Annual report and accounts

2020/21

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report and Accounts 2020/21

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

TABLE OF CONTENTS

1. PERFORMANCE REPORT

2. ACCOUNTABILITY REPORT

SECTION 1

PERFORMANCE REPORT

OVERVIEW OF PERFORMANCE

Statement from the Chief Executive

I am delighted to introduce the 2020/21 Annual Report for Chelsea and Westminster Hospital NHS Foundation Trust (the Trust), which encompasses our two main hospital sites, Chelsea and Westminster Hospital and West Middlesex University Hospital, and all our community-based services.

2020/21 has been the most extraordinary of years in coping with the worldwide COVID-19 pandemic. Our response to these events has been simply remarkable during the year where we have seen:

- hundreds of our staff redeployed
- a remodelling of our hospitals and wards to create additional sideroom capacity
- multimillion-pound investments in expanded ICU facilities at each site
- a tripling of our critical care capacity during the first and the second waves

I have been so proud to see our staff demonstrate their outstanding commitment to delivering excellent patient care and experience.

Our approach over the past year has seen optimal use of resources, more convenient care to patients and ensuring that our staff are focused on delivering direct care to our sickest patients. Against the context of increased and altered demand, we are proud to be ranked as one of the best performing hospitals in the country—however, the impact of COVID-19 has affected how we provide our services, and our challenge in the next 12 months is to reset our service delivery and plan for maintaining the levels of performance that we have previously delivered.

We continue with our ambition to realise the benefits of implementing our digital programme and have successfully implemented our electronic patient record system CernerEPR across the Trust. This means our hospitals share one digital platform and access to patient records is seamless, allowing clinical staff to have access to relevant patient information securely and quickly. This has not only improved coordination of patient care but has also contributed to better and more efficient care for all patients as we adapted pathways in response to the pandemic.

It has never been more evident that to provide excellent care to our patients, we must also provide excellent support to the people who work within the Trust to deliver our aspirations for excellence. During the year we have introduced a comprehensive staff wellbeing and support service to ensure our staff receive the help they need to continue to support our patients. I would like to take this opportunity to thank all our staff, volunteers and partners who have shown incredible commitment to the care of our patients and colleagues. I am confident we will continue to go above and beyond for the patients and communities we serve, and I look forward to the year ahead as the Trust goes from strength to strength.

Our values

The Trust values are firmly embedded throughout our organisation. They outline the standard of care and experience that our patients and members of the public should expect from any of our staff and services.

They are:

- **P**utting patients first
- **R**esponsive to patients and staff
- **O**pen and honest
- **U**nfailingly kind
- **D**etermined to develop

Our priorities

Our Board-agreed strategic priorities have remained the same as the previous year:

Strategic priority 1: Deliver high-quality, patient-centred care

Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department, and their experience and quality of care will be second to none.

Strategic priority 2: Be the employer of choice

We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers. We will recruit and retain the people we need to deliver high-quality services to our patients.

Strategic priority 3: Delivering better care at lower cost

We will look to continuously improve the quality of care and patient experience through the most efficient use of available resources (financial and human, including staff, partners, stakeholders, volunteers and friends).

COVID-19

I cannot fail to acknowledge the COVID-19 global pandemic during the last year, and the impact it has had on our patients, staff and wider communities.

During 2020/21, we managed two significant waves (Mar–Jun 2020 and Dec 2020–Mar 2021). In the intervening months (Jul–Nov 2020) we began a significant recovery programme, one that has recommenced in earnest since Apr 2021.

- Admitted 4,312 COVID-19 patients across the Trust
- Completely reconfigured our hospitals to respond safely and efficiently
- Tripled our critical care bed capacity from 20 to 63
- Managed, at its peak, 342 COVID-19 inpatients with 61 on ICU
- Discharged 3,449 patients and 2,960 back to their homes
- Delivered more than 10,000 babies across our two maternity units
- Continued to look after our non-COVID-19 patients with tens of thousands of outpatient attendances
- Introduced video conferencing tools and held more than 70,000 virtual meetings with nearly 365,000 participants, spending the equivalent of 23,500 hours in video calls
- Provided 1,374 staff with COVID-related training
- Undertook 369 hours of volunteering work by corporate staff in other departments

- Welcomed 400 staff daily to our health and wellbeing hubs to rest and refresh
- Completed 3,972 occupational health risk assessments

We could not have achieved this without a coordinated response across the North West London health and care sector and I thank our acute, community, primary care, mental health and local authority partners for their round-the-clock efforts to keep our staff and patients safe. I also thank our local communities and businesses for their donations to our charity CW+ to support our staff during this time.

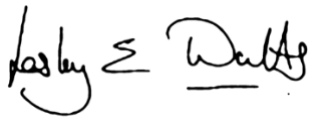
We should assume we will have a combination of further outbreaks of the pandemic and increased non-COVID-19 emergency demand throughout the coming winter. We have demonstrated our ability as an integrated care system to quickly repurpose and create surge capacity locally and regionally.

While we have seen a reduction in patients accessing non-elective care, we have begun our restart of the elective care programme across North West London. The key priority is that we ensure staff and patients are safe as we commence the treatment of our patients waiting.

We have an opportunity to build upon the beneficial changes which we have collectively brought about during the COVID-19 incident to enhance the care for our local populations. This includes supporting local initiatives and flexibility, enhanced local system working, strong clinical leadership, flexible and remote working, where appropriate, and rapid scaling of new technology services such as digital consultations. I look forward to continuing our work to transform how we care for patients in our local communities and ensure equity of access and outcomes for our patients.

I would like to take this opportunity to thank all our staff who have shown consistent commitment to our patients and each other during this challenging year. I know that they will continue to go above and beyond as we look ahead to 2021/22.

Our chairman Sir Tom Hughes-Hallett retired in Mar 2021 after serving for seven years. His dedication and commitment to our organisation has been an inspiration. He has been a fantastic champion for our organisation and, under his leadership, we have been able to develop and deliver outstanding care to our patients and local communities. I wish Sir Tom well for his retirement and future endeavours.



Lesley Watts
Chief Executive Officer

24 June 2021

The year in photos

April 2020


Clap for carers—Amanda Holden and Pickle the dog cheer on the NHS

May 2020



The RHS Chelsea Flower Show gets cancelled due to COVID-19 and Chelsea and Westminster Hospital is gifted a lovely new garden

June 2020


The Trust celebrates National Volunteers Week, giving thanks to all our amazing volunteers who support our hospitals every day

July 2020

Portrait unveiled at our Chelsea site celebrating the late Sir Tom Moore who raised more than £32m for the NHS

A new fish tank is installed at West Middlesex University Hospital

August 2020

Sunny becomes one of the very first patients to have a hip replacement carried out and return home on the same day

A COVID patient is transferred to a ward after more than 100 days on ICU

September 2020

Flu season begins and colleagues start getting their jabs

October 2020

The ‘flu superheroes’ campaign recognised our top vaccinators

Recognising teams with the highest number of staff completing their staff surveys

The Trust celebrated our Black staff and recognises Black women and men throughout the ages during Black History Month

November 2020

Our occupational therapy team tells us what it's like in their role and celebrates Occupational Therapy Week

The festival of flowers is launched, paying respect to colleagues, friends and families who have died during the pandemic

Raising awareness for International Men's Day, our colleagues tell us how they stay healthy in body and mind

December 2020

The Trust celebrates Christmas and colleagues decorate the wards to spread festive cheer

Veterans at the Royal Hospital Chelsea are among the first to be vaccinated by our Chief Nursing Officer Pippa Nightingale

January 2021

Pickle the dog keeps us going during the winter months

Celebrating staff who work and volunteer on our COVID wards

A brief but very festive snowstorm hits London, bringing a bit of cheer

February 2021

Free food outside the ICU at Chelsea as part of our health and wellbeing initiative

Army troops lend a hand at our hospitals

Colleagues start having their COVID jabs to help end the pandemic

March 2021

Celebrating our staff

Celebrating International Women's Day with goodies and live music

Met Police bring their four-legged friends for a visit to our Chelsea site

History and statutory background of the Trust

Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) was founded on 1 Oct 2006 under the Health and Social Care (Community Health and Standards) Act 2003 and is a statutory body. It acquired West Middlesex University Hospital NHS Trust on 1 Sep 2015 and now operates these two hospitals in addition to a range of community services.

Chelsea and Westminster Hospital (CW) is a modern and attractive building which opened in 1993 on the site once occupied by St Stephen's Hospital, bringing together staff, services and equipment from five London hospitals:

- **Westminster Hospital:** Founded in 1719 as a voluntary hospital in a small house in Petty France, Pimlico, with just 10 beds.

- **Westminster Children's Hospital:** Built in 1907 as the Infant's Hospital—originally in Vincent Square SW1, the hospital pioneered the treatment of malnutrition in infants.

- **West London Hospital:** Opened in 1860, the hospital was known from the early 1970s for its women-centred maternity service.

- **St Mary Abbots Hospital:** An infirmary occupied the site of what had been the Kensington workhouse, and the hospital was founded in the late 19th century.

- **St Stephen's Hospital:** A map of 1664 indicates on this site 'the hospital in Little Chelsea'. Later there was a workhouse, then an infirmary, before St Stephen's was founded in the late 1800s.

West Middlesex University Hospital (WM) also has a long history of pioneering, innovative healthcare. It opened in 1894 as the Brentford Workhouse Infirmary and became known as West Middlesex Hospital in about 1920. The main hospital building was redeveloped between 2001 and 2003, with substantial redevelopment continuing today. Both sites are at the hearts of their local communities, providing accessible, state-of-the-art facilities.

Purpose and activities of the Trust

The Trust delivers specialist and general hospital care at Chelsea and Westminster and West Middlesex University hospitals. Both hospitals have major A&E departments and the Trust provides the largest maternity service in England.

Our specialist hospital care includes the burns service for London and the South East, children's inpatient and outpatient services, cardiology intervention services and specialist HIV care. We also manage a range of community-based services, including our award-winning sexual health clinics, which extend to outer London areas.

We are active partners in the North West London Integrated Care System (ICS), which brings together all parts of the NHS and local authorities to focus on improving the health of the local population. Draft legislation has now been published in the form of whitepaper *Integration and Innovation: working together to improve health and social care for all' (11 Feb 2021)*, outlining that the NHS and local government come together legally as part of the integrated care systems to plan health and care services around patients' needs, and

quickly implement solutions to problems. The purpose of the North West London ICS is to reduce inequalities, increase quality of life and achieve outcomes on a par with the best of global cities. All NHS organisations and local authorities in North West London have been working informally as an ICS, ahead of legislation to put ICSs on a statutory footing.

The Trust serves a catchment area of more than one million people, covering:

- Brent
- Central London
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Richmond
- Wandsworth
- West London
- NHS England for specialised services commissioning

We also have a series of contractual, system management and other partnership arrangements with the respective local authorities. This includes membership and reporting arrangements to health and wellbeing boards and overview and scrutiny committees. We have established our partnership duties through a series of accountability and reporting mechanisms to local Healthwatch groups (the statutory patient representative organisation).

Equality of service delivery

Chelsea and Westminster Hospital NHS Foundation Trust is committed to equality of opportunity in the provision of services. In line with our strategic priorities and values, we aim to create the best possible quality of care by delivering the highest quality service to all sections of the community that we serve without discrimination.

The Trust provides many important health services that have been developed over the years to meet a variety of needs. We seek to ensure that in delivering these services they are provided in a fair and equitable manner. We want our services to be accessible and useful to everyone, regardless of age, disability, gender, race, national origin, sexuality or any other factors which may cause disadvantage. We will not tolerate any practices that result in the provision of a lower standard of service to any group or individual because of unfair or unlawful discrimination.

