrangements, which concluded an assurance rating of 'Significant Assurance with Minor Improvement Recommendations' in June 2021 and the Trust has since implemented the 4 Medium and 4 Low priority recommendations from the review to strengthen its arrangements. The Well-Led assessment domain is embedded into the Trusts Integrated Quality and Performance Report, the Board Assurance Framework, and is a core area of assessment within the Trusts Ward and Department Accreditation process. The Trust also commenced a Board led self-assessment against the CQC well-led framework in Quarter 4 of 2021/22, which will be completed in Quarter 1 of 2022/23.

Embed our new divisional structure	The Trust revised its Clinical Divisional structure in October 2021 with the introduction of the Mount Vernon and Clinical Support Services Division. The trust has seen demonstrable impact in terms of performance and financial control through this revised structure. The Trusts Clinical Divisions encompass: • Un-planned Care • Planned Care • Mount Vernon and Clinical Support Services Division (as of October 2021)
Develop a strong performance culture	The Trust strengthened its Integrated Quality and Performance Report (IQPR) in 2021/22, and work is underway to further strengthen the IQPR in 2022/23. The Board approved a business case in 2021 to strengthen the Trust Business Intelligence team and to implement a Business Intelligence System. As part of the Recovery Support Programme plan there has been considerable focus on embedding Grip and Control.

Partnership working - We will develop sustainable models of care centred around our patients

Objective	Summary of Performance
We will actively contribute to the development of the North West London Integrated care system	The Trust is an active partner as part of the North West London Integrated Care System (NWL ICS). More recently this has included helping to shape and contribute to the North West London Acute Strategy and the development of the emerging Integrated Care Board, 5 year plan.

Developing the acute provider collaborative	During 21/22 the four acute Trusts in NWL worked collaboratively in response to the Covid pandemic and as part of the NWL ICS acute board, providing mutual aid and developing systems to respond to the backlog in emergency care. The appointment of Matthew Swindells, who commenced on 1 April 2022, as joint Chair of Hillingdon Hospitals NHS Foundation Trust, Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust is a key next step in strengthening collaboration as we move towards becoming a formal acute care collaborative. Work is now in progressing on the further development of the Acute Collaborative to help realise the benefits that the opportunity of further strengthened collaboration brings i.e. the implementation of a shared Electronic Patient Record (EPR) system Cerner.
Hillingdon Health and Care Partners - work with HHCP to improve integrated care for our local population	The Trust remains an active partners of Hillingdon Health and Care Partners (HHCP). This has included contributing to the refresh of the HHCP strategy, which articulates the priorities of the partnership over the coming period. In addition, detailed work has been undertaken to align the HHCP transformation plan with the THHFT transformation plan in support of the required transformation priorities to support the redevelopment of the New Hillingdon Hospital programme.
As part of North West London Pathology (NWLP) continue to improve our pathology services	As a co-owner of NWLP, the Trust has been actively involved in all decisions about developing the partnership including proposals to include a new partner during 22/23. In addition, the Trust moved onto the new Pathology platform in early 21/22 and there was considerable focus on ensuring the safe transition of services. Concerns about the responsiveness of histopathology services have been raised by all partners with particular delays noted at THHFT and agreement was reached to invest more resource in the service.
Deliver improvements in care through advances in education and research with our university partners.	The Trust is a founder member of Brunel Partners Academic Centre for Health Science (BPACHS), a partnership of local health Trusts and Brunel University, London. The partnership works collaboratively in the areas of workforce supply and development, research, digital health and innovation, and quality improvement. The Trust is also an active member of Imperial College Health Partners (ICHP), which undertakes work on health innovation at a national and local (NWL) level. The partnership has delivered on a range of programmes of work during 21/22.

***Hospital Redevelopment**

Objective	Summary of Performance
Working in partnership with our local population and stakeholders, regional and national leads in finalising plans for our new Hillingdon Hospital	During 21/22 the Trust continued to work with all partners locally (including Hillingdon Health and Care Partners and the London Borough of Hillingdon), regionally (including the NWL ICS and NHSEI, London) and nationally (including the New Hospital Programme (NHP) team) to support the development of plans for the new hospital. Examples include: • Extensive engagement with local people, staff and stakeholders through conducting online surveys, holding a public exhibition (summer 2021), holding new Hillingdon Hospital roadshow meetings, attendance at events organised by partners, and convening focus groups. The redevelopment was regularly promoted via digital channels to staff and local people, asking them to feedback or view the plans. This included a regular e-newsletter, articles for staff bulletins and the intranet and social media content. A process for collating all feedback and ensuring that it is used to support the development of plans for the new hospital is well established. • Ongoing and extensive engagement with the New Hospital Programme team in line with the Collaboration Agreement to ensure national requirements and Ministerial priorities are reflected in the redevelopment plans and to inform the national programme business case. • The Hillingdon Hospital Redevelopment Partnership Board met regularly with key local health, social care, and academic organisations to share progress and ensure partners had the opportunity to input in to the redevelopment plans and associated business cases. • Strategy and Transformation Group (including NWL ICS and Hillingdon Health and Care Partners representatives) was established to ensure alignment between Trust and partner strategies in support of the redevelopment. • Finance and Activity Group with senior NWL ICS and NHS London representation is well established and has overseen the development of the OBC financial case. • The Trust's Clinical Services Strategy was refreshed in partnership at both a Hillingdon Place and North West London system level, overseen by the Strategy and Transformation Group. • Development of the Trust estates strategy through consultation with key partners, ensuring alignment with the North West London estates strategy.

	• Continued partnership work with Hillingdon Health and Care Partners to ensure that plans are aligned across the hospital and community services. • Regular monthly meetings with NHSEI (London). • Updates to the Hillingdon Health and Social Care Select Committee, with the opportunity to provide feedback on plans. • Extensive and positive engagement with the London Borough of Hillingdon planning authority, including five detailed sessions held to develop the Planning Performance Agreement. The planning application remains on track to submit at the end of May 2022 and the Trust is working closely with the London Borough of Hillingdon to prepare a planning application exhibition, which is scheduled to take place at Uxbridge Library in June 2022. The Outline Business Case (OBC) for the redevelopment of the Hillingdon Hospital estate has, therefore, been developed through ongoing and extensive engagement at a local, regional and national level and the Trust will continue to work in partnership to support the finalisation of plans for the new hospital, in line with a comprehensive communications and engagement plan.
Delivering the finance and economic case in the Hillingdon Hospital Redevelopment Strategic Outline Case (SOC) and Outline Business Case (OBC)	The Strategic Outline Case (SOC) for the redevelopment of Hillingdon Hospital was approved by regulators and by Department of Health and Social Care Ministers in February 2021, following approval by the Department of Health and Social Care and NHSEI Joint Investment Committee in October 2020. The SOC identified a new build hospital as the Trust's Preferred Way Forward, amongst a shortlist of options. Following SOC approval, the development of the Outline Business Case (OBC) has continued to progress at pace, working in partnership at a local, system and national level. The OBC has appraised and further developed the shortlist of options and has identified the new build option as the Preferred Option. The OBC, including the economic case and financial case chapters, has been drafted and is now progressing through internal programme governance (May and June 2022) ahead of its submission for Trust Board approval in June 2022. A Finance and Activity Group is well established, with senior NWL ICS and NHS London finance representation and has overseen the development of the financial case in the OBC. Engagement with the NWL ICS is now continuing to agree the position set out in the OBC financial case and progress the receipt of a letter of support for the scheme, ahead of Trust Board approval in June 2022.

Deliver year one of the Trust's Transformation and Innovation Strategy	In 2021/22 we continued to make progress in embedding an improvement methodology, enabling and supporting staff who deliver care and services to develop and implement their own improvement plans based on patient priorities. The NHS I/E Vital Signs Improvement Practice programme formally ended in June 2021; we were able to access extended support from their continuous improvement consultant until November 2021. This allowed us to run two 5 day Rapid Improvement Events (RIEs) in August and October on patient flow and improving discharges respectively. RIEs were a major component of the Vital Signs approach and due to the limitations related to covid-19, it had not been possible for the Trust to run these since 2019. Both events focused on removing waste in processes to improve patient pathways, experiences, and satisfaction of staff working in these busy and challenging environments. The patient flow event saw new direct referral routes introduced to Same Day Emergency Care (SDEC); improved visual management for patients accessing SDEC; experiments to improve access to same day scanning, as well as extensive IT support to address known hot spots in clinical areas to reduce delays in accessing patient level information for front line teams. The improving discharges event focused on the introduction of a new patient departure lounge to support Pathway 0 & 1 discharges. It also experimented with patient level communication tools to improve their knowledge of discharge processes including a new video produced by the Integrated Discharge Team; improved IT systems access for ward teams, and introduced a pilot with Pharmacy and the Volunteer Service for a pharmacy runner role. This role reduced the time it takes to get discharge medication to wards, and they routinely now take no more than 10minutes to reach their destination. We have continued with the improvement practice coaching methodology, introducing new support structures to increase the number of certified improvers, and now have a further 28 staff who have met certification requirements by completing a project that showed a tangible change. A new network, based on their feedback, to support ongoing use of improvement skill will launch in April 2022. During the second part of 2021/22, the team focused on supporting ward multidisciplinary teams with implementing the SAFER principles, improving board and ward round practices through structured huddles. Additional support has been provided to the Emergency Department to improve productivity, quality of care and improvements to the patient journey and to staff satisfaction.

	Significant change within the team has occurred to support empowering staff and increasing change capability and capacity. The improvement practice, transformation and PMO have rolled out a new operating model, function and structure, merging previous teams. Increased capacity and capability is now in place to support the trust to focus on improving patient quality, experiences and outcomes.

1.4.1 Quality

During 2021/22, we have continued to focus on measuring and monitoring the quality of our services and the care delivered to our patients, their families and carers. We have revised processes for monitoring potentially harmful events such as hospital-acquired infections, pressure area issues, and patient falls. We have enhanced our systems for learning from complaints, serious incidents, and near misses and streamlined governance processes. The Board receives regular assurance on Quality and Safety Performance via the Integrated Quality and Performance Report.

Further information on quality performance can be found in the Trusts Quality Accounts for 2021/22.

Progress on our 2021/22 Quality Priorities

The following Quality Priorities were set out in our Quality Accounts Report for 2021/22; the following update demonstrates progress we have made in the course of this financial year.

PRIORITY 1 **Improve the experience of patient discharge**

What has been achieved:

- Patient Discharge Passport trial has been completed and passport continues to be rolled out.
- Patient experience learning tool (Video format) has been shared across the Trust and patient feedback videos have also been completed.
- All ward areas have access to discharge information resources.
- Discharge dashboard is now live. Further development is needed regarding categories and incidents related to discharge.
- Direct communication at care home forum is in progress.
- Collaborative working with adult safeguarding team fully established and effective.
- Working group has been set up with to review a number of staff roles and responsibilities related to discharge across the Trust.
- Standard work flows for Patient Flow Coordinators (PFCS) with clear roles and responsibilities for PFCS have been implemented.

PRIORITY 2 **To work in partnership with our patients and carers to deliver high quality patient experience**

What has been achieved:

- Wayfinding & access signage in relation to COVID 19 has been put in place quickly when needed and also in partnership between Facilities & Communications.
- A further site-wide review of wayfinding signage is due on both sites and this will be carried with Healthwatch. A further costed proposal is still under discussion from 'Access Able' who provide access information for getting onto and around sites particularly for disabled people.
- Complaints response performance against the Trust target of 85% has been achieved each month.
- The Patient Engagement Forum has held three meetings in 2021/22 and has included various initiatives to involve patients and improve patient experience. Examples include ;

  - A service improvement project to improving levels of independent exercise on Daniels Rehabilitation Unit; Members were supportive of the project and provided feedback which can be built into a future audit of the project.
  - Patient involvement in the development of an equality, diversity and inclusion booklet for staff.

  - A recorded patient story is presented at every Trust Board meeting.
  - An FFT survey is sent to all patients (including maternity) following an outpatient appointment, hospital admission and A&E attendance. FFT feedback can be provided via SMS text and paper surveys.
  - FFT results are included in the monthly IQPR report and are discussed at the bi-monthly Patient Experience Review Group.
  - Compliments data is available for divisions to discuss within their Governance meetings.
  - Compliments are included in divisional reports presented to the Patient Experience Review Group.

PRIORITY 3

Improvement to prevention and management of VTE for our patients

What has been achieved:

- Venous thromboembolism (VTE), or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for an individual patient. Each patient that is admitted requires a VTE risk assessment and for 2021/22 the trusts performance has improved but is still below the 95% target achieving 91%. The table below shows how this performance compares to previous years.
- Thrombosis Committee continued to see good multidisciplinary attendance and participation to highlight progress and audit outcomes in 2021/22. This included named representation from the general medical team with engagement from medical consultants to help cascade information and encourage compliance across all medical wards. There has also been pharmacy representation at all meetings ensuring information is cascaded back to ward pharmacists and regular attendance from Anaesthetic Department.
- There has been an education drive for both doctors and nurses on the importance of completing of VTE risk assessments/ These include :
  - Grand Round in December 2021 which included presentation on importance of VTE risk assessments and a follow up presentation in January 2022.
  - E-learning VTE module has been rolled out in mid-November. It is a mandatory module for all old and new medical, nursing and pharmacy staff involved in adult inpatient care.
  - Education around VTE has been delivered at every opportunity within handover sessions and ward rounds.
- The Trust is currently considering electronic options such as QR codes /web- link for VTE Patient information leaflet.

PRIORITY 4

Provide a framework for enhancing quality and safety for patients whose clinical condition may be deteriorating

What has been achieved:

- Improvement is seen in timing of patient sepsis screens
- Improvement is seen in numbers of patients starting the Sepsis 6 care bundle within 60 minutes

- Two e-learning modules for sepsis and for NEWS2 observations each have been designed. They are currently undergoing testing and improvement before being made public to all staff.

1.4.2 Constitutional Standards

Over 2021/22 the Trust did not consistently meet the national operational standards. All constitutional standards were significantly impacted by the ongoing challenges of the Covid-19 pandemic, either due to segregation of pathways, additional infection control and prevention measures or due to not having enough capacity to manage demand.

Emergency Care

Despite the Trust working closely with system partners and staff towards delivering sustained improvements in this key area, delivery was still significantly below the national standard of 95%, although performance was broadly in line with national and London comparators.

By year end Emergency Department activity was back to pre-pandemic levels, with the additional challenge of segregated pathways continuing. This, along with bed base challenges within the Trust and sickness related to Covid-19 contributed to the reduced recovery trajectory.

A number of programmes of work were implemented during the year to improve flow across the emergency pathway including:

- clear escalation processes to manage surges in demand and off load ambulances in a timely manner
- trialling of an Early Clinical Assessment Triage (ECAT) to manage the ‘front door’ in a more collaborative way with the urgent treatment centre and ambulance services, the main aim being to ensure that patients start their journey on the correct pathway as early as possible.
- embedding safety huddles
- fully functioning Emergency Ambulatory Care Unit (EACU) and Frailty team working hand in hand with ED to avoid admission.

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

The performance tables below provide comparative data for each of the performance

standards over 2019/20, 2020/21 and 2021/22. The attendances to A&E do not include those to the Urgent Treatment Centre as this is managed by Greenbrook Healthcare.

Indicator	2019/20	2020/21	2021/22	Target Achieved
A&E: Total time in A&E less than 4 hours (Accident & Emergency, Minor Injuries Unit, Urgent Care Centre) (++)	**82.4%**	**84.4%**	**74.9%**	**×**

Attendance	2019/2020	2020/2021 (*)	2021/2022 (**)	variance
Attendances made to our Accident & Emergency Department	69659	46611	67050	43.9%
Attendances made to our Minor Injuries Unit	29918	208	12018	5677.9%
Attendances made to our Accident & Emergency Department and Minor Injuries Unit	99577	46819	79068	68.9%
Babies born in our maternity unit	4175	3940	4077	3.5%
Attendances made as out-patients	366759	290949	356585	22.6%
Admissions made for emergency treatment	26992	21388	24640	15.2%
Admissions made for planned operations and day-surgery	26338	14196	21876	54.1%
Total Contacts	523841	377292	486246	28.9%

(*) April 2020 to Mar-2021

(**) April-2021 to Mar-2022

Extract Date: 03/05/2022

Cancer

The Trust was able to achieve compliance with the 31-day standards, and the 62 days from NHS Cancer Screening referral standard, but the standards for two-week waits and other 62-day performances were not consistently met.

The Trust is projecting a reduction of 62 day+ waits over 2022/23 and expect volumes to be back to pre-COVID-19 levels by the end of the planning period.

Cancer: Faster Diagnosis Standard

The Trust is aiming to be compliant with the national FDS cancer target of 75% of patients being told whether they have cancer within 28 days of urgent, suspected cancer referral from their GP, by July 2022.

Indicator (+) Up to February-2022 (++) Up to Mar-2022	2019/20	2020/21	2021/22	Target Achieved
All cancers: 31 days for second or subsequent treatment (surgery) (+) Target = 94%	98.2%	100%	94.9%	✓
All cancers: 31 days for second or subsequent treatment (anti-cancer drug treatments) (+) Target = 98%	96.0%	100%	97.8%	✓
All cancers: 62 days for first treatment from urgent GP referral for suspected cancer(+) Target = 98%	82.4%	68.5%	61.3%	×
All cancers: 62 days for first treatment from NHS Cancer Screening Service referral(+) Target = 90%	75.8%	100%	78.4%	×
All cancers: 31 days diagnosis to first treatment(+) Target = 96%	98.2%	98.4%	97.5%	✓

Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected) (+) Target = 93%	87.3%	72.3%	81.1%	×
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected) (+) Target = 93%	90.8%	73.4%	59.9%	×

Referral to Treatment (RTT)

The impact of the Covid-19 pandemic has meant that in 2021/22, the Trust was not able to achieve the 92% constitutional standard for treating patients within 18 weeks. However, there were improvements seen in the number of patients waiting for treatment. Additional activity took place at weekends, to help reduce backlogs. Patients waiting over 104 weeks were prioritised and these waits have reduced with the Trust achieving zero patients waiting over 104 weeks by the end of March 2022.

Indicator (+) Up to January 2022	2019/20	2020/21	2021/22	Target Achieved
Maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway (+) Target = 93%	**76.3%**	**50.5%**	**59.7%**	×

1.5 The Trust's response to the pandemic

The Covid-19 pandemic has continued to result in additional stress on the hospital services and the way in which we care for and protect our patients.

The Trust has, and will continue to respond to the Covid-19 recovery, in line with national and local guidance. The Trust has continued to utilise its internal incident procedures, operating

a gold, silver and bronze command and control structure as required. The Trust continued to closely monitor all waiting lists and key quality and performance metrics to identify gaps in assurance and maintain patient safety and business as usual functions as far as reasonably practicable as we are now in full recovery phase.

The Trust has worked with colleagues in the North West London Integrated Care System (NWL ICS) to maximise the viable capacity for patient care across all our Acute Hospitals. This required an agile and flexible approach and rapid and significant transformation of services.

Elective inpatient and day-case services have resumed with a focus on those most clinically urgent and those waiting over 104 weeks Outpatients services have been reduced in line with IPC guidance, virtual clinics have continued and will do so going forward.