Principal risks for 2020/21

The Trust is committed to consistently delivering the highest quality of care and outcomes for our patients. Our ambition is to strengthen our position as a major health provider in North West London and beyond, to enhance our position as a major university teaching hospital, driving internationally-recognised research and development, and to establish ourselves as one of the NHS's primary centres for innovation.

The Trust's strategic objectives are:

Strategic priority 1: Deliver high-quality, patient-centred care

Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department and their experience and quality of care will be second to none.

Strategic priority 2: Be the employer of choice

We will provide every member of staff with the support information, facilities and environment they need to develop in their roles and careers. We will recruit and retain the people we need to deliver high-quality services to our patients.

Strategic priority 3: Delivering better care at lower cost

We will look to continuously improve the quality of care and patient experience through the most efficient use of available resources (financial and human, including staff, partners, stakeholders, volunteers and friends).

The principal risks that could substantially impact on the achievement of the Trust's strategic objectives, as recorded in the Board assurance framework, are outlined in greater detail within the *Annual Governance Statement* from page 86.

- **North West London Health and Care Partnership System Recovery Plan:** The Trust has robust development and improvement plans in place that are aligned to develop the quality of care and patient experience across North West London. Consistent planning, governance, and leadership across the sector is required to meet this ambition.

- **Achievement of quality, performance and regulatory standards:** The provision of safe, high-quality, patient-centred care is of paramount importance to the Trust—to ensure standards are achieved, the Trust has an embedded a quality monitoring and improvement process.

- **Becoming the employer of choice:** The Trust is committed to the provision of the support, information, facilities and environment our staff need to develop in their roles and careers. The organisation also recognises the need to recruit and retain the people required to deliver high-quality services to our patients. The Trust will continue to deliver its equality, diversity and inclusion action plan and further develop its recovery, retention and recruitment workstreams to mitigate barriers to achievement of this objective.

- **Financial sustainability:** Failure to maintain the organisations financial sustainability would impact on the achievement of all other strategic objectives for the Trust. A robust financial strategy is well embedded within the organisation to ensure identification, escalation and mitigation of risks or barriers to achievement.

- **Embedding innovation and improvement:** The Trust has an ambitious quality improvement plan—a dedicated quality improvement team monitor and support the organisation's change programme to ensure the Trust Board's quality ambitions are delivered.

- **Estate development:** The organisation has ambitious development plans to ensure our patients receive long-term benefit from sustainable estates development. Risks associated with the estate development strategy are monitored by the executive management Board.

- **Implement our digital strategy:** The Trust is committed to the provision of innovative technology to support improvement in patient care, patient experience and the running of our hospitals. Clear programme management and leadership is required to ensure this ambition is realised.

- **Responding to COVID-19:** As with all healthcare providers in the UK, the coronavirus pandemic has fundamentally altered the day-to-day operations of the Trust throughout the year. This major disruption to service provision represents a risk to our patients, staff and the services we offer.

Going concern

The directors are confident that there is a reasonable expectation that the Trust will continue to have adequate cash resources to service the operational activities in cash terms for the next 12 months and into 2022/23. The impact of COVID-19 and associated changes to the cash regime for the first half of 2021/22 (with block and top-up arrangements) have been taken into account for the Trust's plans and projections, including cashflows, liquidity and income base.

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

PERFORMANCE ANALYSIS

How the Trust measures performance

The work of the Trust Board is underpinned by five key committees—the Quality Committee, People and Organisational Development Committee, Audit and Risk Committee, Finance and Investment Committee, and Nominations and Remuneration Committee.

Board level

The Quality Committee and Trust Board receive a monthly integrated performance report, comprising several key performance indicators (KPIs) with associated commentary to explain variances and actions in place to deliver improvement.

The KPIs cover a range of contractual and internally determined metrics, providing a balanced scorecard for the Trust's performance across the four domains of regulatory compliance, quality, efficiency and workforce. Each KPI, where appropriate, has a target based on either the contractual performance standard, or an internally set target based on benchmarking information from a peer group of other NHS organisations.

The integrated performance report presents the KPIs for both hospital sites independently as well as the combined Trust performance, and trend data is also provided for the last 12 months to enable the Trust Board to track progress over time.

During 2020/21, to help provide context in terms of the Trust's relative performance, a national ranking was provided for the main access standards of A&E, referral to treatment (RTT) and cancer. The Trust Board also receives a summary of the Trust's financial performance, with more detailed information provided to and scrutinised by the Finance and Investment Committee.

Divisional level

Performance at divisional level is scrutinised through monthly divisional performance review meetings, providing an opportunity for executive directors to have a more detailed discussion with divisional teams to support performance improvement initiatives, and to celebrate good performance while also challenging underperformance. Divisional performance reviews are supported with the relevant division's performance information against the Board level KPIs, supplemented by additional performance information relevant to the priorities of the division concerned.

A comprehensive programme of specialty-based deep dives was introduced in 2017/18 and is now fully embedded across the organisation. These reviews are executive-led and held with the specialty multidisciplinary teams to review their quality, workforce and efficiency metrics.

Additionally, a weekly performance meeting led by the Deputy Chief Executive/Chief Operating Officer is in place to monitor the key performance metrics across both sites and to monitor data quality.

To support effective operational performance, the Trust employs a team of specialist information professionals who provide analytical support to all parts of the organisation and service the Trust's internal and external reporting obligations.

Performance information is provided to the organisation routinely through a combination of desktop self-service tools, automated routine reports, refreshed periodical scorecards and ad hoc reporting on request. Trust performance is scrutinised and supported through a range of daily, weekly and monthly meetings, with the necessary information available for discussion.

Operational performance

During 2020/21, the Trust has been faced with unprecedented challenges due to the COVID-19 pandemic. This has clearly impacted the Trust's ability to manage performance in a way that would be historically recognised. Despite this, the Trust has continued to deliver a high level of performance and quality in treating patients in the best way that it has been able to.

Post-first wave of COVID, the Trust was returning to a level of recovery that was in line with the national and regional expectations in both activity and performance. Within the current environment, the Trust finds itself in a much stronger position post-second wave of COVID, with a number of key metrics in a strong recovering position.

During 2020/21, the Trust made a significant and important contribution to the ICS and across London, offering support and mutual aid when asked. This year has also been the stabilisation period following the rollout of the new electronic patient record system CernerEPR at the Chelsea site and further deployment of clinical workflows at the West Middlesex site.

Urgent and emergency care has borne the initial brunt of the pandemic as the front door into the hospital. The department continues to be challenged by the requirements of infection prevention and control (IPC) guidance, both for managing the risk of infection within the department and when admitting patients to an inpatient area. Activity remains lower in comparison to activity in previous years. Despite pressures, the Trust has continued to perform well and would, if reporting, rank in the top quartile nationally. The Trust has consistently delivered one of the best levels of performance across the capital as well as one of the best nationally.

Throughout 2020/21, RTT performance has not been delivered and has not been since October 2019 when CernerEPR was deployed at the Chelsea site. The subsequent impacts of ceasing elective activity in Mar 2020 during the first wave of COVID meant the recovery phase was not concluded. Performance dipped to a low of 50.8% in Jul 2020. Significant improvements have been seen since and only the surgery-dominated specialties continue to be challenged.

Despite these challenges, the Trust remains in the top quartile nationally for RTT performance and recovery post-COVID continues. Plans are in place to recover the constitutional standard. During this challenging period the Trust has reported patients waiting more than 52 weeks to be treated on both sites. Despite this, the Trust again is one of the better performing Trusts nationally on this metric.

Our performance in relation to the 62-day cancer GP referral to first treatment standard has been one of our most challenging of 2020/21. This standard has, again, been impacted significantly by the pandemic. Performance has been poor and below the national standard. This is one of the Trust key priorities and a significant amount of resource has been prioritised in this area to not only recover but sustainably deliver a level

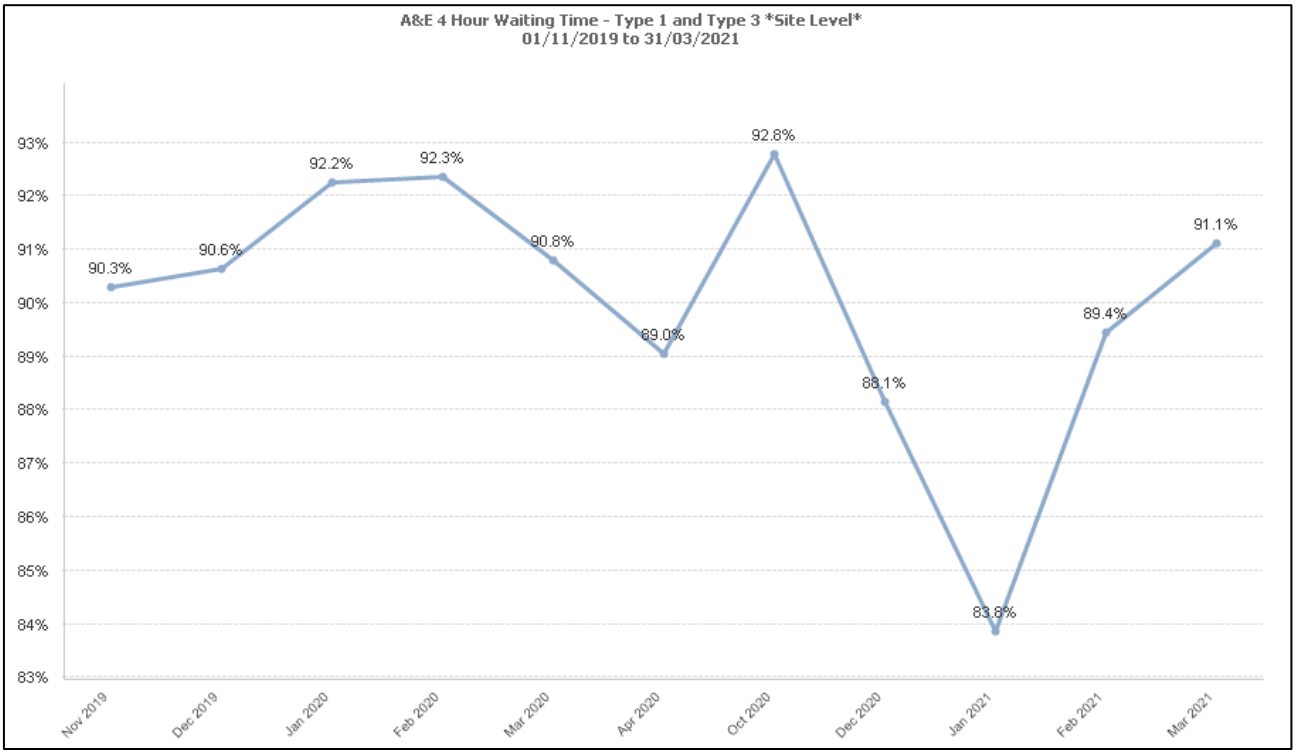
of care to our patients that historically the Trust has offered. However, the patient backlog is now the lowest it has been for over a year.

Our compliance with the two-week wait cancer standard has been excellent despite the challenges and has delivered the standard across the year.

The diagnostic standard has not been delivered throughout 2020/21 due to the pandemic. Performance dipped to a low of 36.9% in Jun 2020. Significant improvements have been seen since and recovery continues, and underperformance is driven by non-imaging modalities.

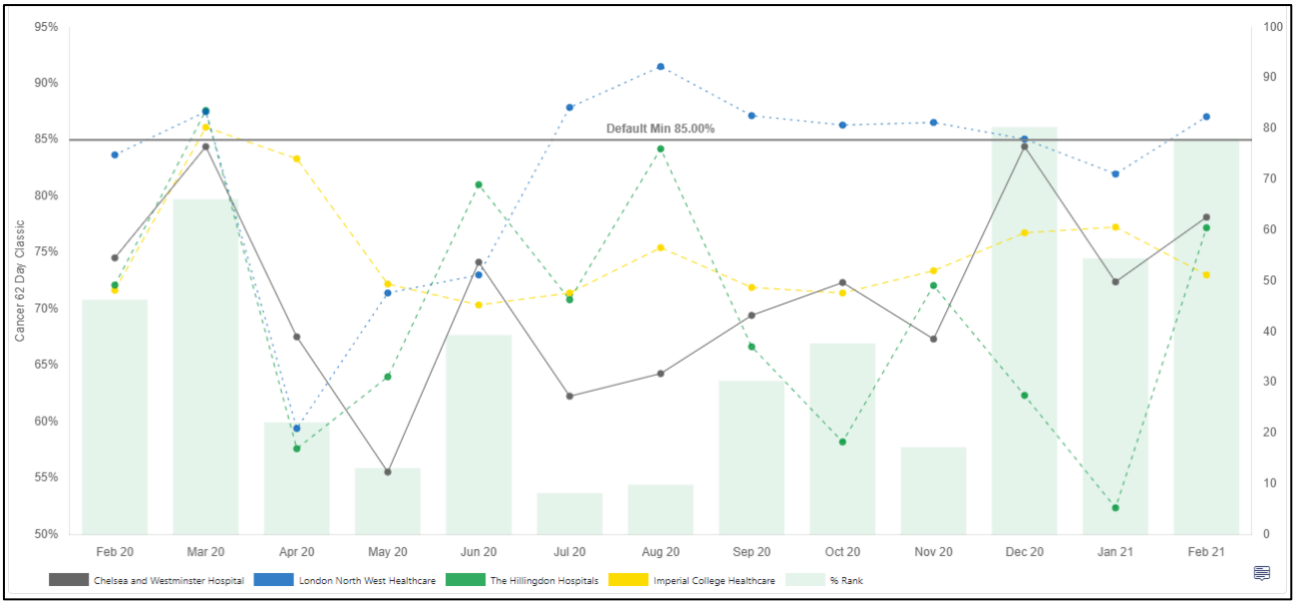
The following graphs illustrate the Trust's performance against each of the key national standards of A&E waits, RTT times and 62-day cancer waits as noted above.

A&E four-hour waiting time—types 1 and 3 (target 95%)



18-week referral to treatment (RTT)—incompletes (target 92%)

Cancer urgent GP referral to treatment waiting time (target 85%)



Financial performance

The Trust achieved an adjusted surplus of £1.6m against the control total of £5.2m deficit. This £6.8m difference is an agreed and NHS England and NHS Improvement approved positive variance to plan, largely relating to additional funding for lost non-NHS income during to COVID-19. The overall reported position is a deficit of £19.8m for the year before reversal of impairments relating principally to land and buildings of £24.7m and other adjustments of (£3.3m). The Trust delivered £3.1m of cost improvement programmes during the year.

The following table shows the 2020/21 financial outturn against the plan for 2020/21 under NHS Improvement's reporting definitions.

	2020/21 outturn (£m)	2020/21 plan (£m)
Operating revenue	£752.5	£706.4
Employee expenses	(£424.5)	(£398.0)
Other operating expenses	(£331.4)	(£296.0)
Non-operating income/expenses	(£15.1)	(£16.6)
Profit on assets and liabilities transferred in respect of the discontinued operations of the investment in joint ventures	(£1.5)	£0
Net reversal of impairments and other non-current asset gains/(losses)	£24.7	£0
Removal of donated assets/PPE consumables	(£3.3)	(£1.1)
Adjusted surplus/(deficit)	**£1.6**	**(£5.2)**
Net surplus/(deficit) %	0.2%	(0.7%)

Total operating revenue for EBITDA	£749.3	£704.9
Total operating expenses for EBITDA	(£709.8)	(£673.0)
EBITDA	**£39.4**	**£31.9**
EBITDA margin %	5.3%	4.5%

Year-end cash	**£141.6**	**£114.0**

During the year, the balance of cash and cash equivalents increased from £117.2m (31 Mar 2020) to £141.6m (31 Mar 2021).

In 2020/21 the Trust invested £38.7m on capital which included £6.9m on the new NICU and ICU wards at the Chelsea site, £6.6m on ward refurbishments, £8.5m on medical equipment and £3.3m on estates backlog maintenance.

Statement on finance—COVID-19

The Trust incurred additional expenditure (£32.6m) during 2020/21 relating to COVID-19 and a reduction in activity and income, which were largely reimbursed by NHS England and Improvement. The NHS funding and cash regime changed through 2020/21 to provide financial support during COVID-19, with block contract, top-up arrangements and additional funding of specific COVID-19 expenditure.

Environmental and sustainability performance

Overall strategy for sustainability

The Trust, with its service partners, will continue to pursue its ambition to reduce the impact of our activities on the environment while providing leading sustainable healthcare. This means that the way we operate today must meet the needs of the present, while collaboratively building on a cleaner, healthier environment for future generations.

The Trust understands the challenging and ambitious goal of being carbon neutral by 2030 and will continue to work in a coordinated way to instil a culture which supports our environmental responsibility. We recognise the increasing and urgent need to take action to halt the negative impacts on the environment and improve efficiencies which will support, protect and enhance biodiversity throughout the organisation.

The Trust will continue to embed this commitment to sustainable development with a clear strategic focus, ensuring that its national and local sustainability responsibilities are firmly embedded in the overall Trust strategy.

We recognise that delivering sustainable healthcare involves working at all levels of healthcare, with staff, patients and partner organisations, to deliver our ambition of a health system that supports social and environmental ambitions which are financially sound and seeks to provide value for financial investment.

We remain proud to continue to embed inclusion of sustainability with our staff, service partners and wider communities and organisations that play important roles in our push towards translating our shared ambition to greater sustainability.

As we continue to effectively respond in 2020/21 to the extraordinary challenges and demands of the COVID-19 pandemic in the form of additional waste generated, it conversely has had a beneficial effect on general air quality in London. We will continue to monitor our impacts as they arise, adapting our approach and resources to manage and reduce our impact on the environment through the efficient use of resources and utilities.

SCOPE 1: Direct GHG Emissions

The NHS Sustainable Development Unit identified that the NHS needed to achieve a 10% reduction in carbon dioxide (CO_2) emissions by 2015 against the base year of 2007/08. This was an interim target to support the NHS in meeting the targets set out in the Climate Change Act (2009) of a 34% reduction by the end of calendar year 2020 and 80% reduction by 2050.

The Trust has achieved a 43% reduction to date against the base year, largely due to the installation of combined heat and power units at both main sites and the use of a waste heat recovery system.

Carbon emission location	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Chelsea and Westminster Hospital CO_2 (source: EUETS / ETS UK/ CHPQA submissions)	15,212	15,510	10,930	8,904	9,382	9,286
West Middlesex University Hospital CO_2 (source: CRC/CHP QA submissions)	7,284	6,815	6,525	5,608	3,934	3,501
Trustwide CO_2	**22,496**	**22,325**	**17,455**	**14,512**	**13,316**	**12,787**
Trustwide emissions reduction	-	-170	-5,040	-7,983	-9,180	-9,709
Compared to base year (2015/16)	-	-1%	-22%	-35%	-41%	-43%

Waste minimisation and management

The Trust, in conjunction with Bouygues Energies and Services Facilities Management Ltd, has installed a waste processing plant on the West Middlesex site. The Sterilwave plant will process offensive waste and alternative treatment waste streams. This waste would have been disposed of at landfill, but will now be processed on site, reducing the carbon transportation to landfill. The waste output is used as fuel for biomass energy. Segregating this waste using a behavioural change programme and creating new waste streams has reduced clinical waste volumes and saves the Trust about £25k per annum.

The ‘21 Elephants’ campaign increases awareness of recycling and reuse in the Trust. The Chelsea and Westminster Hospital Estates and Facilities team developed a creative campaign with children from Chelsea Community Hospital School, St Vincent’s RC School and ISS to engage the entire hospital community, change behaviour and reduce waste.

Involving these young patients in this positive, creative activity also provided them with fun and an alternative focus for those who were staying in hospital.

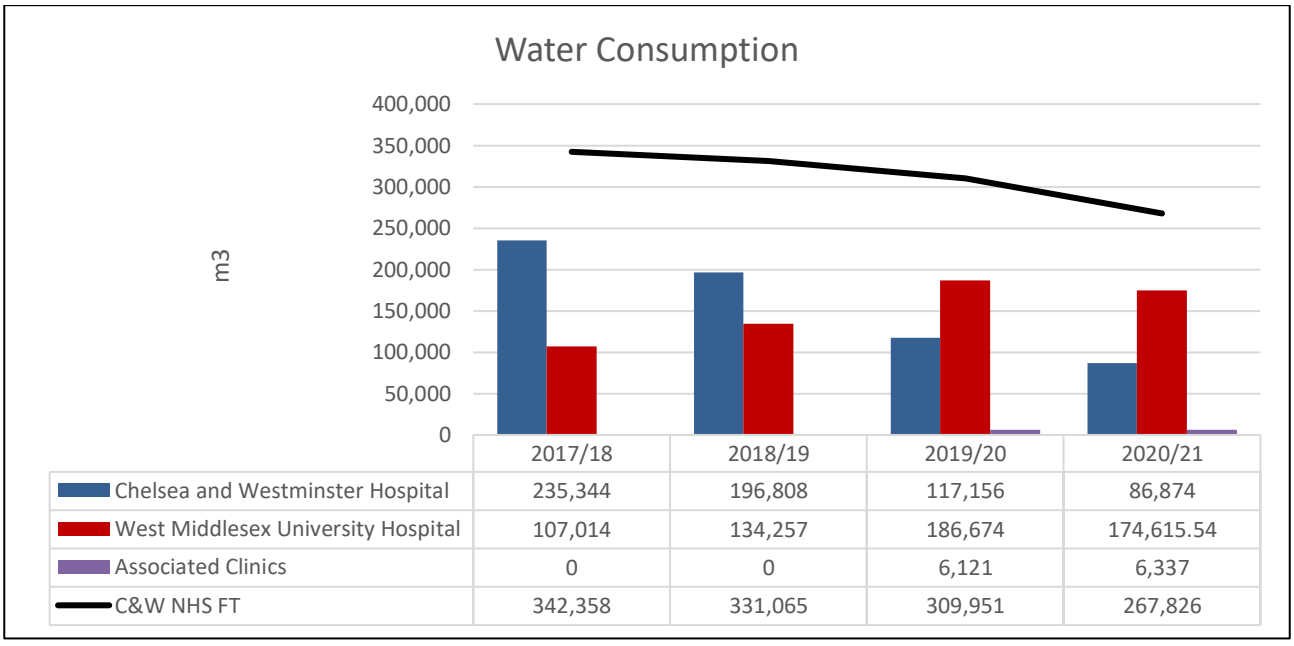
The 21 Elephants campaign was shortlisted for the 2021 Sustainability Leaders Awards for excellence across the spectrum of green business.

Finite resource consumption

Water consumption

The Trust's target was to reduce water consumption by 15% by the end of calendar year 2020, based on the 2014 baseline figure of 360,860 m^3. The table below highlights a current water consumption reduction to date of 26% against the 2014 baseline. However, it should be noted that the impact of reduced patients and hospital activity during the emergency periods have significantly contributed to the reduction in consumption. The installation of new metering onto all fiscal water meters will continue to support activity to monitor water efficiency. It should also be noted that there was a faulty water meter at West Middlesex University Hospital which was changed in 2018/19. This resulted in an increase in consumption due to improved accuracy.