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

- Compliance with national and regional guidance
- Appropriate management of the organisation during a national incident with a gold, silver and bronze command structure in line with the internal incident and pandemic plans
- Effective communication with staff to support dissemination of information, including daily bulletins, materials for managers and Q&A sessions
- Maintenance of time critical emergency work (including cancer and urgent surgery and some diagnostics) as a priority
- Increased Intensive Care Unit (ICU) capacity in line with national and regional guidance and demand and capacity and Acute Respiratory Care
- Creation of risk assessed and distinct areas to care for possible/definite Covid-19 cases and non-Covid-19 cases
- Safe care provided to deteriorating patients
- Consistent and ethical decision making
- Appropriate provision of PPE in line with national guidance
- Staff wellbeing was maintained
- Effective estates management and changes made in a timely manner to facilitate safe patient care
- Maintenance and improvement of governance systems to ensure safe care

1.6 Responding to regulatory action by the CQC

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

The CQC carried out Infection Prevention and Control (IPC) focussed inspections at the Hillingdon Hospital in August 2020 and a follow up joint visit with Health and Safety Executive (HSE) inspectors in September 2020. The inspection focused on the safe and well-led domains in the 'medical care' and 'urgent and emergency care' core services. The Trust received a Notice of Decision under Section 31 and Section 29a of the Health and Social Care Act 2008 following the August and September 2020 respectively requiring the Trust to provide CQC with assurances to implement an effective system to assess, monitor, identify, mitigate and manage any risks identified in the inspection. The Trust took immediate action and has made significant improvements since the inspections took place.

The CQC carried out a further unannounced inspection on 19th and 20th May 2021 to follow up on the enforcement notices. The inspection focused on the safe and well-led domains in the 'medical care' and 'urgent and emergency care' core services and included visits to the Emergency Department, Acute Medical Unit (AMU), Bevan ward and Stroke Rehabilitation ward followed by interviews with the service leads and Infection Prevention and Control (IPC) team. The outcomes of this inspection were generally positive.

Following the successful application made by the Trust to the CQC to remove the conditions imposed on Trust's registration in the Section 31 notice in August 2021, the CQC sent a notice of decision in October 2021, confirming that the conditions imposed on Trust's registration had been removed. The CQC issued the Trust an updated registration certificate on 29th October 2021.

As part of longer term Quality Improvement strategy the Trust has established the Hillingdon Care Quality Programme (HCQP) to provide a proactive management approach to quality improvement in the Trust. The HCQP includes work to meet the CQC's standards and requirements, but also oversees other relevant quality issues and work streams that feed into the programme.

The rationale for the HCQP is explained below.

- Focussed approach on CQC improvement plans (from 2020 and 2018 inspection including enforcement notices and conditions)

- Embedding CQC quality standards in day to day operations
- Ensuring that the Trust is prepared for future inspections and external reviews
- Promote a culture of listening, learning and improving and improving staff engagement
- Team to Board level reporting ensuring a clear line of sight for required assurance
- Trustwide commitment to journey to overall CQC 'good' rating

The programme is led by the HCQP Steering Group which determines the strategic direction of the project, oversees the progress of the project and provides a multidisciplinary and managerial approach to the work streams required. The steering group includes representation from clinical divisions and various corporate functions.

The Trust delivers a 'Ward and Department Accreditation' programme as a part of the HCQP project. It comprises quality and safety assessments of the clinical areas in the Trust, undertaken using a structured, Trust-developed assessment tool by a team of multidisciplinary stakeholders. The accreditation framework is aligned to the CQC's key lines of enquiry and five domains of quality. This programme was temporarily suspended during the first year of the Covid-19 pandemic. In April 2021, the programme was relaunched with an accreditation tool in line with new IPC regulations related to Covid-19 safety and a further streamlined accreditation process. Accreditation is one of the strands of measurement that aims to ensure that Trust divisions and the Executive Team have an accurate and detailed understanding of the quality of care patients receive. As of March 22, 63 clinical areas across both sites of the Trust have been accredited and according to the findings during the assessment, each areas is awarded with one of four grades, namely, gold, silver, bronze or white. All grades awarded are pass grades meeting the standards in the document, *excluding* the white grade.

The Trust also delivers 'Quality Rounds' on three Fridays in a month. The aim of the Quality Round is to highlight a quality theme; assess how that activity is undertaken in the Trust and identify good practice, any existing gaps or risks; and identify any amendment or quality improvement required. A Quality Round consists of a structured set of presentations for learning and sharing of quality improvement presented by subject matter expert. These rounds are attended by multidisciplinary teams who then conduct audits in multiple clinical and non-clinical areas to assess the compliance, followed by feedback and learning. The actions coming from the audits are monitored by the subject matter experts for each Quality Round. As of March 2022, 31 number of Quality Rounds have been undertaken on some important key topics including:

- Pressure Ulcer Prevention
- Falls Prevention
- End of Life Care

- Venous thromboembolism (VTE)
- Medical Gases Safety
- Violence and aggression
- Mental Health
- Health and Safety
- Duty of Candour
- Fire Safety
- Water Safety

These rounds are attended by multidisciplinary teams who conduct audits in multiple clinical and non-clinical areas followed by feedback and learning. The actions are monitored by the Quality Rounds Specialist.

1.7 Improving the Trust's estate

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

As a result of an audit undertaken in July 2019, the Trust has received significant investment into the Estate during the last three years, including emergency capital funding of £16.5m in 2020/21 to address 'business as usual' estate statutory compliance matters as well as additional investment for Fire Improvement works and investment in new Modular Ward Facilities.

Major infrastructure work was undertaken in 2021/22 in the following priority areas:

- Fire Compliance – Tower Wards
- Legionella and Water Quality
- Completion of investment in Lifts
- A range of projects to support Decarbonisation through a Salix Grant

A range of projects were carried out to improve clinical facilities including those below:

- New modular ward facilities have been installed to the south of the hospital providing inpatient, acute respiratory and enhanced Intensive Care accommodation.
- Improvements to Radiology services including installation of a new CT Scanner, transfer of the mammography service to a new facility at Mount Vernon Hospital and installation of an interventional Suite which will be completed in May 2022.

- Development of a new Bereavement Suite in the Maternity building in conjunction with the Trust Charity and generous fundraising by members of the public.

Despite significant investment, the remainder of the estate has continued to deteriorate as a result of general age and obsolescence, and further backlog maintenance will be required to maintain compliance with building standards and to support business as usual (BAU) activity.

The Trust has allocated £4.5m per annum capital allowance for the next financial year to reduce backlog maintenance and improve clinical facilities. An updated Estates Strategy was produced along with a full 6 facet survey to support both BAU projects and the Outline Business Case (OBC) for the New Hillingdon Hospital.

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

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

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

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

The development continues as a key NHS and Trust priority and the OBC is due to be delivered in June 2022.

As part of the progress towards the new hospital a range of enabling and decant works have been completed including the following schemes to support the site clearance:

- Office accommodation at MVH in The Raft and Batchworth House buildings
- Refurbished offices for Clinical Administration staff in the old Pathology space
- New Paediatric Audiology suite at MVH
- Refurbishment of the Medical Block at MVH

1.8 Environmental Performance

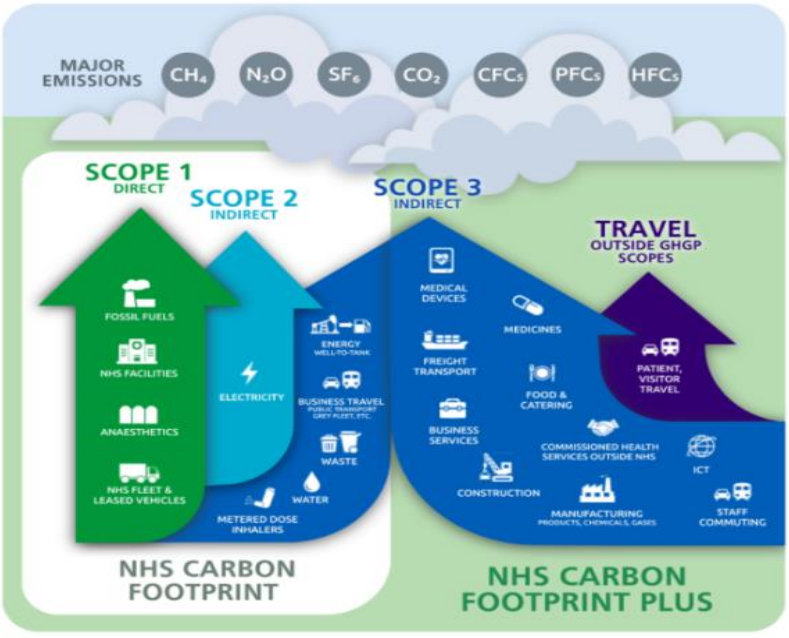
1.8.1 Sustainability and Environmental Performance

The NHS has become the world's first national health system to commit to achieving 'carbon net zero'. The Foundation Trust has plans in line with the NHS England and Improvement's 'Delivering a Net Zero Health Service' report. The Trust is ensuring that these obligations are complied with by delivering the Trust Board-approved Green Plan, the commitments of which are aligned with the wider NHS carbon and other noxious gas emissions reduction targets. These targets are as follows:

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

1.8.2 Assessing Our Impact

The Trust's impact is measured using the 'Delivering a Net Zero National Health Service' guidance which provides a detailed account of the carbon footprint scopes as shown in the figure below. The Trust's focus has been to prioritise actions based on the deliverability factor. The focus has been to ensure that Scope 1 and Scope 2 emissions are fully identified and that significant progress is achieved. Some progress has also been made in Scope 3 emissions.



The national NHS Green Team is working to develop guidance and assess NHS organisation-level total activity related to the carbon footprint, for monitoring and reporting purposes. The Trust is a member of, and is working with, the North West London Sustainability Group to achieve these objectives.

1.8.3 Sustainability Initiatives

The Trust has a Board-approved 5-year Green Plan as well as a Sustainable Travel and Transport Plan. These plans are aligned with the national ambition 'For a Greener NHS' commitments. The following actions and initiatives were delivered in 2021/22:

- Appointed a board member for net-zero targets and Green Plan.
- Developed a Sustainable Procurement Policy.
- Electricity supply purchase is 100% renewable energy from April 2021.
- Secured and delivered a £1.82m Public Sector Decarbonisation Scheme (PSDS) grant to deliver decarbonisation projects such as LED lighting upgrades, Solar PV, Windows double-glazing and metering.
- Solely purchasing and leasing cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs), with 24% already ZEVs (electric).

Operating zero domestic waste to landfill contracts with an increased focus on implementing the waste hierarchy (The waste hierarchy is a ranking system used for the different waste management options according to which is the best for the environment.).

- Launched a Sustainability Store for internal reuse and recycling of items.
- A Sustainability awareness course is a requirement for all staff. The Hillingdon Hospitals NHS Foundation Trust is one of the first Trusts to implement this.
- Regular 'Dr. Bike' events to support cycling to work in partnership with the London Borough of Hillingdon and London Cycle Campaign.
- Ensuring that the Redevelopment programme and the new hospital Strategic Outline Case incorporate a sustainability assessment and net-zero carbon reduction targets.

1.9 The Trust's Duty of Equality

The Trust's three-year patient experience and engagement strategy, covering 2019-22, sets out the Trust's intention to ensure the best possible experience for patients, carers, their relatives and the community. We recognise people are different and that some people will

need different treatment to achieve a fair outcome, which is why we are committed to delivering healthcare around the needs of individual patients and those around them.

We seek to understand what is important to our patients, recognising that this will vary from person to person. We utilise tools such as the Learning Disability Passport and 'This is Me' document for people living with dementia to gain a better understanding of how to provide personalised care. Reasonable adjustments are put in place, where practicable, such as timings of Outpatient appointments and welcoming carers throughout the 24 hour period (except during the Covid-19 pandemic). We ensure that language is not a barrier to high quality safe care through the provision of information in different languages and interpreting services.

a) Equality Act 2010

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

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

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

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

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

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

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

c) Maternity services

The Trust's Maternity Voice Partnership (MVP), which includes representation from mothers/birthing people and their families, has worked hard during 2021/22 to ensure our service users are actively involved in service development and improvement.

During 2021/2 the MVP has been involved in:

- reaching out to our BAME community
- undertaking a gap analysis of the maternity section of the Trust Website
- Involvement in an Induction of Labour task and finish group to coproduce information and services to improve women/birthing people's experience.

The MVP provides a mechanism for ongoing feedback from services users at the monthly MVP meetings with the maternity department. .

d) Religion or Belief

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

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

e) Accessing the Complaints service

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

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

f) Interpreting and Translation Services

The Trust's has a contract with an external provider to deliver face-to-face, telephone interpretation, video and translation to include BSL for patients and carers across the Trust. During 2021/22 the Trust requested interpreting services on 2084 occasions supporting patients with 49 languages. These figures include requests for BSL.

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

g) National Inpatient Survey

A survey of inpatients is part of the annual mandatory survey programme for acute services commissioned by the CQC. A Freephone helpline was available for patients who had queries or concerns about the survey. Access to Language Line was also available with interpreters in over 100 languages. The results of the 2021 national inpatient survey will not be available until later in the year. However, once received, feedback on age, gender and ethnicity of the survey population will be available to help inform a more tailored response to issues raised.

h) Patient information

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

1.10 Financial performance

The Trust has reported in its financial statements a deficit of £11.5m for the 2021/22 financial year against an original plan of a £0.3m deficit. Included in that reported deficit is £21.6m of losses resulting from impairments to the value of fixed assets and investment property.

However, taking into account other movements in relation to impairments of assets and the impact of capital grants and other donations, the Trust reported a £6.0m loss against a breakeven plan. As stated above, following the Trust's financial performance in the first half of the year, the NWL ICS set a target for the Trust to achieve breakeven in the second half of the year. The Trust has achieved that target.

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

	2021/22 outturn (£m)	2021/22 plan (£m)
Operating income from patient care	316.6	286.2
Other operating income	30.7	21.7
Employee expenses	-219.2	-198.6
Other operating expenses	-128.3	-99.9
Non-operating income and expenses	-8.8	-9.7
Gains and losses relating to assets	-2.5	0.0
Surplus / (deficit) for the period	**-11.5**	**-0.3**
Other movements (described in narrative above)	5.5	0.3
Adjusted financial performance: Surplus / (deficit) for the period	**-6.0**	**-0.0**
Year end cash	**56.4**	**16.2**

The Trust delivered £4.3m in efficiency savings during the year (1.2% of 2021-22 operating expenses).

The most significant factors behind variances to plan are as follows:

- Operating income from patient care: additional non-recurrent support funding provided by the NWL ICS.
- Other operating income: notional income from NHS England to fund additional employer pension liabilities.
- Employee expenses: the Trust has significantly overspent on pay costs throughout the year. This variance is also partly the result of the notional employer pension liability mentioned above.
- Other operating expenses: this variance is mostly driven by significant downward revaluation to fixed assets in year. There have also been overspends in a range of other areas from clinical supplies and drug costs, to rental costs for premises.

During the year, the balance of cash and cash equivalents increased from £47.4m at the end of 2020/21 to £56.4m at the end of 2021/22. The most significant driver behind the Trust holding a significant cash balance at year end was the timing of the release of funding to support key areas of the Trust's capital programme. The Trust has approximately £28m in capital creditors at 31 March 2022, a significant proportion of which have been paid to date in 2022-23.

In 2021-22, the Trust invested £53.0m into its capital programme and therefore spent in line with capital forecasts agreed with NHSEI. The principal elements of the Trust's capital spend were:

- £17.2m on decant and enabling works for the new hospital development, including the completion of the new Jubilee building;

- £12.1m on a range of other estates capital projects, including fire remediation and environmental sustainability grant-funded projects;

- £11.1m on continuation of work on the Trust's outline business case for the new hospital;
- £8.3m on upgrading IT software and hardware. £3.4m of this was on development and preparation for the Cerner EPR digital care record system; and
- £4.3m on replacing and upgrading medical equipment.

1.11 Going Concern Disclosure

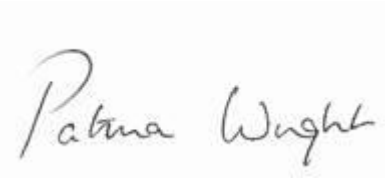
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence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

1.12 Events after the end of the reporting period

The Trust has considered whether there are any material post balance sheet events to disclose. At the time of writing, there are no events that the Trust is disclosing.

1.13 Accounting Officer approval of the Performance Report

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2021/22.



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

21st June 2022

2. Accountability Report

2.1 Director's Report

The Directors present their report and audited financial statement for the year to 31 March 2022.The Directors are responsible for preparing the Annual Report and Accounts, and consider the report, taken as a whole, to be a fair, balanced and understandable account of the performance of the organisation during the year 2021/22. The information within this report provides details for our stakeholders on the Trust's performance business model and strategy.

2.1.1 How we are organised

The Trust is run by a Board of Directors. The Board, led by the Chair, sets the vision, mission and values of the Trust and works to promote the success of the organisation. It is responsible for the organisation's decision-making and performance and for ensuring the Trust delivers high quality, safe and efficient services. The Board met on 24 occasions during 2021/22.

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

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

Board members declare their interests at the time of their appointment and at least annually. The register of directors' interests is available on the website on the Board of Directors' pages and is also available from the Trust Secretary.

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

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

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

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

2.1.2 Board of Directors (as at date of signing this Annual Report)

Chair

- Matthew Swindells (Chair in Common)

Chief Executive Officer

- Patricia Wright

Non-Executive Directors

- Catherine Jervis (Vice Chair)
- Dr Linda Burke (Senior Independent Director)
- Simon Morris
- Janet Campbell
- Dr Ayesha Akbar
- Neville Manuel

Executive Directors

- Jason Seez (Voting) – Deputy Chief Executive Officer and Director of Strategy
- Gubby Ayida (Voting) – Medical Director
- Melanie Van Limborgh (Voting) – Director of Nursing
- Tina Benson (Voting) – Chief Operating Officer
- Jon Bell (Voting) – Chief Finance Officer

- Sue Smith (Non-voting) – Chief People Officer
- Tahir Ahmed (Non-voting) – Director of Estates and Facilities
- David Searle (Non-voting) - Joint Director of Corporate Affairs

Biographies of the Board of Directors can be accessed via The Trust website.

Other roles

- Lesley Watts **–** Special Advisor to the Board.

Non-Executive Directors who left the Trust during 2021/22

- Lord Morse KCB: Trust Chair (31st March 2021)
- Richard Whittington: Non-Executive Director and Senior Independent Director (June 2021)

Executive Directors who left during 2021/22

None

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

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

There are two Nominations and Remuneration Committees in place, one for appointments to Executive roles and the Council of Governors sub-committee for appointments to Non-

Executive roles. These committees consider the structure, size and composition of the Board in making appointments to the Board.

2.1.4 Meetings of the Board, its Committees in 2021/22

The Board

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

In 2021/22 the Board met 24 times, eleven times in public, with a private session on each occasion to deal with confidential matters and additional private meetings held in July and November. In order to make Board meetings accessible to the public and Governors, public meetings, Governors meetings and the Annual Members meeting were conducted via Microsoft (MS) Teams. Public papers were made available via the Trust website. The Board also held a number of seminars and additional meetings to provide oversight throughout the year on governance and regulatory issues and to ensure Board members received appropriate training and development.

Committees of the Board

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

Audit and Risk Committee (ARC)

The ARC 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 and reports assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control together with indicators of their effectiveness.

The committee has overall responsibility for the organisation's risk management and for reviewing the effectiveness of these responsibilities. 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 Service

Quality and Safety Committee (QSC)

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. The committee works closely with the finance and performance committee to ensure there is no detrimental impact on the quality and safety of services as a result of financial and operational performance-related decisions and to ensure that related risks are regularly reviewed, updated and escalated.

Finance and Performance Committee (FPC)

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, 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.

People Committee (PC)

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, diversity and inclusion and health and wellbeing agendas on behalf of the Trust board.

Redevelopment Committee

The Redevelopment Committee was constituted in July 2021. The committee was established to provide assurance to the Trust Board on the management of the redevelopment programme for Hillingdon Hospital, the delivery of the business cases and the construction, completion and opening of the project (including lessons learned and benefits

realisation). The Committee will also provide assurance on the enabling and decant plans, including the work programme at Mount Vernon Hospital that support the redevelopment of Hillingdon Hospital. The Committee is established to provide oversight and scrutiny to the redevelopment programme. On behalf of the Trust Board the Redevelopment Committee is responsible for overseeing the development of the Outline Business Case and Full Business Case and the successful construction, completion, opening of the project and post project evaluation for the redevelopment of the Hillingdon Hospital estate. The Committee is responsible for providing the Trust Board with assurance on all aspects of the Trust's redevelopment programme.

Board of Directors Nomination and Remuneration Committee (RNC)

This committee oversees the process of appointment, performance, remuneration, suspension, termination and succession planning for all executive directors and other very senior managers that report directly to the Chief Executive.

Charitable Funds Committee (CFC)

The CFC provides oversight and direction to the Hillingdon Hospital Charitable Trust. The Trustee of the charity is the Trust Board. 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 Trust's standing financial instructions.

Board and board committee effectiveness reviews

Each board committee reviews its terms of reference annually and makes a summary report to the board of the range of its work through the year. This process facilitates committee chairs in reviewing the effectiveness of their committee and identifying areas for improvement.

Board and Sub Committee Attendance, 2021/22

The following table outlines attendance of board and board committee members at the Trust board meetings and board Committee meetings for the period 1 April 2021 to 31 March 2022.

Board Member	Attendance 2021/22							
	Trust Board (Public)	Audit and Risk Committee	Quality and Safety Committee	Finance and Performance Committee	Board Remuneration and Nominations Committee	Charitable Funds Committee	People Committee	Redevelopment Committee
Total Meetings held in 2021/22	11	6	10	11	2	3	11	3
Lord Morse KCB	10/11				2/2			3/3
Richard Whittington (last day 30 June 2021)	3/3	2/2		3/3			3/3	
Dr Linda Burke	11/11		10/10	10/11	2/2			
Simon Morris	10/11	6/6			2/2	3/3	11/11	3/3
Catherine Jervis	10/11		9/10	10/11	1/2			2/3
Janet Campbell	11/11				2/2	2/3	10/11	
Dr Ayesha Akbar (Start 01 May 2021)	9/10	4/5	8/9		0/2			
Neville Manuel (Start 01 May 2021)	9/10	4/5		10/10	1/2		5/9	
Patricia Wright	11/11		6/6	11/11			11/11	3/3
Jason Seez	10/11			10/11		2/3		3/3
Gubby Ayida	10/11		10/10				10/11	
Tina Benson	11/11			10/11			3/11	
Tahir Ahmed	10/11							3/3
Sue Smith	11/11					2/3	11/11	
David Searle	6/6							

Lesley Watts	10/11							
Jon Bell	11/11			10/11		3/3		3/3
Melanie van Limborgh	10/11		9				8/11	

2.2 Governor's Report

2.2.1 Council of Governors

The Council of Governors represents the interests of the local communities, patients, public and staff, and shares information about key decisions with Foundation Trust members. The Council of Governors is not responsible for the day-to-day management of the organisation, which is the responsibility of the Trust Board. The role of the Council of Governors includes:

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

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

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

Public Governors (elected)	
North Constituency	4
Central Constituency	4

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

Governor elections were held in 2021 and as at 31 March 2022, there were 23 members of the Council of Governors:

- 13 elected to represent the public members.
- 6 elected to represent the staff members (with 2 vacancy remaining in Nurses, Midwives and HCAs Staff Constituency). One of the staff Governors stepped down as on 8th February 2022.

- 5 appointed by partner organisations (Hillingdon Local Authority, Hillingdon CCG, the London Ambulance Service, Hillingdon Healthwatch and Trust's Joint Negotiating & Consultative Committee)

Governors are normally appointed for a term of three years. By having publicly-elected and appointed Governors representing the local area, the Trust ensures the public interests of patients and the community are represented. In 2021/22 the Council of Governors met five times in public and six private session held on to discuss the objectives and appraisal of Non-Executive Directors, leadership of the council and other confidential matters.

Name	Type	Meetings attended 2021/22
Tony Ellis	Public Governor	5/5
Graham Bartram	Public Governor	4/5
Ian Bendall	Public Governor	5/5
Des Brown	Public Governor	5/5
Ian Burnell	Public Governor	4/5
Rosemary Jenkins	Public Governor	5/5
Ahmet Moustafa	Public Governor	5/5
Mohan Sharma	Public Governor	2/5
Harjinder Hoojan	Public Governor	5/5
John Clarke	Public Governor	4/5
Beulah East	Public Governor	1/5
Marian Thompson	Public Governor	2/5
Karen Johnson (elected August 2021)	Public Governor	3/3
Jack Creagh	Staff Governor	5/5
Gillian Pearce	Staff Governor	5/5
Lubna Hussain	Staff Governor	4/5
Arun Natarajan	Staff Governor	4/5
Stefan Krok-Paszkowski	Staff Governor	4/5
Mildred Neale (resigned February 2022)	Staff Governor	1/5

Angela Joseph	Appointed Governor	2/5
Mary O'Connor	Appointed Governor	4/5
Lynn Hill	Appointed Governor	4/5
Natasha Wills	Appointed Governor	3/5
Nicole Rennison	Appointed Governor	4/5

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

b) Meetings of the Council of Governors

The Council of Governors normally meets four times a year. The meetings are held in public, and, given Covid-19 restrictions, have been held virtually via Microsoft (MS) Teams throughout the year (with a telephone dial-in facility also provided). The meetings are followed, where necessary, by a private session to discuss matters of a confidential nature. At the end of the public session, members of the public are invited to ask questions and papers are made available in advance via the website. In addition, the Trust held five briefing sessions for Governors where they were updated on important matters and to allow Governors the opportunity to raise issues of concern with the Chair. In 2021/22, the briefing sessions covered topics such as new hospital redevelopment, CQC inspection and implications, future ICS changes and the role of the Governors and of Non-Executive Directors. The briefing and training sessions have been well attended and appreciated by Governors.

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

Governor Observer roles for Board Sub Committees have remained in place throughout the year (with committees held via MS Teams and observers asked for their reflections at the end of each meeting). The Governor Observer role is formally recognised in the Terms

of Reference and following elections the Governor Observer roles were reviewed and changes agreed in November 2020.

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

Non-Executive Board Member	Council of Governors meetings attended in 2021/22
Lord Morse KCB	5/5
Richard Whittington	1/1
Dr Linda Burke	5/5
Simon Morris	3/5
Catherine Jervis	5/5
Janet Campbell	4/5
Dr Ayesha Akbar	2/4
Neville Manuel	4/4

d) Lead Governor

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

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

Tony Ellis was Lead Governor for the whole of 2021/22 and was re-elected to the role in November 2021. Throughout the year the Lead Governor has held regular individual meetings with the Chair, Vice Chair, Chief Executive and Trust Secretary. In this role, he

has agreed the agenda for Council of Governors and the Governors' briefings and training sessions and attended bimonthly meetings of staff Governors with the Vice Chair.

e) Council of Governors Nominations & Remuneration Committee

The Nominations and Remuneration Committee met four times during 2021/22. The Membership is listed below:

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

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

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

- approving arrangements for the recruitment to Non-Executive Director posts and the Trust Chair (Chair in Common).
- extension of terms of four Non-Executive Directors
- recommending to the Council of Governors the Chair and Non-Executive Director appraisals 2021/22 and their objectives for 2022/23 and approve succession arrangements for departing Non-Executive Directors including approving the appointment at the end of the financial year of a new Vice Chair

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

The Trust's constitution states that the Council of Governors can remove the Chairman or a Non-Executive Director provided that the resolution to remove the individual has the

approval of three quarters of the members of the Council. The Council has not invoked this clause during the financial year.

2.2.2 Membership

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

a) Public Membership

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

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

Public Membership at 31st March 2022

At 31st March 2022, the Trust had 6,110 public members. The table illustrates the number of public members for each constituency compared to the total population. The objective is to achieve a membership broadly equal to the population base.

	Public	% of Membership	Base	% of Area
Hillingdon Central	2,273	37.20	196,708	39.23
Hillingdon North	1,143	18.71	106,275	21.19
Hillingdon South	2,409	39.43	198,469	39.58

Rest of England	285	4.66	0	0.00
Out of Trust Area	0	0.02	0	0.00
Total	**6,110**	**100.00**	**501,452**	**100.00**

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

Analysis of current membership	**Public**	**Base**
Age	**6,110**	**498,482**
0-16	1	116,068
17-21	7	28,107
22+	5,622	354,307
Not stated	480	0
Gender	**6,110**	**498,482**
Unspecified	14	0
Male	2,303	250,840
Female	3,792	247,642
Transgender	1	0
Ethnicity	**6,110**	**456,019**
Asian	1,253	141,803
Black	313	36,872
Mixed	192	16,929
Other	564	14,674
White	3,788	245,741
ONS/Monitor Classifications	**6,099**	**174,921**
AB	1,724	42,122
C1	1,806	56,348

C2	1,213	34,377
DE	1,356	42,074
Total membership	**6,110**	**498,482**

b) Staff membership

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

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

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

Staff Membership at 31 March 2022

At 31 March 2022, the Trust had 4,405 staff members. Staff membership is validated once a year in Quarter 1 to look at staff on permanent contracts, who are on fixed terms for one year, or who have been on the bank for a year.

Member Type Breakdown	Active	Inactive	Suspended	Total
Unspecified	0	0	0	0
Nurses, Midwives & HCAs	1,786	0	0	1,786
Doctor and Dentist	745	0	0	745
Allied Health Professional, Scientific and Technical	580	0	0	580
Support Staff	1,294	0	0	1,294
Total membership	**4,405**	**0**	**0**	**4,405**

c) Membership Development and Engagement

The Trust has a Membership Development and Engagement Strategy, which describes the Trust's objectives for the membership and the approach used to ensure the Trust develops and engages with a representative membership. The strategy was produced with the guidance and input of the Council of Governors. The Trust plans to review its strategy in 2022/23.

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

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

d) Summary of Stakeholder Relations

During 2021/22, a weekly electronic newsletter providing focused updates on the Trust's activities, alongside information and resources that were marked for sharing with the wider community, was introduced for Governors. This enabled them to be more effective in communicating with their constituencies and they have reported the benefit of the regular communication in respect of Covid-19.

Public governors continued to engage with local community groups, including residents' associations, where they talked with local stakeholders.

2.3 Governance Disclosures

2.3.1 Details of any political donations

The Trust did not make any political donations during 2021/22.

2.3.2 Better payment practice code performance

All NHS organisations are required to comply with Better Payment Practice Code (BPPC) requirements. Organisations are set a target to pay 95% of valid invoices within 30 days of receipt.

The Trust aims to comply with the Better Payment Practice Code, which requires Trusts to pay 95% of invoices (volume and value) by the due date of payment (or within 30 days of receipt of goods or a valid invoice). The table below shows that the Trust has again been significantly below the 95% target, reporting an average of 72% by volume and 59% by value.

In August 2021, the Trust received a letter from the Chief Finance Officer of NHSEI, asking the Trust to urgently improve its performance against the target. At this point, the Trust was paying 68% of invoices on time.

The Trust implemented an improvement plan during 2021/22, taking a range of actions that have resulted in modest improvement on the 68% baseline, but should lead to significant improvement against this indicator in 2022-23.

	Actual 31/03/2022 YTD Number	Actual 31/03/2022 YTD £'000	Actual 31/03/2021 YTD Number	Actual 31/03/2021 YTD £'000
Non NHS				
Total bills paid in the year	74,531	239,791	62,391	192,962
Total bills paid within target	44,117	179,805	47,706	161,634
Percentage of bills paid within target	**59.2%**	**75.0%**	**76.5%**	**83.8%**
NHS				
Total bills paid in the year	1,488	32,481	2,561	29,342
Total bills paid within target	488	16,038	1,301	14,131
Percentage of bills paid within target	**32.8%**	**49.4%**	**50.8%**	**48.2%**
Total				
Total bills paid in the year	**76,019**	**272,272**	**64,952**	**222,304**
Total bills paid within target	**44,605**	**195,843**	**49,007**	**175,765**
Percentage of bills paid within target	**58.7%**	**71.9%**	**75.5%**	**79.1%**

2.3.3 Statement of compliance with cost allocation and charging guidance

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

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

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

2.4 Well Led framework

2.4.1 Well Led Framework

The Trust has had regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality. No material inconsistencies have been identified between the Annual Governance

Statement, Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any subsequent action plans.

2.5 Remuneration Report

2.5.1 Annual Statement on Remuneration

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

It provides recommendations to the Board with regard to:

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

The Board of Directors Nominations and Remuneration Committee met twice during 2021/22. It comprises all Non-Executive Directors and the Chief Executive, except where it is dealing with the appointment or removal of the Chief Executive. The Committee is chaired by the Chair of the Trust Board. The Chief People Officer and the Trust Secretary are in attendance.

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

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

Information to support discussion and decisions around Senior Managers' (i.e. Executives') pay is taken from benchmarking exercises undertaken by NHS Providers and information received from NHSEI. This data looks at roles in relation to headcount and turnover of NHS and Foundation Trusts. The Nomination and Remuneration Committee uses data from Trusts of a similar size as a benchmark for these discussions.

Senior Managers Remuneration Policy

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

Chairman and Non-Executive Director Remuneration Policy

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

Expenses

No material expenses were paid to governors during the year 2021/22. Expenses paid to Non-Executives and Executives are shown in the senior managers' remuneration table within section 2.5.3.

2.5.2 Senior Managers' Remuneration

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

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

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

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

Service Contracts

Name	Title	Appointed in	Tenure
Lord Amyas Morse	Chairman	October 2021	Tenure ended on 31st Mar 2022 *(Re-appointed in September 2021 for 6 Months October 2021 – March 2022)*
Matthew Swindells	Chairman (Chair in Common)	April 2022	1st April 2022 – 31st March 2026
Catherine Jervis	Vice Chair	May 2019	1 May 2022 - 30 April 2025 *(Re-appointed in Feb 2022 for 3 years)*
Dr Linda Burke	Senior Independent Director	May 2019	10 May 2022 - 9 May 2025 *(Re-appointed in Feb 2022 for 3 years)*
Janet Campbell	Non-Executive Director	August 2019	1 August 2022 – 31 July 2025 *(Re-appointed in Feb 2022 for 3 years)*
Simon Morris	Non-Executive Director	May 2019	1 May 2022 - 30 April 2025 *(Re-appointed in Feb 2022 for 3 years)*
Dr Ayesha Akbar	Non-Executive Director	May 2021	1 May 2021-30 April 2024
Neville Manuel	Non-Executive Director	May 2021	1 May 2021-30 April 2024
Patricia Wright (Voting)	Chief Executive Officer	November 2020	November 2020 – Present
Jason Seez (Voting)	Deputy Chief Executive Officer and Director of Strategy	February 2019	February 2020 – Present

Gubby Ayida (Voting	Medical Director	October 2020	October 2020 – Present
Melanie Van Limborgh (Voting)	Director of Nursing	November 2020	November 2020 – Present
Tina Benson (Voting)	Chief Operating Officer	December 2019	December 2019 – Present
Jon Bell (Voting)	Chief Finance Officer	February 2021	February 2021 – Present
Sue Smith (Non-voting)	Chief People Officer	June 2020	June 2020 – Present
Tahir Ahmed (Non-voting)	Director of Estates and Facilities	June 2019	June 2019 – Present
David Searle (Non-voting)	Joint Director of Corporate Affairs	August 2021	August 2021 - Present

2.5.3 Report on remuneration in 2021/22:

See tables below:

Single total figure table[1] (Subject to audit)

	Current financial year 2021-22						Previous financial year 2020-21					
Name and title	**Salary and fees (in bands of £5,000)**	**Taxable benefits (total to the nearest £100)**	**Performance-related bonuses (in bands of £5,000)**	**Long-term performance-related bonuses (in bands of £5,000)**	**Pension-related benefits (in bands of £2,500)**	**Total**	**Salary and fees (in bands of £5,000)**	**Taxable benefits (total to the nearest £100)**	**Performance-related bonuses (in bands of £5,000)**	**Long-term performance-related bonuses (in bands of £5,000)**	**Pension-related benefits (in bands of £2,500)**	**Total**
Patricia Wright, Chief Executive	190-195	0	0	0	227.5-230	420-425	60-65	0	0	0	122.5-125	185-190
Jason Seez, Deputy Chief Executive	155-160	10,500	0	0	42.5-45	210-215	155-160	9700	0	0	65-67.5	230-235
Gubby Ayida, Medical Director	170-175	0	0	0	0	170-175	85-90	0	0	0	0	85-90
Tina Benson, Chief Operating Officer	135-140	0	0	0	30-32.5	165-170	135-140	0	0	0	87.5-90	220-225
Melanie van Limborgh, Director of Nursing	105-110	0	0	0	210-212.5	315-320	40-45	0	0	0	90-92.5	130-135
Jon Bell, Chief Finance Officer	160-165	900	0	0	0	160-165	25-30	0	0	0	0	25-30
David Meikle, Interim Director of Finance (to January 2021)	N/A	N/A	N/A	N/A	N/A	N/A	220-225	0	0	0	0	220-225
Sue Smith, Chief People Officer	120-125	0	0	0	37.5-40	155-160	75-80	0	0	0	155-157.5	230-235
Tahir Ahmed, Director of Estates and Facilities	140-145	0	0	0	37.5-40	180-185	140-145	0	0	0	12.5-15	150-155
David Searle, Director of Corporate Affairs (From August 2021)	45-50	0	0	0	0	45-50	N/A	N/A	N/A	N/A	N/A	N/A
Non Executive Directors												
Lord Amyas Morse, Chair	45-50	0	0	0	0	45-50	45-50	0	0	0	0	45-50
Catherine Jervis, Non-Executive Director	15-20	0	0	0	0	15-20	10-15	0	0	0	0	10-15
Linda Burke, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Janet Campbell, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Simon Morris, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Dr Ayesha Akbar, Non-Executive Director (From May 2021)	10-15	0	0	0	0	10-15	N/A	0	0	0	0	N/A
Neville Manuel, Non-Executive Director (From May 2021)	10-15	0	0	0	0	10-15	N/A	N/A	N/A	N/A	N/A	N/A
Richard Whittington, Non-Executive Director (Oct 2014-June 2021)	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15

1. [1] Pension-related benefits do not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table below provides further information on the pension benefits accruing to the individual.
2. Medical Director and Director of Nursing are on secondment from Chelsea and Westminster NHS Foundation Trust. The Chief People Officer has been recharged at 50% to Chelsea and Westminster since November 2020. Her total salary is £120-125k. The Director of Corporate Affairs is a 50:50 post shared with LNW Trust with a total salary of £135-140k
3. Non-Executive Directors do not accrue pension benefits for their role.

Total pension entitlement table[2] (Subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Patricia Wright, Chief Executive	10-12.5	32.5-35	75-80	235-240	1518	0	0	N/A
Jason Seez, Deputy Chief Executive	2.5-5	0-2.5	60-65	130-135	1056	47	1121	N/A
Gubby Ayida, Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tina Benson, Chief Operating Officer	2.5-5	0-2.5	50-55	105-110	894	35	944	N/A
Melanie van Limborgh, Director of Nursing	7.5-10	27.5-30	45-50	135-140	888	0	0	N/A
Jon Bell, Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sue Smith, Chief People Officer	2.5-5	0-2.5	50-55	125-130	1074	56	1142	N/A
Tahir Ahmed, Director of Estates and Facilities	2.5-5	0-2.5	30-35	50-55	521	35	569	N/A
David Searle, Director of Corporate Affairs (From August 2021)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

1. [2] Executives marked as N/A in all columns are not members of the NHS pension scheme.
2. NHS Pensions has advised that a Cash Equivalent Transfer Value is not available for the Chief Executive and the Director of Nursing.
3. The Trust has not made contributions in respect of directors to any stakeholder pension schemes, hence this is not applicable.
4. Gubby Ayida, Jon Bell and David Searle chose not to be covered by the pension arrangements during the reporting year

Fair Pay multiples (Subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2021/22 was £190k - £195k (2020/21, £220k - £225k). This was 4.95 times the median remuneration of the workforce which is £38,923.10. There is a 12.8% change lower this year in the highest paid director's pay due to the highest paid director last year being interim and it is the norm for interim staff to be paid slightly more to cover holiday and pension benefits.