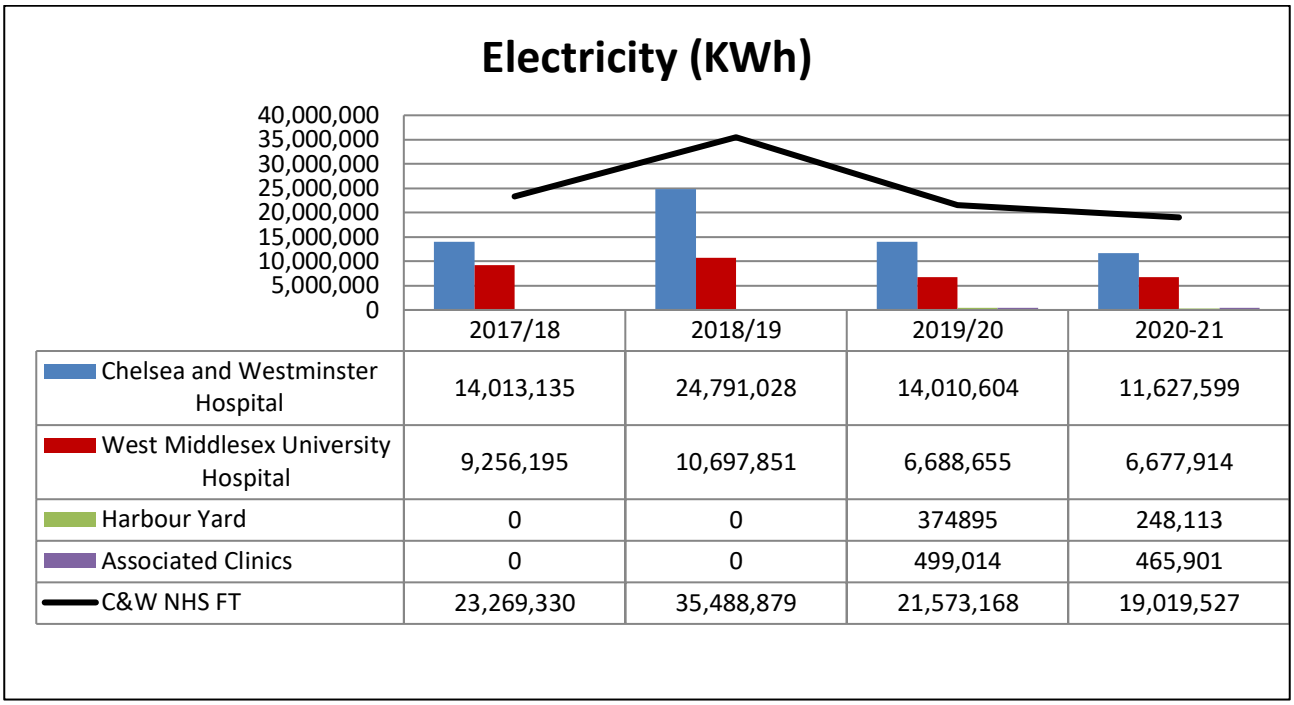
Location	2017/18	2018/19	2019/20	2020/21
Chelsea and Westminster Hospital	235,344	196,808	117,156	86,874
West Middlesex University Hospital	107,014	134,257	186,674	174,615
Associated clinics	-	-	6,121	6,337
Trustwide total	**342,358**	**331,065**	**309,951**	**267,826**
Annual reduction against baseline	-18,502	-29,795	-50,909	-93,034
2014 baseline (360,860 m^3)	-5%	-8%	-14%	-26%



Energy consumption

The Trust is committed to reducing its overall energy consumption with efficient use of plant and investment in LED lighting. The reduction in electricity consumption correlates to the increase in gas consumption, due mainly to the increased runtime of the combined heat and power facilities.

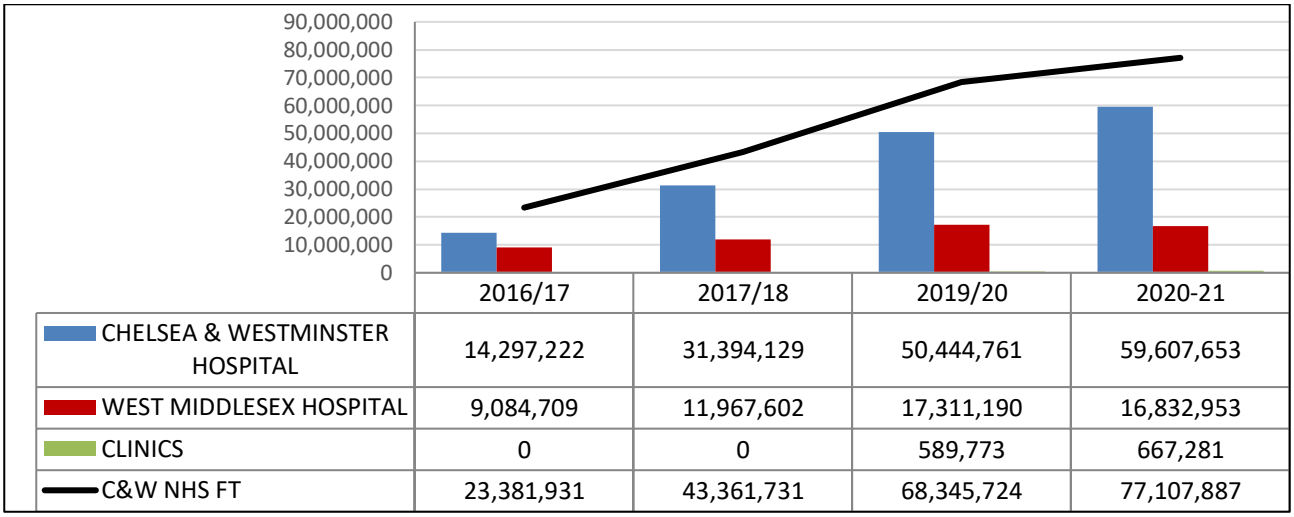
Electricity consumption



	2017/18	2018/19	2019/20	2020-21
Chelsea and Westminster Hospital	14,013,135	24,791,028	14,010,604	11,627,599
West Middlesex University Hospital	9,256,195	10,697,851	6,688,655	6,677,914
Harbour Yard	0	0	374895	248,113
Associated Clinics	0	0	499,014	465,901
C&W NHS FT	23,269,330	35,488,879	21,573,168	19,019,527

Electricity (KWh) consumption	2017/18	2018/19	2019/20	2020/21
Chelsea and Westminster Hospital	14,013,135	24,791,028	14,010,604	11,627,599
West Middlesex University Hospital	9,256,195	10,697,851	6,688,655	6,677,914
Harbour Yard	0	0	374,895	248,113
Associated clinics	0	0	499,014	465,901
Trustwide total	**23,269,330**	**35,488,879**	**21,573,168**	**19,019,527**

Natural gas consumption



	2016/17	2017/18	2019/20	2020-21
CHELSEA & WESTMINSTER HOSPITAL	14,297,222	31,394,129	50,444,761	59,607,653
WEST MIDDLESEX HOSPITAL	9,084,709	11,967,602	17,311,190	16,832,953
CLINICS	0	0	589,773	667,281
C&W NHS FT	23,381,931	43,361,731	68,345,724	77,107,887

Gas (KWh) consumption	2016/17	2017/18	2019/20	2020/21
Chelsea and Westminster Hospital	14,297,222	31,394,129	50,444,761	59,607,653
West Middlesex University Hospital	9,084,709	11,967,602	17,311,190	16,832,953
Associated clinics	0	0	589,773	667,281
Trustwide total	**23,381,931**	**43,361,731**	**68,345,724**	**77,107,887**

Patient-led assessments of the care environment (PLACE)

The annual PLACE assessment in 2020 was postponed due to the COVID-19 pandemic, but the assessment of the hospital environment was replaced by regular local inspections carried out by the hospital directors, Estates and Facilities and the Trust facilities contractors. Any necessary improvements and changes to the environment were performed with infection control input in order to comply with COVID-19 guidance. The inspections followed the directives from the Health and Safety Executive and incorporated a ’59-step’ checklist.

90% of actions from the 2019/20 PLACE assessment have been completed. Some were delayed due to the pandemic but will be completed as environmental access becomes available.

Patient environment

The capital investment and development programme continues to improve the hospital environment for staff and patients, including:

- Nell Gwynne Ward Refurbishment (Trust investment of ~£800k)
- New Same Day Emergency Care unit created (Trust investment of ~£700k)
- Neonatal Intensive Care Unit (NICU) expansion—phases 1 and 2 complete and phase 3 due for completion in May 2021
- Intensive Care Unit (ICU) expansion—phase 1 completed in 2020 and phase 2 due for completion in May 2021
- Distribution lift upgrades (Trust investment of ~£900k)
- ICU surge ward created at CW in St Mary Abbots Ward (Trust investment of ~£1.1m)
- Marjory Warren Ward refurbishment (Trust investment of ~£1.2m)
- Marjory Warren improvement in air handling (Trust investment of ~£500k)
- ICU surge ward created at WM in Richmond Ward (Trust investment of ~£3.6m)

Social, community, anti-bribery and human rights issues

There have been no anti-bribery or human rights issues to escalate throughout the year. The Trust launched its human trafficking statement which was signed off by the Trust Board in Mar 2021 and demonstrates full compliance.

The Trust has worked closely with community NHS and private providers throughout the year to ensure effective care was provided to residents during the pandemic. We are grateful for the support our community providers and the independent sector have provided us to ensure we could manage safe hospitals during the pandemic.

The Trust has also run and supported many community engagement events during the pandemic to provide public health messages and reassurance on the safety of the COVID vaccination programme.

Equality and diversity

During 2020/21, the Trust's work on embedding equality, diversity and inclusion has continued to strengthen as part of the culture within the organisation. Highlights from the year include:

- The 'improving race equality through promoting fairness' action plan was reviewed and has expanded to become the 'improving equality, diversity and inclusion' action plan
- Extraordinary BAME staff network meetings and webinars in response to the COVID-19 pandemic and Black Lives Matter movement
- BAME staff network chair appointed as special advisor to the Trust executive management Board
- Launch of the reciprocal mentoring for inclusion programme
- Staff network chairs became members of the workforce development committee
- Series of executive-led listening events for BAME staff
- LGBTQ+ staff networks supported by CW+ to purchase and distribute pronoun name badges for staff
- Increased representation from diverse backgrounds as Freedom To Speak Up (FTSU) champions
- LGBTQ+ and BAME staff networks launched social media accounts
- Cultural safety champions within maternity
- Listening events for staff with disabilities
- Representation from diverse backgrounds as health and wellbeing champions and mental health first aiders.

Learning disabilities

The Trust has continued to provide learning disability services to its patients during the year. A lead nurse for learning disabilities leads this agenda, enabling the Trust to track all its patients with learning disability to ensure they have the correct care passports in place. The Trust is fully compliant with the learning disabilities mortality review initiative for all mortalities of a patient with a learning disability to have a full mortality review with a learning disability expert on the panel.

The Trust is now in the third year of Project SEARCH with learning disability interns placed within the Trust to gain work experience and future employment within the organisation.

Safeguarding

The Trust has effective safeguarding processes in place with an experience team leading the safeguarding hub. The new safeguarding training principles have been embedded during the year with full compliance with levels 1–3 safeguarding training.