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

For employees of the Trust as a whole, the range of remuneration in 2021-2022 was from £18k to £292k. (2020-21£18k to £212k). The median has been restated to reflect the review undertaken of the calculations which was adjusted to reflect FReM requirements. This has resulted in the prior year median being restated from £28,793 to £37,501. The median remuneration of the workforce was £38,923.10 (2020/21 £37,501.32). The percentage change in average employee remuneration between the years is 4.5%. Three employees (Consultants) received remuneration in excess of the highest paid director (none in 2020/21).

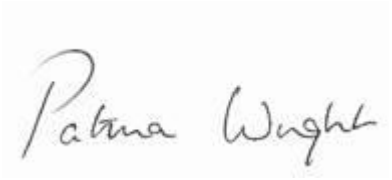
The remuneration of the employees at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Prior year comparatives will be added in 2022/23 as these are new requirements.

Pay Ratio Information			
2021/2022	**25th Percentile Pay Ratio**	**Median Pay Ratio**	**75th Percentile Pay Ratio**
Salary Component of Pay	28,073.16	38,923.10 (37,501.32 Prior Year)	51,514.20
Total Pay and Benefits Excluding Pension Benefits	28,073.16	38,923.10 (37,501.32 Prior Year)	51,514.20
Pay and Benefits Excluding Pension: Pay Ratio for the highest paid Director	6.86:1	4.95:1 (5.9:1 Prior Year)	3.74:1

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

Signed,



Patricia Wright 21st June 2022

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

2.6 Staff Report

2.6.1 Staff costs (Subject to audit)

	2021/22			2020/21
Pay element	**Permanent (£k)**	**Other (£k)**	**Total (£k)**	**Total (£k)**
Salaries and wages	151,540	14,970	166,510	152,756
Social security costs	16,339	965	17,304	16,049
Apprenticeship levy	707	105	812	745
Employer contributions to NHS Pension Scheme	17,202	460	17,662	16,880
Additional contributions to NHS Pensions funded by NHS England	7,690	206	7,896	7,522
Pension costs - other	57		57	52
Termination benefits			-	-
Temporary staff costs		15,431	15,431	13,439
Total gross staff costs	**193,535**	**32,137**	**225,672**	**207,443**
Less recoveries in respect of seconded staff	- 1,753	- 364	- 2,117	- 1,811
Total staff costs	**191,782**	**31,773**	**223,555**	**205,632**

2.6.2 Average staff numbers (Subject to audit)

	2021/22			2020/21
Staff group	**Permanent**	**Other**	**Total**	**Total**
Medical and dental	501	68	569	543
Administration and estates	784	113	897	834
Healthcare assistants and other suppory staff	650	98	748	702
Nursing, midwifery and health visiting staff	944	203	1,147	1,054
Scientific, therapeutic and technical staff	311	32	343	339
Healthcare science staff	57	6	63	63
Total staff numbers	**3,247**	**520**	**3,767**	**3,535**

2.6.3 Exit packages (Subject to audit)

Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
< £10,000	0	0	0
£10,000 - £25,000	0	3	3
£25,001 - £50,000	0	2	2
£50,001 - £100,000	0	1	1
£100,001 - £150,000	0	0	0
Total number of exit packages by type	0	6	6
Total resource cost	0	205,687	205,687

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

	Number of agreements	Total value of agreement (£k)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	6	206
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**6**	**206**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

2.6.4 Off-payroll engagements

The Trust's policy is that off payroll arrangements should only be used on rare occasions where recruitment to key/specialist roles has not been possible. The use of any off-payroll arrangements are regularly reviewed to ensure that they are used for the shortest period of time possible. There were no individuals within the scope if IR35 in 2021/22.

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2022, earning £245 per day or greater	
Number of existing engagements as of 31 March 2022	1
of which	
Number that have existed for less than one year at time of reporting	1
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0

Number that have existed for four or more years at time of reporting	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2022	1
of which	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	0
Subject to off-payroll legislation and determined as out of scope of IR35	1
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

2.6.5 Expenditure on consultancy

The Trust's expenditure on consultancy during 2021/22 was £11.9m compared with £6.5m in 2020/21. As with 2020/21, the amount of consultancy cost charged to revenue was negligible, but the amount charged to capital expenditure is significantly higher in year. The majority of these fees are for consultants and other advisers working on preparation of the Trust's Outline Business Case for the new hospital development, or on other capital projects.

2.6.6 Recruitment and retention

The Trust has continued with a number of activities to reduce vacancy rates. This has included the international nurse recruitment campaign, with 109 nurses arriving during 2021/22, the development of a Health Care Support Worker apprenticeship programme, providing guaranteed job offers for student nurses and creating rotational AHP posts with neighbouring Trusts. Further plans are being developed with the North West London ICS to commence a system approach to international recruitment of Allied Health Professionals and to work jointly on workforce issues for AHPs.

This work has been successful in reducing vacancy rates to 6.4% overall and 5.5% for nursing as at as at 31 March 2022.

Recruitment time to hire has continued to reduce across all non-medical staff groups from 35.4 working days last year to an average 33.5 working days as of March 2022, which is just outside the Trust target of 33 working days.

Retention of our staff remains one of the key priorities for the Trust. The Trust is putting actions in place to reduce turnover to 10%, with a current focus on high Allied Health Professionals turnover. Actions in place to mitigate high turnover levels include the development of the 'Stay Conversation' framework and specific departmental actions in hotspot areas.

Information on staff turnover:

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

2.6.7 Equality, Diversity & Inclusion

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

Work is continuing to progress in this area:

- Board oversight – a Non-executive Director has been designated to work with the Chief People Officer
- The Trust has appointed a Diversity and Inclusion lead to drive the EDI agenda and action plan

- Structure – a Black, Asian, Minority Ethic (BAME) Staff Group has been re-established, sponsored by the Chief Executive. It is chaired by a member of our BAME workforce
- The Trust has established and empowered staff networks, such as Lesbian, Gay Bisexual and Transgender (LGBT) and Disability and Wellbeing networks
- Training – Equality, Diversity & Inclusion training, which incorporates the Equality Act legislation, is compulsory for all staff. Furthermore, we have designed and deliver Equality, Diversity and Inclusion workshops for all teams and departments
- Reporting – the Trust complied with all national reporting (e.g. Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender pay equality) as well as taking part in WRES data collection and processes across London
- Recruitment and Selection- BAME representatives at interviews for band 8a and above roles, to ensure fairness during selection process
- Staff Support – in addition to the Freedom to Speak Up Guardian, the Trust has established a diverse range of staff who are designated Freedom To Speak Up (FTSU) Champions and CARES Ambassadors offering support to other staff members to address issues within the workplace
- Interpreting Service – the Trust has an Interpreting and Translation Policy and has a contract with an external provider to deliver face-to-face, telephone interpretation, video and translation services. The Trust's Interpretation and Translation Policy ensures that patients, relatives and carers have access to the communication tools required to allow complete understanding of their diagnosis and proposed treatment, and to ensure that each patient's communication needs are met.
- Chaplaincy Services – the Chaplaincy Department seeks to offer high quality pastoral and spiritual care to all patients, carers and staff within the Trust. It is available to all and welcomes referrals from colleagues and carers alike. The Trust also has a designated staff chaplain and prayer room facilities
- Equality Impact Assessments – a policy and associated processes are in place, along with a staff training programme, that can be accessed for anyone who is not sure on how to conduct these
- Positive about Disability – in line with the Workforce Disability Equality Standard
- The Trust has designed an EDI calendar to mark several special days throughout the year and also to celebrate our workforce countries of origin by dedicating a day per month to celebrate a specific country

Workforce gender split

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

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

The Trust's gender pay gap information for 2021/22 is published in this annual report, which can be found on the Trust's website.

As at 31 March 2022 the total relevant paid workforce was 3,638 staff across all sites and staff groups.

Gender	Number of Staff	% split of the workforce
Male	874	24.2%
Female	2764	75.98%

Senior Managers

	Female	Male
Directors	3	3
Senior Managers (Band 8a+)	162	70

Average and median hourly rates

Gender	Average hourly rate	Median hourly rate
Male	£23.24	£18.45
Female	£19.65	£17.52
Difference	£3.59	£0.92
Pay gap %	15.43%	5.01%

The gender pay gap when expressed as a mean average shows that female staff earn 15.43% less than male staff. This equates to a difference of £3.59 per hour.

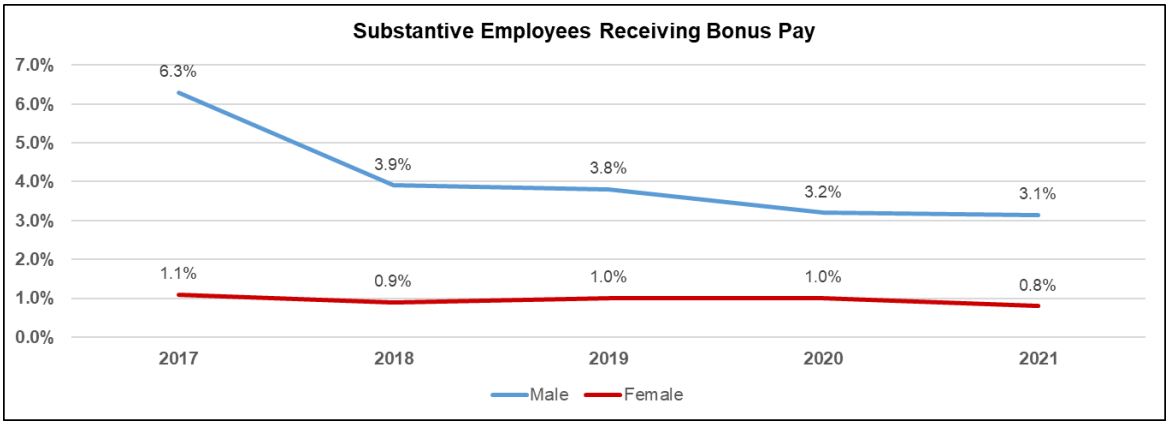
The gender pay gap when expressed as a median average shows that female staff earn 5.017% less than male staff. This equates to a difference of £0.92 per hour.

Bonus gender pay gap by hourly rate

For the purpose of this report the bonus payments referred to are those made to consultants in the form of clinical excellence awards (CEAs). The 2019 gender split of Consultants was 50/50 from being a previously male dominated role. 43% of male Consultants joined the Trust before 2010 compared to only 30% of female Consultants.

Gender	Average bonus pay	Median bonus pay
Male	£12,978.41	£6,936.84
Female	£6,097.74	£6,032.03
Difference	£6,080.67	£908.41
Pay gap %	46.85%	13.04%

Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment



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

Quartile	Female	Male	Female %	Male %
1 (Low)	595	303	66.3%	33.7%
2	748	150	83.3%	16.7%

3	696	202	77.5%	22.5%
4 (High)	671	221	75.2%	24.8%

2.6.8 Performance and development

a) Performance and development reviews (PDRs)

During the year, staff have been completing their PDR's but the ongoing Covid pandemic has impacted on our compliance rates. The Trust is at 62.6% compliance at the end of March 2022, with improvement trajectories across all areas to ensure PDR's are back at target levels.

b) Professional development

In response to Covid-19, all core skills training (statutory and mandatory) was moved to on line delivery, with the exception of Moving & Handling and Basic Life Support. Compliance was 89% overall as at the end of March 2022 compared to the required target of 90% with 14 of the 20 core skills within their respective targets. Additional (non-core) topics have also been made available via our eLearning platform over the past year with positive feedback from staff regarding flexibility of access.

c) Leadership development

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

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

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

d) Recognition schemes

The Trust usually runs an annual staff awards event with categories that recognise individuals and teams for their outstanding work in quality and innovation, compassionate care and 'CARES' values. CARES, standing for Communication, Attitude, Responsibility, Equity and Safety, is the acronym that represents the Trust's behavioural model that was developed by our staff and patients. However, this did not happen in 2020/21 or 2021/22 due to the on-going Covid-19 Pandemic. The Trust did, however, provide every member of staff with another Thank you voucher as a gesture to recognise the hard work over the last year and is currently reviewing proposals to relaunch the Annual Staff Awards during 2022.

The Trust publishes a regular bulletin in which staff or teams that have been identified for 'Shout Outs' are mentioned in recognition of the work they do. The Shout Outs share words of appreciation and gratitude for staff, to recognise those individuals or groups for a noteworthy act or effort.

e) Apprenticeships

Apprenticeships have continued to grow with an increase in our offering, such as the Level 6 Improvement Leader and Level 4 Associate Project Manager. We have had ten staff commenced on the Apprentice Nursing Associate (ANA) programme at Brunel University. This year we had Apprentices who commenced on several degree Apprenticeships such as Physiotherapy, Operating Department Practitioner and Diagnostic Radiographer. We also have three support workers appointed to undertake Assistant Practitioner Apprenticeship - Radiology pathway.

We currently have 15 staff on non-clinical apprenticeships, 31 staff on clinical apprenticeships, with 18 staff on the Level 7 Senior Leader programme.

f) Work experience

Work experience has remained on hold for face to face placements but we have continued to work across the ICS in partnership with Springpod to deliver an interactive online work-related learning programme for students in Years 10-13 who are interested to grow their understanding of the different careers in the NHS. The programme consists of 10 hours' worth of learning including background reading, quizzes and live webinars from professionals in the field. The first cohort included Medicine and Support Services with 1628 students in total completing the programmes. We have since run two more programmes supporting over 3300 students who gained understanding of different NHS careers.

2.6.9 Staff Engagement

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

A series of engagement events were held with staff during 2021/22 to identify what staff felt would make Hillingdon Hospitals NHS Foundation Trust a great place to work. This feedback combined with the results of our 2020 staff survey informed the Trust's People Strategy, which was approved by the Trust Board in September 2021. The strategy lays out our actions under four key pillars:

A People Forum was set up, chaired by the Chief Executive, with a cross section of staff from the organisation including network chairs, Staff Governor and FTSU Guardian. The role of the forum is to develop and deliver the strategic people objective of making THHFT a great place to work. A monthly People Forum newsletter is published to share the work of the group.

One of the Trust's core values is communication, and this has been particularly important in helping us to meet the challenges raised across 2021/22. The Trust continued to communicate with staff via a range of well-established communication channels, including a daily all staff electronic newsletter; executive led briefings; an extensive intranet; use of social media platforms and a weekly blog.

The Trust also continued to embrace the opportunities afforded by technology to increase the reach and impact of existing engagement activity. The monthly Team Brief meeting continues to run virtually, allowing the Trust to open it up to all staff members and to enable senior managers to discuss key updates on strategic priorities and organisational performance with all colleagues.

As Trust members, staff are also invited to participate in internal and external network meetings, including the Annual General and Annual Members meetings. The Trust also has formal mechanisms in place to facilitate partnership working which staff are encouraged to participate in including the Trust Partnership Forum, the Joint Local Negotiating Committee for Doctors, and the Junior Doctors Forum. The Trust also runs an anonymous dialogue system called "SpeakInConfidence", which can also be used for the purposes of raising concerns confidentially.

The Trust held specific communication briefings on key topics across the year to ensure that everyone working at the Trust had consistent access to the latest and most accurate information, including weekly virtual Q&A forums led by Senior Leaders across the Trust, Covid-19 briefings and VCOD (Vaccination as a Condition of Deployment) briefings.

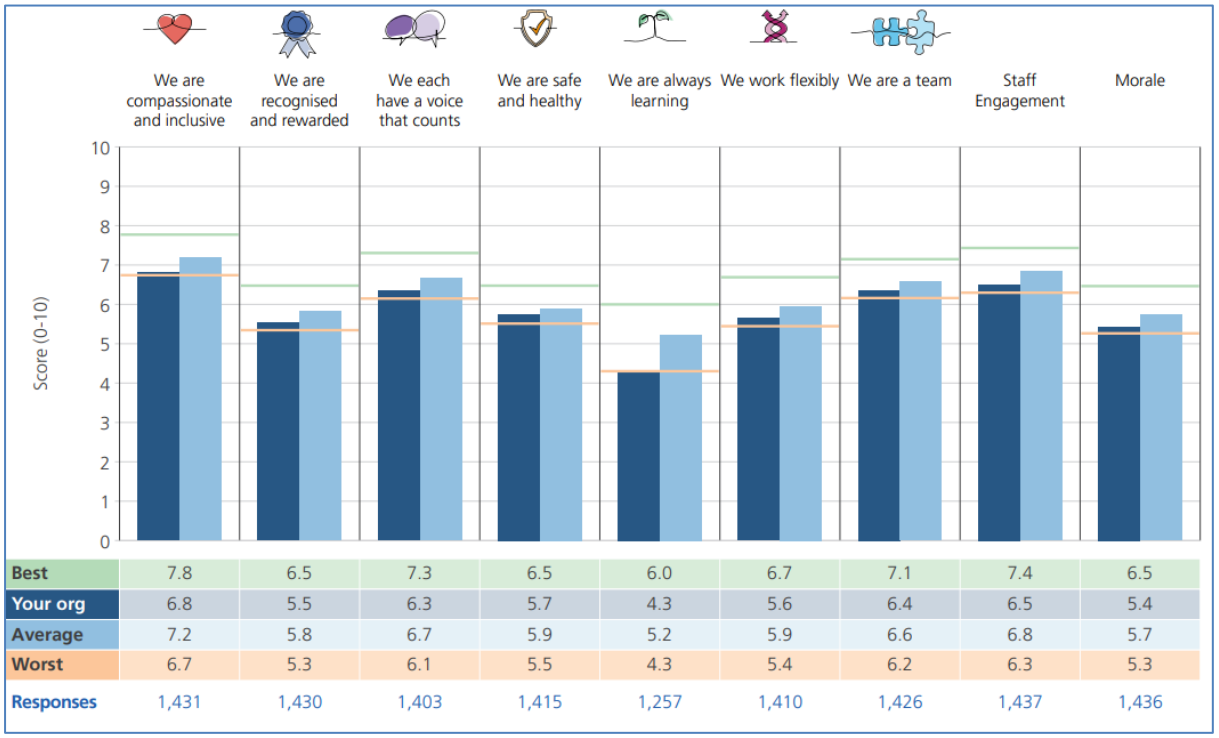
In addition to activity open to all staff, The Trust runs a range of engagement events and forums for specific initiatives, For example wellbeing and engagement focus groups were held during September and October 2021.

Following feedback from the wellbeing and engagement focus groups, and the development of a Trust Wellbeing and Engagement action plan, the long service awards were relaunched in March 2022. All current substantive staff have received an award in recognition for their NHS service and loyalty, and this will follow a rolling process as employees reach additional key milestones. Additionally, three individuals who held over 40 years' service within The Hillingdon Hospitals NHS Foundation Trust were awarded special recognition in the form of a pair of tickets for champagne afternoon tea at The Ritz, a bouquet of flowers, a certificate, a badge, and a thank you card.

Feedback from our Staff – NHS Staff Survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise', and retains the two previous themes of engagement and morale. These replace the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The response rate to the 2021/22 survey among trust staff was 42% (2020/21: 43 %).

The following table shows the Trust and the average scores for the benchmarking group (Acute and Acute &Community Trusts) in 2021.



Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	6.8	5.5	6.3	5.7	4.3	5.6	6.4	6.5	5.4
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,431	1,430	1,403	1,415	1,257	1,410	1,426	1,437	1,436

	2020/21		2019/20	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
Equality, diversity and inclusion	8.3	9.1	8.6	9.0
Health and wellbeing	5.8	6.1	5.9	5.9
Immediate managers	6.5	6.8	6.6	6.8

Morale	5.6	6.2	5.9	6.1
Quality of appraisals	Not included in 2020	Not included in 2020	5.7	5.6
Quality of care	7.3	7.5	7.6	7.5
Safe environment – Bullying and harassment	7.7	8.1	7.7	7.9
Safe environment – Violence	9.3	9.5	9.5	9.4
Safety culture	6.2	6.8	6.5	6.7
Staff engagement	6.6	7.0	6.9	7.0
Team working	6.3	6.5	6.5	6.6

This year's staff survey results show the Trust remains below average across all the themes, with improvement to make across all areas. The Trust is focusing on those areas where we are at the greatest variation from the average benchmark scores and those areas we had identified as priorities for 2021/22. These include:

- We are always learning
- We are compassionate and inclusive
- We each have a voice that counts
- We are safe and healthy
- We are recognised and rewarded

The Trust has a three year People Strategy that was developed following our 2020 survey results with key actions for each year. This year's staff survey results alongside other feedback obtained through the monthly pulse surveys, staff engagement events, People Forum, networks and Staffside are being fed into our review of the People strategy to ensure the actions outlined are still the right ones to drive improvement in staff experience.

2.6.10 Staff health and wellbeing

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

The Trust has appointed a Wellbeing Guardian and dedicated H&W lead and re-established its Trust Health and Wellbeing Steering group. In September and October 2021 it held open engagement events for staff to feedback on the current wellbeing offers available. This feedback shaped its Health and Wellbeing action plan. Actions taken during the year include the increased promotion of the health and wellbeing services available with revised information provided at induction, podcasts by the Trust's Psychology service and walkabouts by our Health and Wellbeing lead. In response to the feedback that staff were missing the opportunity for social interaction with colleagues we have launched a virtual coffee morning and hope to resume face to face networking opportunities as soon as IPC guidance allows.

Following the training of the first cohort of 28 mental health first aiders during March 2021, we trained further cohorts during 2021/22 with a total of 63 mental health first aiders currently. We will be offering further training in 2022/23. We also provided training for managers to hold H&W conversations with their staff.

Sickness absence data

A full breakdown of sickness absence data is available via the NHS Digital website (NHS Sickness Absence Rates - NHS Digital).

2.6.11 Health & Safety

The Trust continues to make good strides in regards to its Health and Safety agenda. Over the past year as the effects of the Covid-19 pandemic waned, there was greater opportunity to return to activities that were more in line with pre-pandemic objectives. The information below provides a summary of key activities, progress and ongoing challenges:

Health & Safety Governance

The Trust's Health, Safety and Environment Committee (HSEC), chaired by the Chief Operating Officer, and deputy-chaired by the Head of Trust Health and Safety, met bi-monthly on six occasions. There was a good breath of representation (including Trade Unions), improvement in the quality of discussions, and meeting quorum was met on all occasions. The HSEC reports to the Trust Management Board and the Audit and Risk Committee.

Health and Safety Reporting

Over the past year, and particularly the latter half, following a review of its Terms of Reference (July 2021), the committee has been diligently working towards, and

improving, the quality of reporting and assurance it receives from its sub-groups, as well as the reporting and assurance it provides upward. Reports were provided to the Audit and Risk Committee in April 2021 and October 2021.

There is now increasing visibility of compliance data across some areas where there was very limited assurance, e.g. water safety and fire safety (particularly in regards to fire safety enforcement). However, there is further work to improve for example, other aspects of fire safety, ventilation, medical gases, radiation protection and general estates compliance. A key part of achieving further improvements will be the forward planning of more detailed subject matter-reporting and auditing.

Health and Safety information, training and support for departmental managers

The Nominated Health and Safety Coordinator role was introduced across the Trust in Q2, which provides key points of contact across teams for Health and Safety matters, and provides a source of local support to line managers. This is supported by a dedicated training programme for coordinators, and compliance is monitored. By end of March 2022, 55 coordinators had completed the training since the launch on 24th August 2021.

The Health and Safety Booklet was also developed as a template document for managers, covering their responsibilities for Health and Safety as well as specific details (they need to input) about their department. The completed document is to be shared with staff during local inductions and safety briefs. The completion of the booklet also allows for continuity were a manager to leave or be away for any lengthy period of time. Completion is monitored through inspection and auditing.

Risk Assessments (implementation and awareness)

A number of initiatives commenced (recommenced in some cases), to address the Trust's Health and Safety Risk Assessment gaps. These included the implementation of the Health and Safety Documents and Risk Assessment Inventory across departments; risk assessment training; improved risk assessment documentation; additional intranet resource; increased direct support from the Health and Safety team; and increased auditing. The next key step will be to ensure that the process for risk assessment being communicated to staff and captured, is robust and effective.

Health, Safety and Environment Inspections

The quarterly Health, Safety and Environment Workplace Self-Inspection process has been developed, piloted and is currently being embedded. This has been implemented to support proactive identification and response to risk, as well as increased assurance. It is still in its infancy but moving forward, will play an important role in compliance monitoring.

Up to the end of March 2022, over 30 areas (a mix of clinical and non-clinical areas) had completed at least one Health, Safety and Environment Workplace Self Inspection. Work is underway to move the inspections into Survey Monkey for improved monitoring and reporting, and is expected to be implemented within Q1 of 2022.

Health and Safety Auditing

Following the shift in focus brought about by the Covid 19 pandemic, the Trust Health and Safety team relaunched its regular Health and Safety audit programme in September 2021, with an initial focus on COSHH, followed by Health and Safety Risk Assessment and Documentation in November 2021. The findings from these audits have led to coordinated, prioritised actions leading to ongoing improvements in compliance.

Further to the above, an internal audit was carried out by KPMG in October 2021, covering Health and Safety Governance. The outcome of the audit was noted as Partial Assurance with Improvements, where gaps were predominantly attributed to Covid 19 disruptions, and were already in the process of being addressed. An audit action plan is in progress and is expected to be fully completed by end of April 2022.

Notable Corporate Risks

A number of projects were ongoing throughout the year under the Estates team, which had a direct effect on risk reduction. This included, for example, improvements to fire compartmentation and safety upgrading to external window glazing in high-risk areas such as the tower block.

Health & Safety Related Incidents

Medical Devices, and particularly, availability was the most common issue across 2021-22. The most pressing device availability needs have now been addressed. However, further work is currently underway to establish a more effective replacement programme across the Trust, and to meet the Trust's Redevelopment plans.

	Top 5 Incident Category 2020-21	Top 5 Incident Category 2021-22
1	Infrastructure (staffing, facilities, environment)	Medical Device
2	Medical Device	Verbal abuse
3	Verbal abuse	Equipment (Non-Clinical)
4	Equipment (Non-Clinical)	Infrastructure (staffing, facilities, environment)
5	Assault	Assault

7 incidents (compared to 32 the previous year), were reported to the Health & Safety Executive (HSE) under the Injuries Diseases and Dangerous Occurrences Regulation (RIDDOR) 2013. "Over 7 day injuries" were the most common Type of RIDDORs reported.

Health & Safety Training

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

Moving and Handling Level 2 persistently fell below the Trust Target of 90%. However, it was noted that over 1000 training places were loss to Covid 19 since July 2020. Training capacity has since been reassessed and increased, and a review of staffing group requirements is ongoing,

The Fit Testing service continues to operate for testing and general Respiratory Protective Equipment (RPE) compliance. Following a drop in compliance across Q2 and 3, on boarding and reporting processes were strengthened, resulting in a resurgence of compliance, which currently stands between 87-90%. There is now a current focus on ensuring the delivery of 2-yearly fit-retesting, in line with Health and Safety Executive (HSE) guidance and the Department of Health and Social Care (DHSC) resilience principles published in 2021.

Looking Ahead

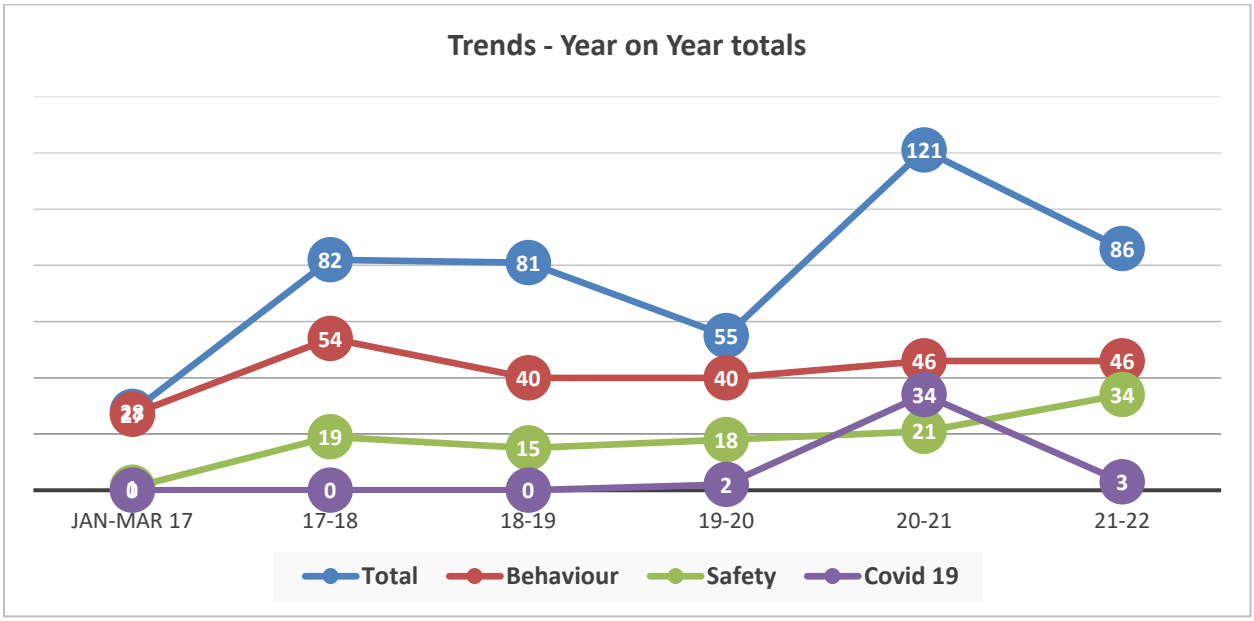
Within the coming year, the Trust's focus is to further imbed and monitor improvement initiatives and ensure there is more robust visibility of compliance, risk and risk mitigation. There will also be greater emphasis on forward planning and support to senior managers in discharging their oversight duties. Additionally, the management of contractors continues to remain high on the agenda, as significant redevelopment activities progresses across the Trust.

2.6.12 Freedom to Speak Up (FTSU)

Speaking Up protects patients and workers, but is only effective if leaders Listen Up and Follow Up. Leaders must set the tone from the top, where compassionate and inclusive leadership are role modelled, where our organisational values are articulated at every opportunity so that they are meaningful and lived by all workers. Leader's commitment to listen up and follow up enables the Freedom to Speak Up Guardian to support workers with a positive culture of learning, continuous improvement and the ability to share with others to deliver safe, excellent quality care.

In 2021-22, 86 workers accessed the Trust appointed FTSUG service. Workers were from a variety of professional backgrounds and professional levels and for many, their concerns were complex and multi-faceted. Nearly half of workers raising concerns were from a BAME background, and a near equal spread between those with managerial responsibilities and those without.

Year-to-year comparison: the FTSU Guardian, supported by a diverse range of Champions, has handled over 450 speaking up cases brought by workers since January 2017. The main category of concerns raised are detailed in the graph below. It is worth noting that about 30% of the cases during 2020/21 were related to the Covid-19 pandemic.



For October 2021, celebration focused for the second year on Black History as well as the Speaking Up agenda and was done this time in collaboration with the Equality, Diversity, and Inclusion lead. The events were a great success, where leaders and workers joined in the story telling events and made pledges in relation to *Speaking Up*.

2.6.13 Trade Union Facility Time

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

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

In line with the Trade Union (Facility Time Publication Requirements) Regulations, which came into force on 1 April 2017, Trade Union representatives are required to record their paid time off to carry out Trade Union duties and the Trust is required to publish this information on an annual basis. To comply with the regulations the Trust is required to publish the data included in the following four tables. This data relates to facility time recorded between the period of 1 April 2021 to 31 March 2022.

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

	2021/22
Number of employees who were relevant union officials during the relevant period	10
Number of full-time equivalent employees as at 31 March 2022	3363 fte

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

	2021/22
0%	
1 - 50%	4.7%
51 – 100%	

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

Percentage of pay bill spent on facility time

Total cost of facility time	£6,062
Total pay bill	£223,555,000
% of total pay bill spent on facility time (total costs of facility time/total pay bill x100)	0.003%

2.6.14 Countering fraud and corruption

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

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

2.7 NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework considers five themes:

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

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

On 9th August 2021, the Trust received notification of being placed in the System Oversight Framework Level 4 (SOF4) and the Recovery Support Programme with a particular focus on finance.

The key issues driving the Trusts SOF4 rating are shown in the table below:

<table>
<tr><th colspan="5">Financial plan delivery</th></tr>
<tr><td colspan="5">Significant risk of non-delivery of 2021/22 financial plan</td></tr>
<tr><th>Core financial controls</th><th>Financial governance</th><th>Operations and clinical</th><th colspan="2">Core team function</th></tr>
<tr><td rowspan="2">Weakness in financial control environment, including:
• Financial forecasting
• Workforce control
• Cash flow forecasting
• Working capital management
• Capital</td><td>Inadequate process to approve business cases for new spend</td><td rowspan="2">Significant risk of non-achievement of the 95% elective recovery target or any subsequent targets (e.g. clock stop)</td><td>Lack of clarity of the role of and required structure for the PMO to drive transformational change</td><td>Availability of data and business intelligence tools to support management to deliver their role</td></tr>
<tr><td rowspan="2">Financial discussion in key meetings can be narrow rather than considering finance in the round</td><td rowspan="2">Capacity and capability issues within management function including:
• Finance
• Operations
• PMO
• HR</td><td>Lack of ownership of issues and change needed to address them – culture of learned helplessness</td></tr>
<tr><td>Best use of data to drive decision making</td><td>Lack of focus on key actions and next steps in reporting with associated lack of accountability to drive financial improvement</td><td>Lack of a comprehensive operational recovery plan, particularly for outpatients</td><td>Lack of clarity of focus in communications with wider organisation and within management functions</td></tr>
</table>

In response, the Trust has developed a plan that outlines twelve programmes of work that aim to deliver against the exit criteria from SOF4, agreed with NHSEI.

3. Annual Governance Statement

3.1.1 Scope of responsibility

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

3.1.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can, therefore, only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Hillingdon Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

3.1.3 Capacity to handle risk

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

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

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

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

Trust Management Board

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

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

Risk Management Group (RMG)

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

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

Divisional Governance Groups

The Divisional Governance Groups are responsible for:

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

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

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

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

Staff are trained and supported to manage risk in a way appropriate to their authority and duties through targeted training of individuals and access to the Trust's Patient Safety, Health & Safety, and Governance Systems team.

3.1.4 Risk Control Framework

Risk Management Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Appetite Levels

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

Risk Tolerance

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

3.1.5 The organisation's major risks

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

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

In 2020/21 the Trust identified six key strategic risks which could impact on the delivery of the Trust's strategic objectives and their supporting priorities. These risks were rolled forward into 2021/22 as follows due to the detrimental impact of the Covid-19 pandemic on delivery of the Trust Strategy and Operational plan:

Strategic Objective 1	Quality – We will deliver consistent High-quality care
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor high quality care which results in consistent achievement of all relevant national and local quality standards: 1a failure to deliver safe care 1b failure to deliver good patient outcomes 1c failure to deliver good patient experience Note – key issues for the Trust in section 1.3 related to: • Maintaining adequate nurse staffing levels • Delivering high quality patient care with medical recruitment challenges and increased patient acuity
Strategic Objective 2	Workforce - Great Place to Work
Risk	Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Great Place to Work' in a competitive labour market
Strategic Objective 3	Performance – We will deliver the right care at the right time for our patients

Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to deliver consistent achievement of all relevant national performance and regulatory standards Note – key issues for the Trust in section 1.3 related to: • Responding to and recovering from the Covid-19 pandemic • Performance against Constitutional Standards
Strategic Objective 4	Money - We will live within our means
Risk	Failure to maintain the financial sustainability of the Trust and the services it provides Note – key issues for the Trust in section 1.3 related to: • the scale of investment required to improve the Trust's fragile estate infrastructure • effectiveness of the financial control system or inability to achieve the financial plan
Strategic Objective 5	Well Led – We will empower our people to deliver
Risk	Failure to embed effective corporate and clinical governance systems and structures
Strategic Objective 6	Quality – estates related in support of quality - We will deliver consistent high-quality care
Risk	Failure to maintain safe estate in a sustainable way to support the delivery of high quality, efficient care in the short and medium term in line with the planned opening of the new hospital in 2025 Note – key issues for the Trust in section 1.3 related to: • Poor condition of our estate

3.1.6 Quality Governance Arrangements

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

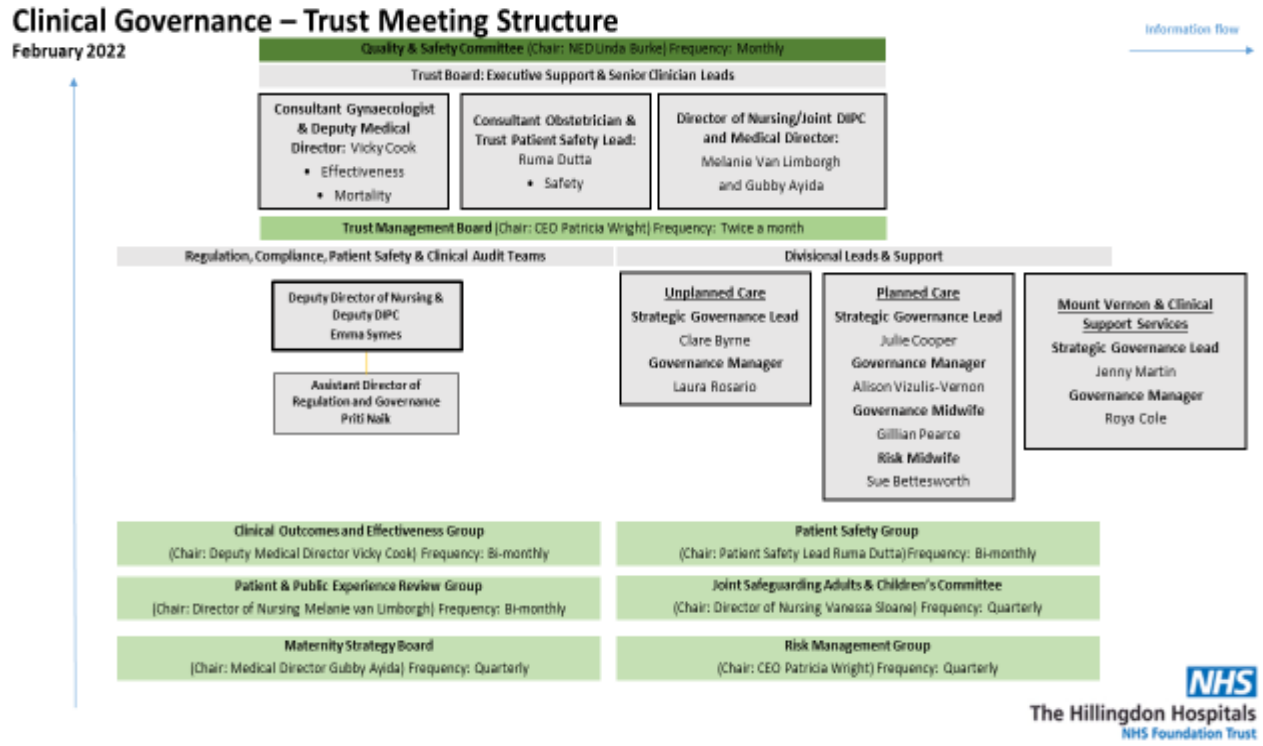
- Monthly reporting to the Board in the form of an integrated quality and performance report with exception narrative
- Presentations on clinical and quality governance issues (including discussion on risk areas, performance reviews against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit) are considered at every Quality & Safety Committee (QSC) meeting
- External quality and safety intelligence is presented at the QSC, and a summary of performance against the Quality and Safety Improvement (QSI) strategy annual action plan is also reported
- Clinical divisional governance boards review quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis
- A process of reporting the investigation of Serious Incidents (SIs) via a weekly Serious Incident Declaration Group. Root cause analysis is used and forms the basis of SI reports together with the creation of action plans which are monitored by divisional governance boards through to completion
- A wider monthly meeting is used to follow up outcomes and action plans from SIs, review the quality of reports and monitor the learning from these.
- The Trust is reviewing the information system for complaints management, with the aim of instituting auditable and proven learning where complaints are received. This will be related to other forms of patient feedback.
- Ward and Department accreditation visits, which comprise of quality and safety assessments of the clinical areas in the Trust, undertaken using a structured, Trust-developed assessment tool by a team of multidisciplinary stakeholders. The accreditation framework is aligned to the CQC's key lines of enquiry (KLOE) and five domains of quality. The outcomes of the accreditation visits are reported to divisional governance, Hillingdon Care Quality Programme meetings and also to the Quality and Safety Committee.
- The clinical divisions have undertaken a gap analysis exercise which includes self-assessment against CQC's KLOEs for each core service which has helped identifying areas of risks and gaps that will limit the core service from achieving the next level of CQC rating. The progress against

the gap analysis is reported to the Hillingdon Care Quality Programme meetings, Quality and Safety Committee and to the Trust Board.