The organisation works effectively with the wider safeguarding community across the boroughs to ensure families are safeguarded.

Anti-bribery

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

KPMG was contracted by the Trust during 2020/21 to provide local counter-fraud specialist services in accordance with secretary of state directions. The Trust Board's Audit and Risk Committee formally approves the counter-fraud annual work plan and progress reports are provided to the committee at each meeting.

Volunteers

In May 2020, Volunteering Services moved from Corporate Nursing into Human Resources. This move was designed to incorporate volunteers into the wider strategic deployment of the Trust's workforce during COVID-19 and beyond.

In the last year, the Trust has been supported by more than 380 volunteers who have collectively contributed more than 30,000 hours. Using the London Living Wage as a basis, this is an equivalent financial contribution of more than £325,500.

The pandemic led to large number of volunteers leaving or pausing their volunteering. This includes almost all 'partner' volunteers (outlined below) as partners stopped their services. The Volunteering Services team are working with these partners to help them restart their volunteering programmes safely and in line with new guidance. In addition, more than 100 'core' volunteers who left the Trust at the start of the pandemic have not returned since.

Organisation	n° of volunteers
CW+ MediCinema	39
Macmillan	5
CW+	20
Radio West Middlesex	12
Radio Chelsea and Westminster	30
Chaplaincy	28
Friends	20
St Stephen's	33
Total	**187**

As well as presenting challenges, the pandemic provided an opportunity for volunteers to play a key part in supporting the Trust. More than 160 volunteers were recruited in response to the pandemic, collectively delivering more than 500,000 meals to staff, more than 1,800 hours supporting vaccine distribution across both sites, and dedicating thousands of hours to inpatient wards, both COVID and non-COVID.

Despite the pandemic, the Trust was able to launch a new youth pathway for volunteers aged 16–21 in full time education. To date, more than 40 young people have participated and the offering is set to expand through the coming year.

Volunteering Services played a key role in the successful deployment of more than 40 military personnel at both hospital sites. The military helpers have contributed more than 5,000 hours from Jan–Mar 2021.

A key reason for the success of the service was the creation of a volunteering hub at each site. The hubs allowed the Trust to better retain volunteers through the pandemic.

Volunteers were kept safe as they started and finished their shifts at the hub so they could receive the latest PPE guidance, briefings on any ward closures or outbreaks, lateral flow tests etc. The volunteers were better motivated and more committed. Partly because of this (and not discounting lockdown, furlough and other factors), the average hours per volunteer per month doubled last year.

Charity matters—CW+

The Trust is very proud and grateful to be supported by our official charity CW+ and the charity is proud to work in partnership with us to provide our patients, families and staff with excellent care, experience and facilities. The Trust is committed to actively promoting and supporting CW+ and several directors of the Trust Board are CW+ Trustees. This shared governance arrangement is designed to ensure clear alignment between the strategic priorities of the Trust and the charity.

CW+ has been an essential source of support to the Trust's staff and patients during the COVID-19 pandemic—in Mar 2020, the charity launched its COVID-19 rapid response fund, encouraging new and existing donors to support our hospitals throughout the pandemic. We were deeply moved by the incredible generosity and kindness of our supporters, whose monetary donations and gifts in-kind funded new equipment and technology for the Trust, wellbeing support for our staff, and research and development.

Transforming our estate

In 2017, CW+ launched a £12.5 million Critical Care Campaign to transform the adult and neonatal intensive care units at Chelsea and Westminster Hospital. This target was reached in 2019 and, in Mar 2020, phase 1 of the adult ICU was opened in time to treat the increased number of patients during the COVID-19 pandemic. Having this extra capacity was particularly helpful during this challenging time and patients continue to be treated in the new, state-of-the-art facility. Once the rest of the construction phases are complete, Chelsea and Westminster Hospital will house one of the leading critical care services in the UK, treating 2,000 critically ill adults and babies every year. The aim is for this world-class patient-focused environment to become an optimum template, influencing NHS guidelines and best practice nationally and beyond.

Phase 1 of the new Neonatal Intensive Care Unit (NICU) at Chelsea and Westminster Hospital opened in Feb 2020. Babies are now being treated in the unit, which features new technology and equipment, bespoke furnishing, specialist lighting and a 40% increase in space. The second phase of the redevelopment was completed in in Nov 2020, with the opening of the High Dependency Unit (HDU), and the final expansion, due to be completed in 2021, will allow us to provide life-saving care to 1,000 babies each year.

CW+ has also been working to provide staff with essential wellbeing support during the COVID-19 pandemic. The CW+ Studio on the 2nd Floor at Chelsea and Westminster was transformed into a wellbeing hub for staff as a result of the COVID-19 outbreak, providing a welcoming environment for staff to relax, chat with colleagues, reflect and refuel, with refreshments, toiletries and phone charging points. The charity has also been leading on the transformation of the 5th Floor Sky Garden as a space for intensive care staff to take breaks and relax. At West Middlesex University Hospital, CW+ also set up a staff wellbeing

hub, including massage chairs, colouring supplies, yoga mats and more. Both sites continue to be supported with ongoing donations of food and drink from local businesses and friends.

The CW+ Sun and Stars Appeal to transform the children's wards at West Middlesex successfully met a £150,000 fundraising target, and the SEGA Teenage Space and the Tigerplay playroom have now been installed, alongside an ongoing installation of graphic artist Supermundane's artwork throughout the department. With the success of this appeal, CW+ are now aiming to raise a further £50,000 to transform the children's outpatient department.

Grants and innovation

CW+ continues to offer a discretionary grants programme, funding projects which improve patient care and experience and support staff, including:

- Small Change Big Impact initiative fast-tracked awards (up to £2,000) to support patient experience
- Patient-focused grants up to £100,000 to fund larger project which transform care
- Staff wellbeing and amenities
- Training, education and development

The charity hosted its annual special funding call for nurses, midwives and allied health professionals in 2020, which was very successful and resulted in several innovative staff-led projects receiving funding, with support from the Rosetrees Trust.

CW Innovation, the Trust's joint programme with CW+, celebrated its one-year anniversary in Sep 2020. In response to the COVID-19 pandemic, we introduced a range of innovations, digital systems and platforms into our day-to-day functioning to reduce the need for patients to come into our hospitals and to meet the increasingly varied ways in which we need to communicate with our patients.

CW Innovation has a pipeline of more than 80 health innovation projects for the Trust, including sensor technologies, remote wearable monitors, new clinical devices, digital rehabilitation, virtual clinics and appointments, and apps with partners such as Sensyne, Sensium, Viiv and DrDoctor. Our work with accelerator partners, such our longstanding partnership with DigitalHealth.London Accelerator, complements a new partnership with Los Angeles-headquartered KidsX Accelerator, which aims to fill the unmet need of deploying digital health technologies in paediatric care.

In Feb 2021, CW Innovation launched RADICAL, the Rapid Adoption Innovation Call in partnership with the Rosetrees Trust, to fund a programme of exciting new digital innovation projects that deliver rapid improvement to patient care at our Trust and that have potential to be scaled across the NHS.

Arts in health

The Trust is a pioneer in the arts in health field and the CW+ arts programme encompasses exhibitions, installations, participatory arts, creative activities, music and more. Virtual Connections was created in May 2020 in response to the COVID-19 pandemic as a digital version of the CW+ Arts for All programme. The online arts programme allows the charity to support the health and wellbeing of our patients, staff, and

those self-isolating in the wider community with new videos from many of our resident artists and local partners. CW+ also launched livestream music for patients in Chelsea and Westminster Hospital's ICU, and 'music on call' performances for staff in the Sky Garden.

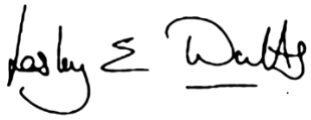
Throughout the year, CW+ has been working to refurbish and enhance our wards at both sites, installing new artworks and digital interventions for patients, and transforming both clinical and non-clinical areas into healing environments for patients, staff, and visitors. Refurbishments include new furniture, adaptable lighting, sound systems, signage and artwork by artists including Annu Kilpeläinen, Sarah Beck Mather, Yinka Ilori, Quentin Blake and more.

Working with a range of health technology partners, as well as renowned and emerging artists, architects and designers, the CW+ arts programme also aims to elevate patient care and empower our staff with its Future Hospital studies, featuring virtual reality, artificial intelligence and interactive robots, to reduce patient anxiety and support staff in the delivery of care.

Celebrating our history

In Sep 2020, we marked the centenary of West Middlesex University Hospital. With in-person events on hold due to the COVID-19 pandemic, CW+ helped to celebrate the hospital's heritage online with the release of two short films in which some of the hospital's key leaders, staff and supporters came together to acknowledge West Middlesex's remarkable achievements and uncover the hospital's role during the First and Second World Wars, its ties to Norway, and its international pioneering staff, who continue to transform patient care at West Middlesex and beyond.

CW+ is also working on an exhibition of archive photos and documents. Digital celebrations of the centenary will continue this year until Sep 2021, when we hope to hold an in-person event.



Lesley Watts
Chief Executive Officer

24 June 2021

SECTION 2

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Names of Trust directors during 2020/21

Name	Title	Period	Unexpired term
Sir Tom Hughes-Hallett	Chairman	1 Feb 2014–31 Mar 2021	n/a
Aman Dalvi	Non-executive Director	1 Dec 2019–present	1 year 8 months
Nilkunj Dodhia	Non-executive Director	1 Jul 2014–present	1 year 3 months
Nick Gash	Non-executive Director	1 Nov 2015–present	1 year 7 months
Stephen Gill	Deputy Chairman and Senior Independent Director	1 Nov 2017–present	2 year 7 months
Eliza Hermann	Non-executive Director	1 Jul 2014–present	1 year 3 months
Jeremy Jensen[1]	Deputy Chairman and Senior Independent Director	1 Jul 2014–30 Sep 2020	n/a
Dr Andrew Jones[2]	Non-executive Director	1 Jul 2014–3 Jul 2020	n/a
Ajay Mehta	Non-executive Director	1 Dec 2019–present	1 year 8 months
Lesley Watts	Chief Executive Officer	14 Sep 2015–present	Open ended
Dr Roger Chinn	Chief Medical Officer	4 Apr 2020–present	Open ended
Robert Hodgkiss	Deputy Chief Executive and Chief Operating Officer	7 Apr 2016–present	Open ended
Virginia Massaro	Chief Financial Officer	1 Oct 2019–present	Open ended
Pippa Nightingale	Chief Nursing Officer	18 Jul 2016–present	Open ended
Zoë Penn[3]	Chief Medical Officer	1 Mar 2013–3 Apr 2020	n/a
Thomas Simons[4]	Director of HR and OD	4 Mar 2019–19 Oct 2020	n/a

Register of interests

Board members are required to declare their interests annually and as they change, in addition to confirming they meet the fit and proper person condition as set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Members of the public can view the register of directors' interests on the Trust website at www.chelwest.nhs.uk/bod, by emailing chelwest.ft.secretary@nhs.net or by writing to:

Board Governance Manager
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH

Compliance with cost allocation and charging guidance

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

Political donations

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

1 Left the Trust Board in Sep 2020
2 Left the Trust Board in Jul 2020
3 Left the Trust Board in Apr 2020
4 Left the Trust Board in Oct 2020

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier. The Trust's compliance with the code is set out below:

Measure of compliance	2020/21 n°	2020/21 £000
Non-NHS payables		
Total non-NHS trade invoices paid in the year	81,032	265,198
Total non-NHS trade invoices paid within target	77,268	243,950
Percentage of non-NHS trade invoices paid within target	**95.4%**	**92.0%**
NHS payables		
Total NHS trade invoices paid in the year	3,646	44,399
Total NHS trade invoices paid within target	2,650	39,581
Percentage of NHS trade invoices paid within target	**72.7%**	**89.1%**
Totals		
Total trade invoices paid in the year	84,678	309,597
Total trade invoices paid within target	79,918	283,531
Percentage of total trade invoices paid within target	**94.4%**	**91.6%**

Well-led framework

The organisation was inspected in Nov 2019 and rated 'outstanding' for the well-led domain.

Ratings for the Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Outstanding ➔➔ Jan 2020	Good ➔➔ Jan 2020

The Care Quality Commission (CQC) recognised that there were effective and compassionate leaders who worked in effective structures in the organisation, all with a clear vision.

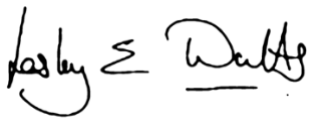
Disclosure of information to Trust auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Income disclosures

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 must be 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.



Lesley Watts
Chief Executive Officer

24 June 2021

REMUNERATION REPORT

Annual statement on remuneration

The Nominations and Remuneration Committee is a committee of the Trust Board which is appointed in accordance with the constitution of the Trust to determine the remuneration, allowances, pensions and gratuities or terms of service of the executive directors, and rates for the reimbursement of travelling and other costs and expenses incurred by directors.

In 2020/21, the committee met on two occasions to consider several matters within its terms of reference, including making decisions on the remuneration and terms of service of the executive directors' and very senior managers' pay, including new appointments. When making decisions on the salaries of executive directors, the committee considered benchmarking data for comparable positions, particularly to ensure that salaries remained appropriate where responsibilities of senior managers were amended in line with national guidance.

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 at a general meeting.

Stephen Gill
Chair of Nominations and Remuneration Committee

24 June 2021

Senior managers' remuneration policy

The Nominations and Remuneration Committee sets pay and employment policy for the executive directors and other senior staff designated by the Trust Board. The Trust's policy is for all executive directors to be on permanent Trust contracts with six months' notice.

Remuneration consists mainly of salaries (which are subject to satisfactory performance) and pension benefits in the form of contributions to the NHS Pension Fund. There were four senior managers whose pay exceeded £150,000 during 2020/21.

Remuneration is set with due regard to benchmarking information from other NHS organisations and public sector bodies as appropriate and survey data. Experience, performance and portfolio are also taken into account.

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

Increases in pay can be withheld where it is considered, through the annual appraisal process, that individual or Trust performance does not warrant an increase, but also subject to affordability and labour market conditions.

There are provisions within the directors' contracts of employment for recovery of sums should performance fall below the required standard. Trust employees were not specifically consulted on the policy and procedure for determining the remuneration of directors, however the policy was developed with full consideration given to the terms and conditions of other staff groups within the Trust and in accordance with national guidance. The policy is aligned in many ways to the terms and conditions of other staff groups.

The Council of Governors determines the terms of appointment for non-executive directors based on benchmarking data for similar posts elsewhere in the NHS. Typically, non-executive directors are appointed for three-year terms of office and do not have access to the NHS pension scheme.

Information on the salaries and pensions of directors is included within the senior manager remuneration tables from page 47.

Diversity

The Trust recognises that it has a legal obligation to ensure that its practices through service provision and its employees do not discriminate. The Trust is committed to promoting equality of opportunity for all its employees. Individuals will be treated fairly in all aspects of their employment at the Trust.

The Trust has an equality and diversity policy which details the guiding principles to remove any barriers, bias or discrimination that prevent individuals or groups from realising their potential and contributing fully to the Trust's performance. This policy and associated documents, such as the gender pay gap plan, are implemented in accordance with statutory requirements. This policy supports the work of the Nominations and Remuneration Committee.

Future policy table

	Salary/fees	Taxable benefits	Annual performance-related bonus	Long term-related bonus	Pension-related benefits
Support for the short- and long-term strategic priorities of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives	none disclosed	n/a	n/a	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid monthly	none disclosed	n/a	n/a	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	As set out in the remuneration table, salaries are determined by the Trust's Nominations and Remuneration Committee	none disclosed	n/a	n/a	Contributions are made in accordance with the NHS pension scheme
Framework used to assess performance	Trust appraisal system	none disclosed	n/a	n/a	n/a

	Salary/fees	Taxable benefits	Annual performance-related bonus	Long term-related bonus	Pension-related benefits
Performance measures	Based on individual objectives agreed with line manager	none disclosed	n/a	n/a	n/a
Performance period	Concurrent with the financial year	none disclosed	n/a	n/a	n/a
Amount paid for minimum level of performance and any further levels of performance	No performance-related payment arrangements	none disclosed	n/a	none paid	n/a
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any sums paid in error may be recovered	none disclosed	Any sums paid in error may be recovered	none paid	n/a

Service contracts

Information relating to directors' service contracts is included within the section *Names of Trust Directors during 2020/21* from page 39.

Policy on payments of loss of office

Payments for loss of office in a compulsory redundancy situation are made under the nationally negotiated compensation scheme. The Nominations and Remuneration Committee has the authority to consider compensation in relation to exit arrangements for directors.

In the event of early termination, executive director contracts provide for compensation in line with the contractual notice period. There were no payments for loss of office made in 2020/21.

Nominations and Remuneration Committee

The executive Nominations and Remuneration Committee is chaired by the Trust chairman and membership comprises all other non-executive directors.

The Trust's chief executive may be invited to attend all or part of the committee meetings provided they are not present when their executive role is subject to committee discussion/decision-making.

The committee is supported by the director of corporate governance and compliance. Details of committee attendance in 2020/21 may be found in the section *NHS Foundation Trust Code of Governance Disclosures* from page 67**.**

Disclosures required by Health and Social Care Act

The Trust is governed by a Board of Directors. At 31 Mar 2021, the Trust Board comprised seven non-executive directors (including the chairman) and five executive directors

(including the chief executive). There are 30 governor positions (28 were in post as at year end), comprising:

- **8 patients (elected)**—patients treated at the hospital in the last three years, or their carers
- **13 public (elected)**—two each from seven local boroughs, except for one borough having one representative
- **6 staff (elected)**—one each from the six staff constituencies
- **3 appointed governors (appointed)**—nominated from partnership organisations

Expenses paid to governors and directors are outlined in the table below:

	Total n° in post	N° receiving expenses	Total sum of expenses £000
2020/21			
Governors	28	1	0.03
Directors	12	1	0.63
2019/20			
Governors	27	7	1.59
Directors	15	6	2.05

Senior manager remuneration tables

Senior manager remuneration 2020/21[5]

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	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 Mar 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 Mar 2021 (bands of £5,000)	Cash equivalent transfer value at 1 Apr 2020 (£000)	Real increase in cash equivalent transfer value (£000)	Cash equivalent transfer value at 31 Mar 2021 (£000)
Executive directors[6]												
Lesley Watts, Chief Executive[7]	280–285	0	0	n/a	280–285	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Zoë Penn, Chief Medical Officer[8]	0–5	0	0	0	0–5	0	0	70–75	155–160	1,836	0	0
Roger Chinn, Chief Medical Officer[9]	175–180	0	0	0	175–180	0	0	65–70	170–175	1,451	0	1,464
Rob Hodgkiss, Deputy Chief Executive/ Chief Operating Officer[7]	190–195	0	0	n/a	190–195	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Virginia Massaro, Chief Financial Officer	145–150	0	0	155–157.5	300–305	7.5–10	15–17.5	30–35	65–70	343	122	471
Pippa Nightingale, Chief Nursing Officer	160–165	0	0	40–42.5	200–205	2.5–5	0–2.5	50–55	110–115	786	62	861
Thomas Simons, Director of Human Resources and Organisational Development[10]	80–85	0	0	35–37.5	115–120	2.5–5	0	25–30	0	282	36	322

5 There were no long-term performance-related bonuses paid to directors in 2020/21. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

6 The Accounting Officer has reviewed which officers act as 'senior managers' for the purposes of the remuneration report, and considers that for 2020/21, this only includes the chair and executive and non-executive directors of the Trust.

7 Figures for CETV are not available as the individuals are no longer part of the NHS pension scheme.

8 Left the Trust Board in Apr 2020

9 Appointed to the Trust Board in Apr 2020. The remuneration of the Chief Medical Officer includes £157k in respect of their clinical role.

10 Left the Trust Board in Oct 2020

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	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 Mar 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 Mar 2021 (bands of £5,000)	Cash equivalent transfer value at 1 Apr 2020 (£000)	Real increase in cash equivalent transfer value (£000)	Cash equivalent transfer value at 31 Mar 2021 (£000)
Non-executive directors												
Sir Thomas Hughes-Hallett, Chairman[11]	55–60	0	0	n/a	55–60	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nilkunj Dodhia, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nick Gash, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Stephen Gill, Non-Executive Director/Interim Chairman[12]	15–20	0	0	n/a	15–20	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Eliza Hermann, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Jensen, Non-Executive Director[13]	5–10	0	0	n/a	5–10	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Andrew Jones, Non-Executive Director[14]	0–5	0	0	n/a	0–5	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ajay Mehta, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Aman Dalvi, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a

11 Left the Trust Board in Mar 2021
12 Interim from Mar 2021
13 Left the Trust Board in Sep 2020
14 Left the Trust Board in Jul 2020

Senior manager remuneration 2019/20[15]

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	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 Mar 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 Mar 2020 (bands of £5,000)	Cash equivalent transfer value at 1 Apr 2019 (£000)	Real increase in cash equivalent transfer value (£000)	Cash equivalent transfer value at 31 Mar 2020 (£000)
Executive directors[16]												
Lesley Watts, Chief Executive[17]	275–280	0	0	n/a	275–280	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Zoë Penn, Chief Medical Officer[18]	160–165	0	0	135–137.5	300–305	7.5–10	5–7.5	95–100	165–170	1,634	163	1,836
Rob Hodgkiss, Deputy Chief Executive/Chief Operating Officer[17]	195–200	0	0	n/a	195–200	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sandra Easton, Chief Financial Officer[17,19]	90–95	0	0	n/a	90–95	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Virginia Massaro, Acting Chief Financial Officer[20]	60–65	0	0	80–82.5	140–145	2.5–5	5–7.5	25–30	45–50	278	59	343
Pippa Nightingale, Chief Nursing Officer	155–160	0	0	102.5–105	260–265	5–7.5	7.5–10	45–50	105–110	670	100	786
Thomas Simons, Director of Human Resources and Organisational Development	145–150	0	0	35–37.5	180–185	2.5–5	0	25–30	0	240	36	282

15 There were no long-term performance-related bonuses paid to directors in 2019/20. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

16 The accounting officer has reviewed which officers act as 'senior managers' for the purposes of the remuneration report, and considers that for 2019/20, this only includes the chair and executive and non-executive directors of the Trust.