- The Executive and Senior Management Team make regular visits to clinical departments where they have the opportunity to talk to staff and patients about their experiences.
- A robust framework is in place to ensure that all service changes are subject to a Quality Impact Assessment (QIA) which is reviewed and signed off by the Medical Director and Director of Nursing to ensure appropriate actions are being taken to mitigate any associated risks to quality
- Listening to patients and Governors: A range of opportunities exist to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation striving for quality improvement
- Opportunities also exist for patients and members of the public to attend the Council of Governors and Trust Board meetings. Patients have been involved in reviewing patient information leaflets and Trust publications. The Hospital Redevelopment Public Partnership Forum (HRPPF) ensures that the patient voice is a central part of shaping the plans to build a new hospital. Members attend virtual meetings and are an active member of the Forum, bringing their experience to ensure that the public voice is represented and considered as part of our decision making

The Trust current Clinical Governance Meeting Structure is detailed below in Figure 1 highlighting information flow from ward to Board.

Figure 1



3.1.7 Incident Reporting

At the Hillingdon Hospital NHS Foundation Trust, we are committed to building a strong safety culture providing our patients and service users with high quality, safe care. As part of this commitment there is a focus on continual improvement and learning from incidents.

As part of our commitment to learning and continuous improvement, incidents which are considered to have significant opportunities for learning, but do not meet the criteria outlined for a serious incident, will still undergo a root cause analysis investigation in the form of an Internal Investigation. The investigation is based on the same methodologies with divisional oversight and scrutiny to identify any changes to practice which might be required to prevent a similar incident reoccurring. Although there is not a specific requirement to report these incidents externally, the learning forms a key part of our wider commitment to improve patient safety across the trust

Structured processes and systems are in place in respect of incident reporting, the investigation of Serious Incidents and following up outcomes from Board commissioned external reports. The Board, through the Risk Management Strategy and Policy and the Incident Policy, promotes open and honest reporting of incidents, risks and hazards.

The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the organisation. The latest available National Reporting Learning System (NRLS) report (covering October 2019 to March 2020) does not indicate any evidence of potential under-reporting at the Trust. The Board monitors incident reporting trends via the Integrated Quality and Performance Report.

3.1.8 Serious Incidents

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

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

The Hillingdon Learning and Safety Programme which consists of a learning bulletin, disseminates key safety and learning messages from Serious Incidents, complaints, claims and inquests, clinical audit and mortality reviews.

In addition, a poster campaign, learning videos and a safety stand were launched in 2021/22 to maximise exposure to deliver key safety messages to all staff and are based on learning from all incidents including trends and themes.

3.1.9 Ensuring Safe Staffing

The Trust has a Safe Staffing policy in place which is reviewed regularly in line with the cycle of policy updates. There is an effective establishment review process in place, which is reported to board level and which supports the divisional teams in planning their staffing investment for the year ahead. This process ensures input from relevant clinical, operational and corporate teams, making plans reflective of the clinical environment and issues affecting the Trust as a whole.

Workforce plans form part of divisional business plans and are reviewed as part of the quarterly divisional review process. Progress against the outcomes of the workforce plan (and the overarching Trust People Strategy) is monitored though the Nursing, Midwifery and AHP productivity meeting and reported via the People Committee and direct to the Trust Board. Workforce development and performance is also assured through the Board Assurance Framework.

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

The Trust Board and sub-committees received a monthly update on staffing (covering CHPPD, planned vs actual fill rates and nurse-sensitive quality indicators by clinical area – in line with NQB guidance) in the form of the integrated quality performance report (IQPR). This is supplemented by a quarterly trend report which highlights any areas of concern and actions which have been taken.

The Trust has continued to further strengthen the implementation of its e-rostering system and there is an established oversight programme to ensure that clinical areas are meeting the relevant KPIs for rostering.

Nursing, midwifery, AHP and medical staffing is overseen by the Nursing and Medical directors who provide yearly sign-off that the budgets set are anticipated to provide safe and effective care to patients. Where risk is identified mid-year (out with budget setting) this is recorded on the relevant risk register and addressed and monitored accordingly.

3.1.10 Engagement with Stakeholders

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

- engagement with the local Healthwatch
- the Council of Governors, who are an integral part of our governance infrastructure as a Foundation Trust, are consulted throughout the year on key issues and risks as part of the annual operational planning process.
- annual Members' Meeting
- public members and local stakeholders are invited to join Trust staff to agree priorities for the Quality Report
- engagement with user and support groups, including the Maternity Voices Partnership, Patient-led Assessment of the Care Environment, and Stroke Forum
- patients and members of the public are offered opportunities to attend the virtual Council of Governors and Trust Board meetings
- patients are invited to review patient information leaflets and trust publications.
- the Trust continues to engage with patients and the public in respect of the patient safety and quality agenda and service improvement through CARES+
- material/information is also available via our public website, including the Annual Quality Report and Annual Report.

3.1.11 Emergency Preparedness Resilience and Response (EPRR)

The Year 2021/22 was still dominated by the Covid-19 Pandemic Response. However, with the vaccination programme rolling out nationally and a steady decrease in patients with Covid for the first half of the year there were opportunities to carry out significant reviews and improvements of the EPRR Frameworks within the Trust. The latter part of the year saw an increase in patients with Covid over the summer months and then a significant increase in patients with the Omicron variant during December 2021 – April 2022. These were managed as a continuation of the Covid-19 response incident.

Over the course of 2021/22 the Trust responded to a number of Business Continuity events.

Date	Incident	Outcome
25 August 2021	Repatriation flights into LHR from Kabul airport.	Successfully admitted and treated casualties
10 January 2022	Hoax Bomb Threat called into Switchboard	Full sweep of hospital site, police in attendance. No

		intelligence to suggest threat was real. Full debrief carried out and Incident report and action plan created
3 February 2022	Burst Water Main Mount Vernon Hospital site, no mains water across site – Business Continuity Incident Declared	Short debrief carried out – report and action plan to follow
18 February 2022	Storm Eunice – Pagett Ward roof damage - Business Continuity Incident Declared	Area made safe, ward relocated

In November 2021 the Trust was reviewed against the EPRR Core Assurance standards. The standards used were the same as previous years but with some removed to account for operational limitations caused by the Covid-19 response.

The Trust was viewed as fully compliant against 43 of the 46 standards and partially compliant against the remaining 3. There were no areas of non-compliance. This provided the Trust with an overall rating of Substantial compliance. Substantial is the second of four potential ratings with full compliance only being achieved with all 46 standards showing as fully compliant (i.e. 100%)

The areas of partial compliance were two within the area of Business Continuity (self- assessed as lower than previously following an internal review) and one against CBRNe Training which requires LAS training to be made available (currently on hold since the pandemic began).The Trust was also noted as an example of good practice in 5 areas, (more than any other Acute Trust in London).

3.1.12 Care Quality Commission: compliance with registration requirements

The Trust is fully compliant with the Care Quality Commission registration requirements and has been issued with its certificate for 2021/22. The CQC had imposed conditions on the Trust's registration in respect of a regulated activity 'Treatment of disease, disorder or injury' as a consequence of issuing the Trust with a notice of decision under Section 31 of the Health and Social Care Act 2008. Following the successful application (supported by strong evidence) made by the Trust to the CQC in August 2021 to remove the conditions imposed on Trust's registration in Section 31 notice, the CQC sent a notice of decision in October 2021, confirming that the conditions imposed on Trust's registration had been removed. The CQC issued the Trust with an updated registration certificate on 29th October 2021.

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

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

3.1.14 Compliance with the Code of Governance

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

3.1.15 Recovery Support Programme

On 9th August 2021, the Trust received notification of being placed in the System Oversight Framework Level 4 (SOF4) and the Recovery Support Programme with a particular focus on finance.

The key issues driving the Trusts SOF4 rating are shown in the table below:

<table>
<tr><th colspan="5">Financial plan delivery</th></tr>
<tr><td colspan="5">Significant risk of non-delivery of 2021/22 financial plan</td></tr>
<tr><th>Core financial controls</th><th>Financial governance</th><th>Operations and clinical</th><th colspan="2">Core team function</th></tr>
<tr><td rowspan="2">Weakness in financial control environment, including:
• Financial forecasting
• Workforce control
• Cash flow forecasting
• Working capital management
• Capital</td><td>Inadequate process to approve business cases for new spend</td><td rowspan="2">Significant risk of non-achievement of the 95% elective recovery target or any subsequent targets (e.g. clock stop)</td><td rowspan="2">Lack of clarity of the role of and required structure for the PMO to drive transformational change</td><td>Availability of data and business intelligence tools to support management to deliver their role</td></tr>
<tr><td>Financial discussion in key meetings can be narrow rather than considering finance in the round</td><td rowspan="2">Capacity and capability issues within management function including:
• Finance
• Operations
• PMO
• HR</td><td>Lack of ownership of issues and change needed to address them – culture of learned helplessness</td></tr>
<tr><td>Best use of data to drive decision making</td><td>Lack of focus on key actions and next steps in reporting with associated lack of accountability to drive financial improvement</td><td colspan="2">Lack of a comprehensive operational recovery plan, particularly for outpatients</td><td>Lack of clarity of focus in communications with wider organisation and within management functions</td></tr>
</table>

In response, the Trust has developed a plan that outlines twelve programmes of work that aim to deliver against the exit criteria from SOF4, agreed with NHSEI.

3.1.16 London Fire Brigade Enforcement Notice

The London Fire Brigade (LFB) carried out a fire safety audit on 6th November 2019 to review the Trust fire safety systems and processes. As a result, the Trust received an Enforcement Notice on 30th January 2020 which highlighted items within the Articles from the Regulatory Reform (Fire Safety) Order 2005 which the LFB were concerned about.

These issues were around fire detection and warning, means of escape, training, compartmentation and a lack of fire-fighting lifts mainly related to the Tower Block.

A 35-point action plan was developed to address the concerns, and were required to be undertaken by 23rd December 2021. 31 of 35 actions are complete, the remaining 4 actions relate to capital works in the Tower block and are expected to complete in June 2022.

The Trust has closely liaised with the LFB and NHSEI on progress to date, formally presented progress to the LFB on 10th December 2021 and is awaiting formal feedback.

3.1.17 Information Governance

Risks relating to information are managed and controlled in accordance with the Trust's Information Governance Policy. The Senior Information Risk Owner (SIRO) is the Board lead for information risk. The Trust follows guidance for incident reporting issued by NHS Digital. The guidance, based on the requirements of the UK General Data Protection Regulation (GDPR), Data Protection Act 2018 and the National Data Security Standards, requires incidents to be reported via the Data Security and Protection Toolkit (DSPT).

The Trust reported one incident to the Information Commissioner's Office (ICO) in 2021/2022 relating to failure to secure records. The ICO closed this incident but made a number of recommendations concerning training and awareness which is in place.

Each year, the Trust is required to provide assurance to NHS Digital via the Data Security Protection Toolkit. The results of assessments are published. The Data Security Protection Toolkit contains 10 data security standards that all healthcare providers should meet. These standards were established following a review conducted by the National Data Guardian and are published in their guidance on 'Data Security, Consent and Opt-Outs' 2016. The submission date for the Data Security Protection Toolkit is the 30 June 2022.

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

We have reported on the Trust's financial performance elsewhere in this Annual Report. The Trust reported a £11.5m deficit in the financial year, but received additional funding in the second half of the year to help achieve this. The Trust has significant financial challenges and a worsening underlying financial position once non-recurrent financial benefits are removed.

Regular monthly block funding allowed the Trust to forecast cash with improved accuracy through the year. The additional funding in the second half of the year meant that the Trust was relatively cash healthy for the majority of the year. Looking forward to 2022/23, the forecast financial deficit of the Trust in that year means that there could be cash challenges towards the end of the next financial year.

The Trust Board receives a monthly overview of the Trust's use of resources through the monthly finance report, allowing grip and control on financial performance and cost-effectiveness. Additionally, the Trust's involvement in the Recovery Support Programme means that the Trust's governance structure is receiving significantly enhanced information about all aspects of the Trust's use of resources. This includes regular detailed updates on Trust action plans to exit the Recovery Support Programme by making improvements to the control environment and translating to business as usual.

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

3.1.19 Data Quality Governance

Following a post pandemic review of the Data Quality (DQ) function at the Trust, the Data Quality Assurance Group (DQASG) has now been running for a full 12 months chaired by the Chief Information Officer (CIO). The group provides strategic direction on all matters relating to data quality, to promote good data quality practices within the organisation and to ensure processes are in place for good quality data to be available to support the delivery of clinical services and Trust objectives. This group reports into

the Data Security & Protection Group (DSPT) chaired by the Deputy CEO/SIRO and then on to the Audit and Risk Committee.

Standing agenda items include a review of the available national DQ dashboards such as Secondary Uses Service (SUS) datasets, Emergency Care Data Set (ECDS), Referral to Treatment (RTT) datasets, Maternity Services Data Set (MSDS) and the Diagnostic Imaging Dataset (DID). These dashboards highlight areas of DQ concern and good practice against a set threshold or benchmarked against other providers and allows local DQ resources to be targeted effectively.

As well as the national dashboards, the DQ Analyst also presents issues surfaced through local intelligence. Issues worked through in the past year range from clinic profile set up on the Patient Administration System (PAS) to support effective digital communications through to supporting clinical colleagues to improve the capture of observations data through the electronic observations system.

The group continues to support 'data owners' to manage the data that they have responsibility for to improve data quality and for them to be able to provide assurance around any data that is reported either internally or externally. Any external audits and resulting actions are monitored through the DQASG.

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

The Trust reports to the North West London (NWL) Elective Programme Board providing weekly standardised Referral to Treatment (RTT)/Patient Treatment List (PTL) for regional performance, decision making and data quality monitoring. . Patient pathways are clinically risk assessed based on nationally agreed standards. Source Systems (including the main patient access system) are updated to allow recording and monitoring of new requirements.

Through this work stream, there is an ICS wide implementation programme to introduce a system designed for clinicians to assess and prioritise patients on the Inpatient Waiting List with the longer term aim to allow management of this waiting list at an ICS level.

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

Data Quality within A&E is monitored through the national daily Urgent and Emergency Care Situation Reports, (which are reviewed internally and regionally though the NWL working Group) and internal daily reports. Automated data flow procedures and Standard Operating Procedure documents were reviewed in 2021/22, with a focus on reducing single points of failure and improving reporting consistency.

3.1.20 Data Security

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

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

3.1.21 Register of interests for decision-making staff

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

3.1.22 Bribery

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

3.1.23 Equality, Diversity and Human Rights

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

The Trust has taken seriously the key metrics' results (WRES, WDES, and Gender Pay Gap (GPG)) and the staff survey feedback, and has created an EDI action plan to address the issues raised from the reports. A Diversity and Inclusion lead has been appointed to drive the EDI strategy and agenda; so the organisation can meet its obligations under the equality, diversity and human rights legislation. Our key objectives for 2022/23 are the Trust's networks (existing and proposed); their activities, and improving staff engagement. The EDI lead has also designed an EDI calendar and events to mark special days, throughout the year. The BAME and LGBT history month's events were engaging and inspiring. EDI workshops have been running for all teams and departments, as well as an EDI Good Practice Points booklet which is available for staff when looking after patients from diverse backgrounds. Reciprocal mentoring is our next key action, where staff with protected characteristics are signed up to mentor a member of executive team or senior leader of the Trust. The Trust is refining the Interview panel experts programme by providing robust training and clear procedures.

3.1.24 Pension Scheme Regulations

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

3.1.25 Modern Slavery

The Trust has a modern slavery statement on its website as required which is reviewed annually.

3.1.26 Overseas operations

The Trust does not have any overseas operations.

3.1.27 Assessing our Impact on the environment

The Trust 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 are complied with by delivering the Trust Board approved Green Plan whose commitments are aligned with the wider NHS carbon and other noxious gas emissions reduction targets, which are:

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

3.2 Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached separately to 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 Trust Board, the Audit and Risk Committee and the Quality and Safety Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The clinical audit programme also supports my review of the effectiveness of the system of internal control. A full internal review of each clinical audit is undertaken, with action plans developed and implemented to address any identified risks and improve the quality of healthcare that is provided.

The role of the Trust Board and the Sub-Committee of the Trust Board in maintaining and reviewing the Trust's systems of internal control is described throughout this Annual Report.

The internal audit programme provides a further mechanism for doing this. KPMG, the Trust's internal auditors, identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker, and reviewed frequently by the executive team. In 2021/22 there were 4 high-priority recommendations identified by our internal auditors. The overall head of internal audit opinion for the period 1 April 2021 to 31 March 2022 is that 'Partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control, and not all the prior year recommendations had been implemented i.e. Capital Governance.

The table below summarises the assurance ratings for internal audit work undertaken in 2021/22:

			Management actions accepted			
	Internal audit	Assurance rating	H	M	L	Total
01/22	IPC risk management	Significant assurance with minor improvement opportunities	0	1	1	**2**
02/22	Financial controls – Accounts Payable	Partial assurance with improvements required	2	4	2	**8**
03/22	Capital procurement	Partial assurance with improvements required	0	7	0	**7**
04/22	Patient safety data – Falls and HAPUs	Partial assurance with improvements required	0	5	1	**6**
05/22	Health and safety governance	Partial assurance with improvements required	1	3	3	**7**
06/22	eRostering and ESR interface	Partial assurance with improvements required	1	2	2	**5**
07/22	Risk Governance	Significant assurance with minor improvement opportunities	0	3	7	**10**
08/22	DSP Toolkit	Significant assurance with minor improvement opportunities	0	2	2	**4**
Total actions raised			**4**	**26**	**19**	**49**

3.3 Conclusion

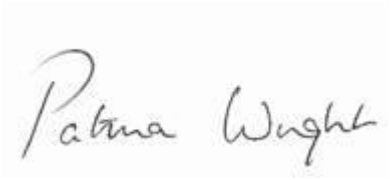
Significant internal control issues have been identified. Where significant control issues have been identified, appropriate plans are in place to deliver the required improvements. These are monitored and assurance sought via the Trusts Governance framework.

The significant control issues identified are:

- The Trust continues to be rated as 'Requires Improvement', with the Hillingdon site rated as 'Inadequate' by the CQC following their core services inspection in 2018 (see section 1.6 above).
- The Trusts Head of Internal Audit Opinion for 2021/22 is one of 'Partial assurance with improvement required', and not all the prior year

recommendations had been implemented i.e. Capital Governance (see section 3.2 above).

- The Trust continues to be subject to enforcement undertakings as issued by NHS Improvement in 2018, which identified that the Trust was not meeting its licence requirements and was required to improve governance systems and processes to address weaknesses in infection control processes, and A&E waiting time performance.
- In August 2021 the Trust entered System Oversight Framework Level 4 (SOF4) and the Recovery Support Programme with a particular focus on finance (see section 2.7 above).



Patricia Wright

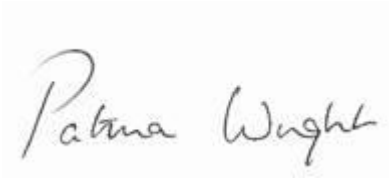
Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

21st June 2022

Accounting Officer approval of the Accountability Report

As Accounting Officer, I am satisfied that this accountability report provides a true and accurate summary of the performance of the Trust during the year 2021/22.



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

21st June 2022

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

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

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

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

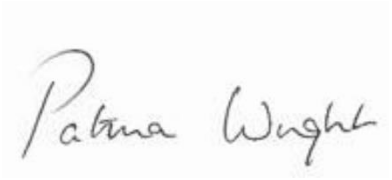
- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in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

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

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

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

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



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

21st June 2022

Appendix

The Hillingdon Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

The Hillingdon Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by The Hillingdon Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Patricia Wright**
Job title **Chief Executive**
Date **21 June 2022**

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

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

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

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

Basis for opinion

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

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

Conclusions relating to going concern

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

We discussed among the audit engagement team, including relevant internal specialists such as valuations, IT, and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address it are described below:

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

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

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

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance,

- and reviewing internal audit reports.

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Use of resources

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

On 17 June 2022 we reported to the foundation trust significant weaknesses in the foundation trust's governance arrangements and arrangements to secure financial sustainability. The significant weaknesses reported are as follows:

- In our audit report, dated 8 July 2021 on the 2020/21 financial statements, we identified a significant governance weakness due to findings raised by the CQC in their report issued to the Trust in December 2020. We recommended that the Trust implements the recommendations from the CQC report. We note that the Trust has not subsequently received a rated CQC report and so the Hillingdon Hospitals' rating remains "inadequate" and the Trust's overall rating remains "requires improvement" and these ratings are indicative of weaknesses in the Trust's arrangements. We have not raised a further recommendation as our recommendation is unchanged to the one reported in our prior year audit report.
- The foundation trust received an opinion from its head of internal audit for 2021/22 of "Partial Assurance with some improvements required". The significant areas of weakness identified were in respect of capital purchasing and procurement, financial controls, Financial Instruction Waiver processes, and Data Quality and Assurance. We also note that control recommendations from our 2020/21 audit with respect to capital accounting have not been implemented. We recommended that management addresses the recommendations made by internal audit and external audit in line with the agreed timeframe for remediation.
    - In our audit report, dated 8 July 2021 on the 2020/21 financial statements, we reported a significant weakness in the foundation trust's governance arrangements in relation to enforcement undertakings from NHS Improvement. We recommended that the foundation Trust implements the requirements of its action plan. These undertakings remained in force throughout the year to 31 March 2022, therefore, this weakness has not yet been fully addressed. We have not raised a further recommendation as our recommendation is unchanged to the one reported in our prior year audit report.
- In August 2021, the foundation Trust was notified that it entered Level 4 of the NHS System Oversight Framework due to a significant risk of the Trust not meeting its financial plan in FY21/22. We therefore report a significant weakness in the Trust's financial sustainability

arrangements. We recommend that the Trust should continue to act according to their Recovery Support Programme to exit these measures.

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

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

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

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

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

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

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

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

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

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

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

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

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

Use of our report

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

Jonathan Gooding.

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

Date: 22 June 2022

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2022 issued on 22 June 2022 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

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

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

As at the date of issue of our audit report for the year ended 31 March 2022 on 22 June 2022, we had not completed our work on the foundation trust's arrangements.

In our audit report for the year ended 31 March 2022 issued on 22 June 2022, we reported significant weaknesses in the foundation trust's governance arrangements in respect of: weaknesses identified by the Care Quality Commission; weaknesses identified by the Trust's internal auditor in respect of capital purchasing and procurement, financial controls, Financial Instruction Waiver processes, and Data Quality and Assurance; weaknesses reflected in the Trust's enforcement undertakings from NHS Improvement which remained in force during the year; and weakness in the Trust's financial sustainability arrangements in relation to entering Level 4 of the NHS System Oversight Framework due to a significant risk of the Trust not meeting its financial plan in FY21/22.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2022 issued on 22 June 2022, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

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

We have nothing further to report in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources above the significant weaknesses already reported at 22 June 2022 as referenced above.

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

Jonathan Gooding, FCA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
08 September 2022

Statement of Comprehensive Income

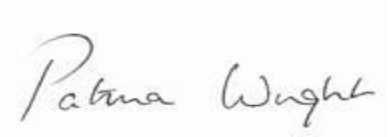
	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	316,641	258,853
Other operating income	4	30,750	47,825
Operating expenses	6, 8	(347,533)	(301,444)
Operating (deficit) / surplus from continuing operations		**(142)**	**5,234**
Finance income	11	0	5
Finance expenses	12	(1,823)	(2,042)
PDC dividends payable		(6,944)	(5,913)
Net finance costs		**(8,767)**	**(7,950)**
Other losses	13	(2,542)	(2,456)
Deficit for the year from continuing operations		**(11,451)**	**(5,172)**
Deficit for the year		**(11,451)**	**(5,172)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,348)	(3,743)
Revaluations	17	8,209	3,519
Total comprehensive income / (expense) for the period		**(9,590)**	**(5,396)**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	10,887	7,759
Property, plant and equipment	15	231,006	207,981
Investment property	18	46,826	49,855
Receivables	20	1,719	1,459
Total non-current assets		**290,438**	**267,054**
Current assets			
Inventories	19	3,736	4,670
Receivables	20	14,148	25,786
Cash and cash equivalents	21	56,421	47,363
Total current assets		**74,305**	**77,819**
Current liabilities			
Trade and other payables	22	(64,629)	(73,662)
Borrowings	24	(1,199)	(1,236)
Provisions	26	(158)	(158)
Other liabilities	23	(6,100)	(2,997)
Total current liabilities		**(72,086)**	**(78,053)**
Total assets less current liabilities		**292,657**	**266,820**
Non-current liabilities			
Borrowings	24	(14,792)	(15,855)
Provisions	26	(2,822)	(1,666)
Total non-current liabilities		**(17,614)**	**(17,521)**
Total assets employed		**275,043**	**249,299**
Financed by			
Public dividend capital		283,049	247,715
Revaluation reserve		53,408	53,133
Income and expenditure reserve		(61,415)	(51,549)
Total taxpayers' equity		**275,043**	**249,299**

The notes on pages 15 to 63 form part of these accounts.

These financial statements have been authorised for issue on behalf of the Board by:



Name	Patricia Wright
Position	Chief Executive
Date	21 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	**247,715**	**53,133**	**(51,549)**	**249,299**
Surplus/(deficit) for the year	-	-	(11,451)	**(11,451)**
Other transfers between reserves	-	(1,586)	1,586	**-**
Impairments	-	(6,348)	-	**(6,348)**
Revaluations	-	8,209	-	**8,209**
Public dividend capital received	35,334	-	-	**35,334**
Taxpayers' and others' equity at 31 March 2022	**283,049**	**53,408**	**(61,415)**	**275,043**

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

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

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 / (deficit)		(142)	5,234
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,189	9,723
Net impairments	7	19,044	3,222
Income recognised in respect of capital donations	4	(2,036)	(1,288)
(Increase) / decrease in receivables and other assets		11,611	(2,151)
(Increase) / decrease in inventories		934	(1,503)
Increase / (decrease) in payables and other liabilities		9,036	10,012
Increase / (decrease) in provisions		1,173	(82)
Net cash flows from operating activities		**49,809**	**23,166**
Cash flows from investing activities			
Interest received		0	5
Purchase of intangible assets		(3,429)	(4,740)
Purchase of PPE and investment property		(64,321)	(34,350)
Sales of PPE and investment property		26	-
Receipt of cash donations to purchase assets		2,036	-
Prepayment of PFI capital contributions		(254)	(2)
Net cash flows (used in) investing activities		**(65,942)**	**(39,087)**
Cash flows from financing activities			
Public dividend capital received		35,334	172,378
Public dividend capital repaid		-	(3,600)
Movement on loans from DHSC		(390)	(106,341)
Capital element of finance lease rental payments		(417)	(645)
Capital element of PFI, LIFT and other service concession payments		(293)	(251)
Interest on loans		(156)	(739)
Other interest		(8)	(7)
Interest paid on finance lease liabilities		(66)	(100)
Interest paid on PFI, LIFT and other service concession obligations		(1,610)	(1,597)
PDC dividend (paid) / refunded		(7,203)	(5,606)
Net cash flows from / (used in) financing activities		**25,191**	**53,492**
Increase / (decrease) in cash and cash equivalents		**9,058**	**37,571**
Cash and cash equivalents at 1 April - brought forward		**47,363**	**9,791**
Cash and cash equivalents at 31 March	21	**56,421**	**47,363**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Note 1.2 Going concern

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

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

The main source of income for the Trust is contracts with commissioners for health care services. In 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 the Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. 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.

NHS injury cost recovery scheme

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

Note 1.4 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Depreciation has been calculated on the straight line basis. 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 are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

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

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

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

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

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

Useful lives of property, plant and equipment

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

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

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

Note 1.8 Intangible assets

Recognition

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

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	5	15

Note 1.9 Inventories

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

In 2020/21 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 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure. The fair value of investment properties is determined by an annual valuation by an independent valuer engaged by the Trust. The valuer is Gerald Eve LLP, whose staff hold recognised and relevant professional qualifications to complete the work; the valuer also has experience of valuing these properties.

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

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

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

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

Derecognition

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

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

Note 1.13 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

The trust as a lessor

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective 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 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.
Contingent liabilities are not recognised unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy

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

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively 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 reviewed all leases and contracts that could contain leases to obtain a complete picture of the impact of the implementation of the standard. Based on this review, it has populated DHSC models to assess the financial impact. This is set out below. The Trust has fully participated in the various DHSC data collection exercises from January 2022 onwards.

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	2,036
Additional lease obligations recognised for existing operating leases	(1,988)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**48**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(934)
Additional finance costs on lease liabilities	(26)
Lease rentals no longer charged to operating expenditure	927
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(33)**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's LIFT liabilities where future payments are linked to a price index representing the rate of inflation. The LIFT 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.

Note 1.23 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements about the carrying amount of assets and liabilities, and to disclose material judgements here. The Trust considers that no material judgements have been made during the production of the financial statements.

Note 1.24 Sources of estimation uncertainty

In the application of the Trust's accounting policies management is required to make estimates, and assumptions about the carrying amount of assets and liabilities. The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

In this disclosure, in line with accounting standards, we focus only on uncertainties that have a potential material impact on the financial statements.

Asset valuations

In line with the Trust's Property, Plant and Equipment (PPE) policy (and to comply with accounting standards) a desktop valuation of all land and property owned by the Trust was undertaken in March 2022 by Gerald Eve LLP, an independent firm of professional valuers. In the case of some assets (for example Modular North and South) additional inspection work was carried out. This valuation was carried out in accordance with the Valuation – Global Standards 2020 of the Royal Institution of Chartered Surveyors (RICS) and was consistent with the requirements of HM Treasury, the Department of Health and Social Care and NHS Improvement and International Financial Reporting Standards (IFRS).

As a result of the continuing impact of the novel coronavirus (COVID-19), which was declared a global pandemic on 11 March 2020, on market activity, the external valuers have included a "market conditions explanatory note" in their report. The note makes clear that the valuation is not subject to a material valuation uncertainty, and states the following:

The outbreak of COVID-19, declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has and continues to impact many aspects of daily life and the global economy – with some real estate markets having experienced lower levels of transactional activity and liquidity. Travel restrictions have been implemented by many countries and "lockdowns" applied to varying degrees. A third national lockdown has now been deployed to attempt to stem the emergence of significant further outbreaks.

The COVID-19 pandemic and measures to tackle it continue to affect economies globally. Nevertheless, as at the valuation date property markets are mostly functioning, with transaction volumes and other relevant evidence at levels where enough market evidence exists upon which to base opinions of value. Accordingly - and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

To reflect their judgement on the impact of COVID-19 on prevailing land values, the valuer has land sales, which it should be noted were all before the Covid-19 pandemic, and a land price of £2,300,000 per acre at the Hillingdon site was determined; this was applied to the alternative hospital site.

Within the valuation, other factors also considered were build cost inflation, differing choice of cost rates for individual assets, differing non-physical obsolescence judgements, positive adjustments or impairments on capital improvements held at cost until revaluation, differing assumptions on professional fees levels, finance costs etc. the majority of which are inter-linked and are not analysed here.

Note 2 Operating Segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely available and the cost to develop this information would be significant.

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 £000	2020/21 £000
Acute services		
Block contract / system envelope income	290,554	233,919
High cost drugs income from commissioners (excluding pass-through costs)	12,169	12,799
Other NHS clinical income	2,473	3,415
Ambulance services		
Patient transport services income	1,218	1,198
All services		
Elective recovery fund	2,331	-
Additional pension contribution central funding*	7,896	7,522
Total income from activities	**316,641**	**258,853**

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	22,604	28,231
Clinical commissioning groups	290,616	227,204
Other NHS providers	560	1,077
Non-NHS: private patients	40	7
Non-NHS: overseas patients (chargeable to patient)	2,397	1,617
Injury cost recovery scheme	35	430
Non NHS: other	389	287
Total income from activities	**316,641**	**258,853**
Of which:		
Related to continuing operations	316,641	258,853

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

	2021/22	2020/21
	£000	£000
Income recognised this year	2,397	1,617
Cash payments received in-year	861	468
Amounts added to provision for impairment of receivables	1,890	1,183
Amounts written off in-year	12	76

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	418	-	**418**	331	-	**331**
Education and training	8,918	146	**9,064**	9,131	107	**9,238**
Non-patient care services to other bodies	9,289		**9,289**	6,747		**6,747**
Reimbursement and top up funding	1,019		**1,019**	21,836		**21,836**
Income in respect of employee benefits accounted on a gross basis	316		**316**	466		**466**
Receipt of capital grants and donations		2,036	**2,036**		1,288	**1,288**
Charitable and other contributions to expenditure		934	**934**		3,224	**3,224**
Rental revenue from operating leases		2,802	**2,802**		2,694	**2,694**
Other income	4,872	-	**4,872**	2,001	-	**2,001**
Total other operating income	**24,832**	**5,918**	**30,750**	**40,512**	**7,313**	**47,825**
Of which:						
Related to continuing operations			30,750			47,825

Note 5.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	276,286	226,462
Income from services not designated as commissioner requested services	40,355	32,391
Total	**316,641**	**258,853**

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	97	396
Staff and executive directors costs	217,523	202,348
Remuneration of non-executive directors	201	144
Supplies and services - clinical (excluding drugs costs)	31,060	27,654
Supplies and services - general	3,764	4,716
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,675	15,317
Consultancy costs	10	16
Establishment	7,814	6,154
Premises	11,394	9,657
Transport (including patient travel)	2,733	2,446
Depreciation on property, plant and equipment	9,321	8,682
Amortisation on intangible assets	868	1,041
Net impairments	19,044	3,222
Movement in credit loss allowance: contract receivables / contract assets	2,629	1,436
Movement in credit loss allowance: all other receivables and investments	-	171
Increase/(decrease) in other provisions	930	61
Fees payable to the external auditor		
audit services- statutory audit	229	142
other auditor remuneration (external auditor only)	-	-
Internal audit costs	103	89
Clinical negligence	13,514	11,102
Legal fees	226	231
Insurance	417	371
Research and development	402	379
Education and training	1,741	1,520
Rentals under operating leases	791	782
Redundancy	89	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	507	525
Car parking & security	472	526
Hospitality	3	1
Losses, ex gratia & special payments	51	25
Other services, eg external payroll	1,439	2,236
Other	1,486	54
Total	**347,533**	**301,444**
Of which:		
Related to continuing operations	347,533	301,444

The audit fee payable to the external auditors for the 2021/22 audit, excluding VAT, is £141k. The figure reported above contains overrun expenditure in relation to the 2020/21 audit.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	11,590	3,222
Abandonment of assets in course of construction	1,316	-
Other	6,138	-
Total net impairments charged to operating surplus / deficit	**19,044**	**3,222**
Impairments charged to the revaluation reserve	6,348	3,743
Total net impairments	**25,392**	**6,965**

The Trust had a desktop revaluation undertaken as at 31 March 2022. There are some buildings on the Trust's sites which have advanced levels of obsolescence, and the valuation reflects that. In particular, some assets have a low or zero revaluation reserve balance; and when the valuation was updated and showed further downward movement due to the age and condition of the assets, these amounts were taken to I&E in line with accounting standards.

Part of the impairment recorded above relates to the completion of the Modular North and South buildings. This impairment is different to the obsolescence-related impairments in that it relates directly to the difference between how much the buildings cost to construct versus the 31 March valuation.

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	166,510	152,756
Social security costs	17,304	16,049
Apprenticeship levy	812	745
Employer's contributions to NHS pensions	25,558	24,402
Pension cost - other	57	52
Temporary staff (including agency)	15,431	13,439
Total gross staff costs	**225,672**	**207,443**
Recoveries in respect of seconded staff	(2,117)	(1,811)
Total staff costs	**223,555**	**205,632**
Of which		
Costs capitalised as part of assets	4,335	1,705

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 £375k (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.

Note 10 Operating leases

Note 10.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where The Hillingdon Hospitals NHS Foundation Trust is the lessor.

The most significant operating leases generating income for the Trust are located at the Mount Vernon site, most notably the BMI Bishops Wood hospital. In addition the Trust generates some income through the rental of mobile phone masts on the Trust's tower block.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	2,065	2,626
Contingent rent	737	68
Total	**2,802**	**2,694**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,657	1,706
- later than one year and not later than five years;	6,588	6,598
- later than five years.	91,810	93,456
Total	**100,055**	**101,760**

Note 10.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Hillingdon Hospitals NHS Foundation Trust is the lessee.