17 Figures for CETV are not available as the individuals are no longer part of the NHS pension scheme.

18 The remuneration of the Chief Medical Officer includes £47,667 in respect of her clinical role.

19 Left the Trust Board on 30 Sep 2019

20 Appointed to the Trust Board on 1 Oct 2019

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	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 Mar 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 Mar 2020 (bands of £5,000)	Cash equivalent transfer value at 1 Apr 2019 (£000)	Real increase in cash equivalent transfer value (£000)	Cash equivalent transfer value at 31 Mar 2020 (£000)
Non-executive directors												
Sir Thomas Hughes-Hallett, Chairman	55–60	0	0	n/a	55–60	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nilkunj Dodhia, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nick Gash, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Stephen Gill, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Eliza Hermann, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Jensen, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Andrew Jones, Non-Executive Director	10–15	0	0	n/a	10–15	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ajay Mehta, Non-Executive Director[21]	0–5	0	0	n/a	0–5	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Aman Dalvi, Non-Executive Director[19]	0–5	0	0	n/a	0–5	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Liz Shanahan, Non-Executive Director[22]	5–10	0	0	n/a	5–10	n/a	n/a	n/a	n/a	n/a	n/a	n/a

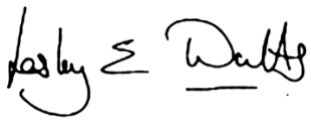
21 Appointed to the Trust Board 1 Dec 2019
22 Left the Trust Board 30 Nov 2019

Fair pay multiple

The banded remuneration of the highest paid director in the Trust in the 2020/21 financial year was £280,000–£285,000 (2019/20: £275,000–280,000). This was 6.76 times the median remuneration of the workforce (2019/20: 6.95 times), which was £41,766 (2019/20: £40,270).

In 2020/21 zero employees received remuneration in excess of the highest paid director (2019/20: nil). Remuneration ranged from £12,000 to the highest paid director banded remuneration of £280,000–£285,000 (2019/20: £12,000 to the highest paid director banded remuneration of £275,000–280,000).

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



Lesley Watts
Chief Executive Officer

24 June 2021

STAFF REPORT

Analysis of staff costs

Staff costs	Permanent £000	Other £000	2020/21 total £000	2019/20 total £000
Salaries and wages	287,617	44,170	331,787	311,983
Social security costs	32,051	3,015	35,066	33,056
Apprenticeship levy	1,577	-	1,577	1,503
Employer's contributions to NHS pension scheme	47,248	2,380	49,628	47,836
Pension cost—other	38	-	38	37
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	9,071	9,071	15,248
Total gross staff costs	368,531	58,636	427,167	409,663
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**368,531**	**58,636**	**427,167**	**409,663**
Of which:				
Costs capitalised as part of assets	2,064	640	2,704	8,219

Analysis of average staff numbers

Average number of employees (WTE basis)	Permanent n°	Other n°	2020/21 Total n°	2019/20 Total n°
Medical and dental	1,246	107	1,353	1,313
Ambulance staff	-	-	-	-
Administration and estates	1,159	152	1,311	1,398
Healthcare assistants and other support staff	798	167	965	968
Nursing, midwifery and health visiting staff	2,254	318	2,572	2,558
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	576	44	620	598
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	**6,033**	**788**	**6,821**	**6,835**
Of which:				
N° of employees (WTE) engaged on capital projects	21	4	25	106

Breakdown of employees

The following chart provides information of the gender split between the different staff groups as at 31 Mar 2021.

Employee	Female	Male	Total
Executive director	3	2	5
Non-executive director	1	6	7
Senior manager	109	73	182
Other	4,784	1,514	6,298
Total	**4,899**	**1,596**	**6,495**

Sickness absence

The chart below details the Trust's sickness absence data for 2020/21.

Sickness absence	2020/21 (n°)	2019/20 (n°)
Total days lost	92,985	67,935
Total staff	6,033	5,763
Average working days lost per whole time equivalent	15	12

Staff health and wellbeing

The increased pressures our staff have endured over the past year has highlighted the importance of a substantial and inclusive Trust Health and Wellbeing (HWB) offer. The Trust is aware of the negative impact of poor staff health and wellbeing on patient outcomes, including safety, experience and neglect and that improved wellbeing leads to better functioning workforce outcomes such as productivity, satisfaction, absenteeism, presenteeism and staff turnover. The past year has moved us a step closer to creating a culture which wholeheartedly supports staff wellbeing and the best place to work.

The Trust is implementing a three-year plan focusing on a comprehensive staff HWB programme aligned to the national staff wellbeing framework, acknowledging that any successful health and wellbeing programme requires engagement, time and investment. This framework consists of activities within three pillars of health and wellbeing:

- **Healthy Mind**—enhanced psychological and mental wellbeing support for staff
- **Healthy Body**—programme to support our staff be physically well
- **Healthy Living**—programme to support our staff live well

The HWB programme activities incorporate feedback from staff about the HWB interventions that they valued—data from a wellbeing survey sent out after the first wave of the pandemic and the 2019 NHS staff survey results. The COVID-19 response undoubtedly acted to accelerate our work around supporting staff wellbeing, recognising that healthcare staff are more at risk of stress, anxiety and burnout than ever before.

The Trust continues to have an in-house Occupational Health and Wellbeing department which is in place to support both managers and staff by providing the full remit of occupational health services. This includes making reasonable adjustments, and the Trust also seeks guidance from Access to Work when necessary. In terms of mental wellbeing support, the funding from the business case has enabled us to train 50 staff as mental health first aiders, increase our counselling provision and expand our psychological teams support service. The business case funding has also allowed us to implement a back-up care service for all substantive and bank staff, and additional funding from our hospital charity CW+ allowed us to offer free cycle servicing days for staff over the winter. During the peak of the pandemic, additional practical support was offered to staff, including short-term accommodation, a free taxi service and free car parking.

The Trust continues to run a monthly Health and Wellbeing committee, which is used to pitch and feedback on current and future wellbeing services and programmes. In addition to the HWB committee, the Trust has introduced the health and wellbeing champions role, for which 30 staff have now been trained. A wellbeing forum has been set up to support

our HWB champions and mental health first aiders by giving them the opportunity to share best practice and voice any concerns in their department.

The Trust is shortly launching the wellbeing conversation tool for all managers in the Trust, as well as looking to appoint a wellbeing guardian. The Trust is building on its foundation level status for the healthy workforce charter by working towards healthy workplace status.

The Trust's recruitment policy and Trac/NHS Jobs process alongside our status as a Disability Confident Employer confirms that if an applicant meets the minimum essential criteria of a post, then they will be shortlisted. We also have the *Maintaining People with Disabilities Guidance for Managers* which describes how we support staff with a disability or long-term health condition.

Our equality, diversity and inclusion (EDI) action plan, which covers a 2–3-year period, details the plans and activities which will be delivered to meet our EDI objectives. Success against these will be measured via our WRES and WDES reports as well as by the annual staff survey. Compliance and progress supported by relevant statistics are monitored via divisional meetings and the executive management Board with regular oversight and challenge via the Trust's People and Organisational Development Committee and the Trust Board.

We engage regularly with our workforce, identifying areas of concern and highlighting best practice via regular communication emails, a weekly all-staff webinar, and promotion of our Freedom to Speak Up guardians.

Staff engagement

The Trust knows that an engaged workforce will provide improved quality of care and was pleased to see that staff engagement scores, while lower than the previous year due to the extraordinary year staff have had, remained above the national average. Our approach over the last year has focused on wide-ranging events and daily communication from the executive team to keep staff engaged. The executive team also holds a weekly all-staff webinar to update staff on key issues and answer any questions. Staff are also asked to complete a joiners' survey three months after they have joined so we can see what their experience has been and continue to support them in their roles.

National NHS staff survey 2020

59% of the workforce (3,674 members of staff) took part in the survey which, despite the pandemic, is the highest response rate the Trust has ever received—a 13% increase on the previous year and well above the national median response rate of 45%. The Trust also presented team awards to 45 teams who had achieved over a 70% response rate.

While there is much to be proud of within this report, the senior leadership team recognises that it is our responsibility to listen and engage further with the workforce to address the issues that have been raised about working in the Trust.

One of the biggest influences on culture is the style of leadership in an organisation, and collective leadership is recognised as the key to creating a culture that will give staff the freedom and confidence to act in the interests of patients and support sustainable improvements.

An existing programme of work is already in place at Trust level that will support how we address the key themes identified within the report as below average when compared to our benchmark group—acute/acute community Trusts. Work is also ongoing within the divisions to develop a bottom-up action planning process through the development of pledges and commitments to address local themes and issues. An organisational priority, the first draft of the 'You said… we did' action plan encompassing these actions will be in place by the end of May 2021.

The Trust will oversee the further development and delivery of the staff survey action plan. The plan will include divisional level actions plans which will allow a clear focus on specific areas for improvement within each division, while maintaining a Trustwide overview of areas of challenge and where best practice can be shared. Progress against the plan will be monitored via appropriate meetings at divisional and Trust level, with regular updates to executive management Board and the wider workforce. This will be underpinned by a clear ongoing programme of staff engagement and listening, supported by a refreshed people strategy based on the NHS people plan and the North West London people priorities.

Headlines

The overall results of the 2020 staff survey are highlighted in the table below and indicate that the Trust was above the national average for immediate managers, quality of care, safety culture, staff engagement and teamworking. The Trust's key areas for improvement are areas where the Trust is below the national average and have been priorities in our plans over the last year, which are equality, diversity and inclusion, health and wellbeing, morale and safe environment. The comparison to last year is difficult given the context of when the survey was carried out, and it is also relevant that 57% of staff completing the survey had worked on a COVID area compared to 39% nationally and 32% of staff had been redeployed compared to 21% nationally.

Indicator	2018	2019	2020	Best	Average	Worst
Equality, diversity and inclusion	8.7	8.6	8.5	9.5	9.1	8.1
Health and wellbeing	5.8	5.8	5.9	6.9	6.1	5.5
Immediate managers	6.9	6.9	6.9	7.3	6.8	6.2
Morale	6.1	6.0	6.0	6.9	6.2	5.6
Quality of care	7.7	7.8	7.7	8.1	7.5	7.0
Safe environment (bullying and harassment)	7.7	7.7	7.6	8.7	8.1	7.2
Safe environment (violence)	9.3	9.3	9.3	9.8	9.5	9.1
Safety culture	6.8	6.9	6.9	7.4	6.8	6.1
Staff engagement	7.3	7.3	7.1	7.6	7.0	6.4
Teamworking	6.7	6.9	6.5	7.1	6.5	6.0

In terms of the three staff engagement questions:

Indicator	2018	2019	2020	Best	Average	Worst
Q18a: Care of patients/service users is my organisation's top priority	84.4%	82.6%	83.9%	79.4%	90.7%	61.8%
Q18c: I would recommend my organisation as a place to work	72.4%	69.8%	70.5%	66.9%	84.0%	46.6%
Q18d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	81.0%	79.2%	78.4%	74.3%	91.7%	49.7%

Areas of strength

- Topics above the national average were staff engagement, immediate managers, quality of care, safety culture and teamworking
- 71% of staff would recommend the Trust as a place to work, 78% are happy with the standard of care delivered and 84% believe the care of patients is the Trust's top priority, all of which remain higher than the national average
- While the Trust is below the national average for health and wellbeing overall, this was the only area to increase across the 10 themes in 2020 and reflects the Trust has made a significant investment in health and wellbeing for staff—69% of staff believe their managers take a positive interest in their health and wellbeing and 56% are satisfied with the opportunities for flexible working, which remains above the national average
- Safety culture—79% of staff believe the Trust would act on concerns raised and 74% would also feel secure raising concerns

Areas for improvement

- The Trust is below national average for equality, diversity and inclusion, health and wellbeing, morale and safe environment (bullying and harassment/violence)
- Equality, diversity and inclusion remains an issue whereby more than 14% of staff who participated in the survey stated that in the last 12 months they had personally experienced discrimination at work from patients or relatives and 11% from managers
- Morale is a key priority, especially due to the last year, as more than 25% of staff who participated in the survey admitted that they would probably look for a job at a new organisation in the next 12 months
- Within the topic of safe environment (bullying and harassment), 36% of staff who participated in the survey stated that they had experienced at least one episode of harassment, bullying or abuse at work from patients, service users, relatives of members of the public, 22% from colleagues and 14% from managers.