The Trust is involved in non-material operating leases for temporary buildings and medical equipment. The most significant is for the Bevan ward, for which the Trust pays approximately £350k per year and has two years to run.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	731	731
Contingent rents	60	51
Total	**791**	**782**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	751	782
- later than one year and not later than five years;	665	1,395
- later than five years.	-	-
Total	**1,416**	**2,177**

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	0	5
Total finance income	**0**	**5**

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	156	282
Finance leases	66	100
Interest on late payment of commercial debt	8	8
Main finance costs on PFI and LIFT schemes obligations	787	806
Contingent finance costs on PFI and LIFT scheme obligations	823	791
Total interest expense	**1,840**	**1,987**
Unwinding of discount on provisions	(17)	55
Other finance costs	-	-
Total finance costs	**1,823**	**2,042**

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

	2021/22	2020/21
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	8

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	-	26
Total gains / (losses) on disposal of assets	**-**	**26**
Fair value gains / (losses) on investment properties	(2,542)	(2,482)
Total other gains / (losses)	**(2,542)**	**(2,456)**

Note 14 Intangible assets - 2021/22

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**10,423**	**4,488**	**14,911**
Additions	109	3,320	**3,429**
Valuation / gross cost at 31 March 2022	**11,099**	**7,808**	**18,907**
Amortisation at 1 April 2021 - brought forward	**7,152**	**-**	**7,152**
Provided during the year	868	-	**868**
Amortisation at 31 March 2022	**8,020**	**-**	**8,020**
Net book value at 31 March 2022	**3,079**	**7,808**	**10,887**
Net book value at 1 April 2021	**3,271**	**4,488**	**7,759**

Note 14.1 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**8,397**	**1,774**	**10,171**
Additions	71	4,669	**4,740**
Reclassifications	1,955	(1,955)	**-**
Valuation / gross cost at 31 March 2021	**10,423**	**4,488**	**14,911**
Amortisation at 1 April 2020 - as previously stated	**6,111**	**-**	**6,111**
Provided during the year	1,041	-	**1,041**
Amortisation at 31 March 2021	**7,152**	**-**	**7,152**
Net book value at 31 March 2021	**3,271**	**4,488**	**7,759**
Net book value at 1 April 2020	**2,286**	**1,774**	**4,060**

Note 15.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**53,506**	**76,674**	**211**	**62,133**	**37,871**	**18**	**22,015**	**93**	**252,521**
Additions	-	19,724	-	25,746	3,227	-	912	-	**49,609**
Impairments	-	(24,208)	-	(1,316)	-	-	-	-	**(25,524)**
Reversals of impairments	-	132	-	-	-	-	-	-	**132**
Revaluations	-	7,844	365	-	-	-	-	-	**8,209**
Reclassifications	-	46,629	1,612	(49,239)	898	-	20	-	**(80)**
Valuation/gross cost at 31 March 2022	**53,506**	**126,795**	**2,188**	**37,324**	**41,996**	**18**	**22,947**	**93**	**284,867**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**27,842**	**18**	**16,600**	**80**	**44,540**
Provided during the year	-	5,906	365	-	1,888	-	1,159	3	**9,321**
Accumulated depreciation at 31 March 2022	**-**	**5,906**	**365**	**-**	**29,730**	**18**	**17,759**	**83**	**53,861**
Net book value at 31 March 2022	**53,506**	**120,889**	**1,823**	**37,324**	**12,266**	**-**	**5,188**	**10**	**231,006**
Net book value at 1 April 2021	**53,506**	**76,674**	**211**	**62,133**	**10,029**	**-**	**5,415**	**13**	**207,981**

Reclassifications include transfers from assets under construction to other categories in this note; but also transfers to intangible assets (note 14.1) and investment properties (note 18.1).

Note 15.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**52,080**	**93,053**	**1,696**	**20,431**	**32,779**	**18**	**17,677**	**93**	**217,827**
Additions	-	350	-	53,486	4,542	-	2,686	-	**61,064**
Impairments	-	(6,527)	-	(574)	-	-	-	-	**(7,101)**
Reversals of impairments	-	136	-	-	-	-	-	-	**136**
Revaluations	1,426	(18,334)	(1,485)	-	-	-	-	-	**(18,393)**
Reclassifications	-	7,996	-	(11,210)	550	-	1,652	-	**(1,012)**
Valuation/gross cost at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**37,871**	**18**	**22,015**	**93**	**252,521**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**14,870**	**1,152**	**-**	**25,874**	**18**	**15,779**	**77**	**57,770**
Provided during the year	-	5,557	333	-	1,968	-	821	3	**8,682**
Revaluations	-	(20,427)	(1,485)	-	-	-	-	-	**(21,912)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**27,842**	**18**	**16,600**	**80**	**44,540**
Net book value at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**10,029**	**-**	**5,415**	**13**	**207,981**
Net book value at 1 April 2020	**52,080**	**78,183**	**544**	**20,431**	**6,905**	**-**	**1,898**	**16**	**160,057**

Note 15.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	52,906	110,268	1,823	37,324	9,642	-	5,188	10	**217,161**
Finance leased	-	-	-	-	1,044	-	-	-	**1,044**
On-SoFP PFI contracts and other service concession arrangements	600	9,405	-	-	-	-	-	-	**10,005**
Owned - donated/granted	-	1,216	-	-	1,580	-	-	-	**2,796**
NBV total at 31 March 2022	**53,506**	**120,889**	**1,823**	**37,324**	**12,266**	**-**	**5,188**	**10**	**231,006**

Note 15.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	52,906	65,483	211	62,133	7,310	-	5,390	13	**193,446**
Finance leased	-	-	-	-	1,431	-	25	-	**1,456**
On-SoFP PFI contracts and other service concession arrangements	600	9,384	-	-	-	-	-	-	**9,984**
Owned - donated/granted	-	1,807	-	-	1,288	-	-	-	**3,095**
NBV total at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**10,029**	**-**	**5,415**	**13**	**207,981**

Note 16 Donations of property, plant and equipment

The Trust received £0.255m in donated assets during the year (£1.288m in 2020/21), all originating via the Trust's linked charity. £0.22m of this was a donation to partly fund the construction of a maternity bereavement suite. The remainder was for the purchase of assorted low value medical equipment.

The Trust also received £1.8m in grant from Salix to fund environmental sustainability projects at the Trust.

Note 17 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued as at 31 March 2022 following an inspection by qualified independent valuers Gerald Eve LLP. The assets were revalued on the basis of their current value in existing use.

As has been the case with previous valuations of operational land and buildings, most of the hospital buildings on both the Hillingdon and Mount Vernon sites are designated as specialised assets (on the grounds that there is no active market for them and hospital buildings are seldom sold in the market). On this basis, valuation guidance available in the RICS Red Book determines that a Depreciated Replacement Cost basis be used to value such assets.

The valuation of land assets has been completed using available and comparable market information, which represents an estimate of the likely sale price in the unlikely event that it were to be sold. As is common in NHS organisations, the size of the site is calculated using a Modern Equivalent Asset methodology, which aims to estimate what size site the Trust's buildings would occupy if it were newly built at the valuation date.

Dwelling assets are not specialised, and are valued at market value.

The values for buildings reported in the accounts reflect the significant amount of investment made in the site over the last 2-3 years, but also the advanced obsolescence of some parts of the site.

Assets are depreciated on the straight line basis, with the useful economic lives of the buildings reflecting their level of obsolescence.

The valuer has significantly reduced the useful economic lives of a group of assets at Hillingdon Hospital, which are subject to demolition in 2022/23 or 2023/24.

Note 18.1 Investment Property

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**49,855**	**50,162**
Acquisitions in year	-	1,163
Movement in fair value	(2,542)	(2,482)
Reclassifications to/from PPE	(487)	1,012
Carrying value at 31 March	**46,826**	**49,855**

Note 18.2 Investment property income and expenses

	2021/22	2020/21
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(1,982)	(2,361)
Direct operating expense arising from investment property which did not generate rental income in the period	-	(137)
Total investment property expenses	**(1,982)**	**(2,498)**
Investment property income	2,510	2,497

Note 18.3 Fair value of investment property

As stated above in note 1.10 (Accounting Policies: Investment Properties) the Trust's investment properties are held at fair value. As such, there is a requirement for the Trust to comply with IFRS 13 Fair Value Measurement. Note 18.1 above demonstrates the fair value of those investment properties.

All of the Trust's properties are categorised at level 3 of the fair value hierarchy. This means that there are "unobservable inputs" in the valuation of the properties (that there is not an active market for the properties with quoted market prices that determine the valuation of the assets). As the properties are categorised at level 3, some additional disclosures are required by the accounting standard. These are below.

As stated in note 1.10, to ensure that the value of the Trust's investment properties are not materially misstated, the properties are valued on an annual basis. This work is carried out by an independent valuer engaged by the Trust. The valuer is Gerald Eve LLP, whose staff hold recognised and relevant professional qualifications to complete the work; the valuer also has experience of valuing the properties. To complete the work, the Trust provides the valuer with two key inputs:
- the annual rental income for each property; and
- floor plans showing the Gross Internal Area (GIA) of each property.

There has been no change to the GIA of any of the assets held as investment properties at 31 March 2022. As such, the only significant unobservable input to the valuation is the rental income. Below we demonstrate the relationship between rental income and valuation. The valuer uses the rental income to generate a valuation using the income capitalisation approach. There has been no change in the valuation technique or approach between the last and the current financial years.

The Trust owns a range of investment properties ranging in value from £81,000 to £33.1m. The rents generating these valuations range from £7,000 per year to £1.6m per year. Based on the valuation and the rents driving it, we can see that there is a broadly linear relationship between the two factors.

As such, the sensitivity of the rent is not particularly high. The example provided above demonstrates that it takes a significant change in rental income to result in a significant change in value. Most of the other investment properties owned by the Trust have seen relatively small changes to rent, and as such the resulting change in valuation between years is also small.

Note 19 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	1,548	1,320
Consumables	2,060	3,039
Energy	32	108
Other	96	203
Total inventories	**3,736**	**4,670**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £2,096k (2020/21: £3,016k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £0k).

In response to the COVID-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £934k of items purchased by DHSC (2020/21: £3,224k).

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 £000	31 March 2021 £000
Current		
Contract receivables	14,061	24,284
Capital receivables	-	26
Allowance for impaired contract receivables / assets	(5,409)	(2,716)
Allowance for other impaired receivables	(179)	(1,135)
Prepayments (non-PFI)	2,308	2,190
PDC dividend receivable	393	134
VAT receivable	1,885	1,251
Other receivables	1,089	1,752
Total current receivables	**14,148**	**25,786**
Non-current		
Contract receivables	507	807
Allowance for impaired contract receivables / assets	(114)	(181)
Prepayments (non-PFI)	910	810
Other receivables	416	23
Total non-current receivables	**1,719**	**1,459**
Of which receivable from NHS and DHSC group bodies:		
Current	8,335	19,415
Non-current	416	23

Note 20.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,897**	**1,135**	**1,537**	**964**
New allowances arising	2,629	-	1,436	171
Utilisation of allowances (write offs)	(3)	(956)	(76)	-
Allowances as at 31 Mar 2022	**5,523**	**179**	**2,897**	**1,135**

Note 21 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**47,363**	**9,791**
Net change in year	9,058	37,572
At 31 March	**56,421**	**47,363**
Broken down into:		
Cash at commercial banks and in hand	1,257	1,184
Cash with the Government Banking Service	55,164	46,179
Total cash and cash equivalents as in SoFP	**56,421**	**47,363**
Total cash and cash equivalents as in SoCF	**56,421**	**47,363**

Note 22 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	18,613	13,111
Capital payables	19,477	34,443
Accruals	19,033	18,947
Other taxes payable	4,744	4,475
Other payables	2,762	2,686
Total current trade and other payables	**64,629**	**73,662**
Of which payables from NHS and DHSC group bodies:		
Current	8,095	10,125

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	6,100	2,997
Total other current liabilities	**6,100**	**2,997**

Note 24.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	397	397
Obligations under finance leases	493	546
Obligations under PFI, LIFT or other service concession contracts	309	293
Total current borrowings	**1,199**	**1,236**
Non-current		
Loans from DHSC	3,565	3,955
Obligations under finance leases	615	979
Obligations under PFI, LIFT or other service concession contracts	10,612	10,921
Total non-current borrowings	**14,792**	**15,855**

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	**4,352**	**1,525**	**11,214**	**17,091**
Cash movements:				
Financing cash flows - payments and receipts of principal	(390)	(417)	(293)	**(1,100)**
Financing cash flows - payments of interest	(156)	(66)	(787)	**(1,009)**
Non-cash movements:				
Application of effective interest rate	156	66	787	**1,009**
Carrying value at 31 March 2022	**3,962**	**1,108**	**10,921**	**15,991**

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	**111,150**	**2,170**	**11,466**	**124,786**
Cash movements:				
Financing cash flows - payments and receipts of principal	(106,341)	(645)	(251)	**(107,237)**
Financing cash flows - payments of interest	(739)	(100)	(807)	**(1,646)**
Non-cash movements:				
Application of effective interest rate	282	100	806	**1,188**
Carrying value at 31 March 2021	**4,352**	**1,525**	**11,214**	**17,091**

Note 25 Finance leases

Note 25.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

The Trust has no finance lease arrangements in which it is the lessor. This was also the case in 2020/21.

Note 25.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**1,185**	**1,655**
of which liabilities are due:		
- not later than one year;	531	603
- later than one year and not later than five years;	550	948
- later than five years.	104	104
Finance charges allocated to future periods	(77)	(130)
Net lease liabilities	**1,108**	**1,525**
of which payable:		
- not later than one year;	493	546
- later than one year and not later than five years;	513	877
- later than five years.	102	102

The vast majority of the Trust's finance leases as lessee relate to the lease of medical equipment. None of the individual items included are significant in value.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**1,413**	**387**	**-**	**23**	**1,824**
Arising during the year	143	27	886	393	**1,449**
Utilised during the year	(126)	(24)	-	-	**(150)**
Reversed unused	(126)	-	-	-	**(126)**
Unwinding of discount	(13)	(4)	-	-	**(17)**
At 31 March 2022	**1,291**	**387**	**886**	**416**	**2,980**
Expected timing of cash flows:					
- not later than one year;	62	96	-	-	**158**
- later than one year and not later than five years;	-	-	-	-	**-**
- later than five years.	1,229	291	886	416	**2,822**
Total	**1,291**	**387**	**886**	**416**	**2,980**

Much of the provisions held by the Trust relate to pensions. The most significant group relates to early retirement benefits for the Trust's former staff. The scheme is controlled by NHS Pensions; they inform the Trust of movements in the provision and advise when payments are due to individuals. As such, they control the timing of
those cash outflows; other than that the length of the provision is determined by the longevity of the individuals concerned.

Legal claim provisions relate to the potential outcome of legal cases involving the Trust, primarily employment tribunals.

'Other' provisions relate to clinicians' pension tax, which was introduced in 2019/20. The Government Actuaries Department and the NHS Business Services Authority provided an updated overall estimate of £416,000 for the Trust to include in its accounts.

Note 26.2 Clinical negligence liabilities

At 31 March 2022, £371,736k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust (31 March 2021: £227,125k).

Note 27 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	9,546	6,740
Total	**9,546**	**6,740**

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has one Local Improvement Finance Trust (LIFT) scheme on balance sheet. It relates to the Treatment Centre on the Trust's Mount Vernon site, and was added to the balance sheet in 2008/09.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**18,015**	**19,095**
Of which liabilities are due		
- not later than one year;	1,075	1,080
- later than one year and not later than five years;	4,057	4,312
- later than five years.	12,883	13,703
Finance charges allocated to future periods	(7,094)	(7,881)
Net PFI, LIFT or other service concession arrangement obligation	**10,921**	**11,214**
- not later than one year;	309	293
- later than one year and not later than five years;	1,397	1,385
- later than five years.	9,215	9,536

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**23,104**	**25,484**
Of which payments are due:		
- not later than one year;	1,557	2,380
- later than one year and not later than five years;	5,839	6,228
- later than five years.	15,708	16,876

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**2,380**	**2,347**
Consisting of:		
- Interest charge	787	806
- Repayment of balance sheet obligation	293	251
- Service element and other charges to operating expenditure	477	499
- Contingent rent	823	791
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	30	26
Total amount paid to service concession operator	**2,410**	**2,373**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing commissioner provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations; this assessment has not changed since the last financial statements.

Interest rate risk
The Trust's borrowings are all with Department of Health and are disclosed in note 21. Nominally, the borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is generally charged at a fixed 1.5%. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the trade and other receivables note; and the Trust has taken further action during 2021-22 to reduce its exposure to default, through increasing bad and doubtful debt provisions in critical areas such as overseas patients.

Liquidity risk
The Trust has set out in the going concern section of the accounting policies accompanying these financial statements that the accounts are being prepared on the going concern basis. However, the Trust is in receipt of working capital support and does not expect this position to change in the foreseeable future. The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament.

The Trust assesses that liquidity risk, while underwritten by DHSE, is low.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	9,955	-	**9,955**
Cash and cash equivalents	56,421	-	**56,421**
Total at 31 March 2022	**66,376**	**-**	**66,376**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	22,809	-	**22,809**
Cash and cash equivalents	47,363	-	**47,363**
Total at 31 March 2021	**70,172**	**-**	**70,172**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,962	**3,962**
Obligations under finance leases	1,108	**1,108**
Obligations under PFI, LIFT and other service concession contracts	10,921	**10,921**
Trade and other payables excluding non financial liabilities	59,857	**59,857**
Total at 31 March 2022	**75,848**	**75,848**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,352	**4,352**
Obligations under finance leases	1,525	**1,525**
Obligations under PFI, LIFT and other service concession contracts	11,214	**11,214**
Trade and other payables excluding non financial liabilities	66,527	**66,527**
Total at 31 March 2021	**83,618**	**83,618**

Note 29.4 Maturity of financial liabilities

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

	31 March 2022 £000	31 March 2021 £000
In one year or less	61,995	68,756
In more than one year but not more than five years	6,595	7,304
In more than five years	15,243	16,539
Total	**83,833**	**92,599**

Note 30 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				
Cash losses	1	21	1	18
Bad debts and claims abandoned	15	968	33	76
Total losses	**16**	**989**	**34**	**94**
Special payments				
Ex-gratia payments	21	393	18	36
Total special payments	**21**	**393**	**18**	**36**
Total losses and special payments	**37**	**1,382**	**52**	**130**

During the year, the Trust wrote off £759,000 of debts for a charity. This was connected to the purchase of the freehold on a building at Mount Vernon. The building has been an integral part of the Trust's strategy to decant staff away from the Hillingdon site to allow progress on the proposed new development.

Special payments include a nationally approved and funded payment of £331,000 to Trust staff in respect of overtime corrective payments following the resolution of the Flowers case. This was accrued at 31 March 2021 following HM Treasury approval of the payments, but was not included in the special payments disclosure. This has been reported in the current year following clarification from NHS Improvement on disclosure requirements for this settlement. This has been shown as a single special payment following national guidance on the case.

Note 31 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust. Transactions that did take place are set out below, and related party transactions and balances are included in the table below.

Sir Amyas Morse, Chair of the Trust during 2021/22, was also the Chair of London North West University Hospitals NHS Trust during the same period.

Linda Burke is a non-executive director at the Trust and also a councillor for Ealing Council.

Catherine Jervis is a non-executive director at the Trust and also at Barnet, Enfield and Haringey (BEH) NHS Trust and temporarily at Camden and Islington (CANDI) NHS FT. There were no transactions with BEH or CANDI in year.

Neville Manuel was a non-executive director at the Trust and also at London North West University Hospitals NHS Trust.

Sue Smith, Chief People Officer, has also been the CPO at Chelsea and Westminster Hospitals NHS FT since October 2020.

David Searle has been the Director of Corporate Affairs at both Hillingdon Hospitals (since August 2021) and London North West University Hospitals NHS Trust.

	Income (£000s)	Exp (£000s)	Debtors (£000s)	Creditors (£000s)
London North West University Hospitals NHST	163	1,036	572	723
Ealing Council	1	2	1	0
Chelsea and Westminster Hospitals NHS FT	60	750	165	407

The Trust has a linked charity, Hillingdon Hospitals NHS Foundation Trust Charity (1056493). No material transactions flowed between the Trust and the Charity during 2021-22. The Charity is not consolidated into the accounts of the Trust on the grounds that it is not material.

The Department of Health is considered a related party as the parent department of the Trust. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department (please note, for the purposes of this section, management has set materiality at £5m). Material transactions occurred with the following such entities within the NHS (all numbers reported are in £000s):

	Income (£000s)	Exp (£000s)	Debtors (£000s)	Creditors (£000s)
Imperial College Healthcare NHS Trust	1,691	8,410	3,222	4,819
East and North Hertfordshire NHS Trust	5,416	1,676	333	322
NHS England	17,320	29	759	0
NHS North West London CCG	283,054	0	0	448
Health Education England	9,484	0	158	0
NHS Pensions	0	25,558	0	2,663
NHS Resolution	0	13,508	0	17

In addition, the Trust has had a number of material transactions with other governmental bodies. Most of the material transactions have been with HMRC, as follows:

	Income	Exp	Debtors	Creditors
HM Revenue and Customs	0	18,116	1,885	4,744

Note 32 Events after the reporting date

Having considered whether there are any material post balance sheet events to disclose, the Trust is not including any such events in this disclosure.