The full staff survey report is published at www.nhsstaffsurveyresults.com.

Gender pay

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 report for 2019/20 is published at www.chelwest.nhs.uk/edi.

Workforce gender split

As at 31 Mar 2021 the total relevant paid workforce was 6,117 staff across all sites and staff groups.

Gender	N° of staff	% split of the workforce
Male	1,486	24% of the total workforce
Female	4,691	76% of the total workforce

Average and median hourly rates

Gender	Average hourly rate	Median hourly rate
Male	£24.95	£20.42
Female	£20.53	£18.17
Difference	£4.42	£2.25
Pay gap %	**18%**	**11%**

The gender pay gap when expressed as a mean average shows that female staff earn 18% less than male staff. This equates to a difference of £4.42 per hour.

The gender pay gap when expressed as a median average shows that female staff earn 11% less than male staff. This equates to a difference of £2.25 per hour.

Bonus gender pay gap by hourly rate

For the purpose of this report the bonus payments referred to are those made to consultants in the form of clinical excellence awards (CEAs). As at 31 Mar 2020 there were 482 consultants at the Trust, of which 51% were male and 49% female.

Gender	Average pay	Median pay
Male	£14,726.24	£9,048
Female	£11,306.26	£9,048
Difference	£3,419.98	£0
Pay gap %	**23%**	**0%**

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

Quartile	Female	Male	Female %	Male %
1	1,198	398	75%	25%
2	1,290	310	81%	19%
3	1,297	292	82%	18%
4	997	613	63%	38%

Plans to address the gender pay gap include the addition of an equality and diversity champion at Band 7 interviews and assisting with the cultural induction of overseas nurses to fast-track assimilation within the organisation. The Trust will further be supporting women in the workplace by revising our flexible working policy and working with Timewise to become a fully flexible employer and by introducing a staff menopause policy and support with the aim of retaining experienced female staff. Further details of key actions are detailed in the Trust's Gender Pay Gap report for 2019/20 which can be accessed at www.chelwest.nhs.uk/genderpaygap.

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 Apr 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 Apr 2019 to 31 Mar 2020.

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

	2019/20
Number of employees who were relevant union officials during the relevant period	20
Number of full-time equivalent employees as at 31 Mar 2020	6,336

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

	2019/20
0%	14
1–50%	5
51–100%	1

* 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

	2019/20
Total cost of facility time	£73,000
Total pay bill	£401,583,000
% of total pay bill spent on facility time (total costs of facility time/total pay bill x100)	0.02%

Hours spent by employees who were relevant union officials during the relevant period on paid union activities, as a percentage of total paid facility time

	2019/20
Time spent on paid union activities as a percentage of total paid facility time hours calculated as (total hours spent on paid trade union activities by relevant union officials during the relevant period/total paid facility time hours) x100	0.31%

Workforce improvement activity

Recruitment and retention

The Trust has continued with several activities to reduce vacancy rates and streamline the recruitment process. This has included several initiatives to maximise collaborative working across the sector on opportunities such as local, national and international recruitment drives, as well as guaranteed job offers for student nurses or a process for fast-tracking temporary staff to permanent roles. Despite significant change to our services over the last 12 months due to the COVID-19 pandemic, the Trust has maintained a relatively low vacancy rate which currently stands at 6.7%. In line with the national people plan, work is also underway to work collaboratively across North West London on the 'Attracting Talent' workstream, including work on the Capital Nurse Project.

The Trust's recruitment and selection policy has been revised to ensure better fairness, transparency and governance throughout the onboarding process. This has led to the successful launch of the diversity and inclusion champions initiative for all roles at bands 8a and above with plans underway to roll this out to bands 6 and 7 roles across the Trust.

Due to the pandemic, recruitment time to hire has fluctuated across non-medical staff groups on a monthly basis throughout the year, but remains as 8.8 weeks as an overall average, which is within the current Trust target of 9 weeks.

Further plans are being developed to improve the candidate recruitment journey through better engagement during the onboarding stage and to work with the relevant departments to streamline the new starter processes to ensure 'day 1 readiness' for all new staff.

Retention of our staff remains one of the key priorities for the Trust. This focuses on the following key themes:

- Improving training, career development and enhancing support from managers
- Creating advanced scope roles to provide attractive career pathways
- Improving how we gather feedback from our staff throughout their employment with us—joiners, regular pulse and leavers surveys so we can better understand and act
- Widening and communicating our health, wellbeing and benefits offering
- Increasing the opportunities for working flexibly

As at the end of Mar 2021, the Trust had reduced overall turnover in the year from 18% to 16% and voluntary turnover from 14% to 11% delivering on the Trust target of 13%.

This year we revised our leadership offer and have implemented a top leader and senior leadership programme, working with Ashridge-Hult Business School utilising our apprenticeship levy. We have also continued to deliver our emerging leaders programme virtually and the management fundamentals have been resumed also virtually.

Performance and development reviews (PDRs)

During the year staff have where possible had their PDRs completed and we are currently at 89% compliance. Work is underway to include Health and Wellbeing and EDI discussions in the PDRs for the coming year.

Under guidance from the GMC and HEE, medical appraisals at the Trust were placed on hold from mid-Mar–Sep 2020.

Throughout the pandemic, the Trust sought to offer a supportive and non-pressured approach to completion of appraisals. Once the programme was restarted, doctors were encouraged to complete an appraisal, if possible, but it was understood that due to COVID this may be difficult. It was communicated that it was acceptable to have the meeting without the normal amount of supporting information, and to look at it as opportunity to reflect and discuss with the appraiser how COVID has and continues to have an effect.

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

- **CW:** 195 completions, 98 logged as 'cancelled/approved due to COVID19' and 128 pending
- **WM:** 86 completions, 118 logged as 'cancelled/approved due to COVID19' and 101 pending

Professional development

During the past year, a lot of the normal clinical development opportunities were put on hold while we supported staff development to enable them to provide care to COVID wards. The table below shows the training provided:

Course	N°
289 COVID-19 Care of the critically unwell patient	166
289 COVID-19 Caring for a critically unwell patient—module 3	291
289 COVID-19 HCA ICU familiarisation	49
289 COVID-19 ICU familiarisation	985
289 COVID-19 Intravenous drug administration refresher	48
289 COVID-19 Leading in ICU during a pandemic	73
289 COVID-19 Non-invasive ventilation	48
289 COVID-19 Training update—ICU	30
289 COVID-19 Ward helper (non-clinical staff)	83
289 COVID-19 Ward refresher training	22
Total	**1,795**

We continue to run development programmes for other junior leaders. Medical education and other clinical education have been focussed on supporting COVID as above, however we have also ensured they have provided staff with the opportunity to discuss their experiences and be supported—for example, through Schwarz rounds.

Advanced resus programme and simulation and clinical skills training have resumed in Mar 2021.

Leadership development

We launched our senior and top leaders programmes with Ashridge Hult Business School, and currently have 19 staff undertaking an MBA and 37 staff undertaking an MSc in leadership. Emerging leaders and management fundamentals were put on hold during COVID but have begun to resume as virtual sessions, where possible.

Recognition schemes

The PROUD awards have been recommenced, ensuring staff nominated last year have been awarded where they have won, and letters advising them of their nominations have been sent. 234 nominations were received in the past 12 months, and we have recognised 29 individuals and 10 teams. We have recommenced the excellence reporting and are in the process of catching up, but at the time of publication all excellence reporting to the end of March have been sent. There were 553 excellence report nominations received in the period 1 Apr 2020–19 Mar 2021.

Apprenticeships and work experience

Work experience was put on hold during the past year for students coming into the hospital. We have, however, worked across the ICS and developed a work experience programme in partnership with Springpod which is 10 hours of interactive online learning and webinars to enable students to understand different careers in the NHS. The initial areas have been nursing and midwifery, and allied health professionals, and this year we are adding in medicine and support staff.

First programme we ran in July had two programmes—nursing and allied health professionals. There were 1,367 applications (552 for nursing and 815 for AHP) and 200 students were offered a place with 100 on each programme. 86% completed the AHP programme and 80% completed the nursing programme. This year we have added medicine and support staff and plan to run two programmes (during Easter and summer) making a total of three programmes.

- 107 staff on clinical apprenticeships
- 33 staff on other apprenticeships

This has increased our utilisation of the levy to 37% in Feb 2021. In the past 12 months, we averaged a utilization rate of 35%, with the lowest rate in Jul 2020 at 19% and the highest in Dec 2020 at 62%.

We held a virtual celebration of achievements in apprenticeship week recognising, the 24 staff who completed their apprenticeship this year.

Health and safety and occupational health

The Trust's core health and safety and occupational health policies continue to be updated to ensure that such documents support both main hospital sites and satellite locations.

Details and data relating to incidents, complaints, claims, risk registers and occupational health data are captured on Datix, a web-based, integrated safety learning system. The Datix system is subject to further enhancements to include other patient safety topics, such as patient experience and mortality reviews, and supports a robust reporting culture throughout the Trust to improve our safety practices.

There were 23 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents reported to the Health and Safety Executive (HSE) during 2020/21, of which 7 related to CW and 16 to WM. The Trust's health and safety team works with clinical and corporate departments to support a system of self-assessment and

independent spot-checks. Areas subject to spot-checks are identified using a risk-based approach.

During 2020, the Trust put in place a programme of support for staff during the COVID-19 pandemic. This included an innovative offer for psychological support and access to various health and wellbeing initiatives. This work is ongoing. The occupational health team focussed on reviewing all Trust COVID-19 risk assessments, offering advice to both management and staff. A confidential clinical reference group was established to inform decision-making, relating to fitness to work and/or reasonable adjustments in the workplace. Comprehensive clinical COVID-19 assessments were carried out by the team for staff identified as being clinically extremely vulnerable, pregnant and those with high risk factors as defined by government guidelines.

Policies and procedures in respect of 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.

During 2020/21, KPMG was contracted by the Trust to provide its local counter-fraud specialist (LCFS) services 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.

Expenditure on consultancy

In 2020/21, the Trust incurred £0.4m (£0.7m in 2019/20) on consultancy which included finance/procurement systems integration work, procurement consultancy costs to support the Trust's contract portfolio, and hosted consultancy services across the North West London sector.

Off-payroll arrangements

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 of IR35 in 2020/21.

Off-payroll engagements as at 31 Mar 2021 for more than £245 per day and that last for longer than 6 months

	Total
N° of existing engagements as of 31 Mar 2021	4
Of which the number that have existed:	
For less than 1 year at the time of reporting	1
For between 1 and 2 years at the time of reporting	2
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	1
For 4 or more years at the time of reporting	0

New off-payroll engagements, or those that reached 6 months in duration, between 1 Apr 2020 and 31 Mar 2021, for more than £245 per day and that last for longer than 6 months

	Total
N° of new engagements, or those that reached six months in duration, 1 Apr 2020–31 Mar 2021	11
Of which the number that have existed:	
N° assessed as caught by IR35	0
N° assessed as not caught by IR35	11
N° engaged directly (via PSC contracted to department) and are on departmental payroll	0
N° of engagements reassessed for consistency/assurance purposes during the year	0
N° of engagements that saw a change to IR35 status following the consistency review	0

Exit packages

Reporting of compensation schemes—exit packages 2020/21

Exit package cost band (including any special payment element)	N° of compulsory redundancies	N° of other departures agreed	Total n° of exit packages
≤£10,000	-	-	-
£10,001–25,000	-	1	1
£25,001–50,000	1	-	1
£50,001–100,000	-	-	-
£100,001–150,000	-	1	1
£150,001–200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**2**	**3**
Total resource cost (£)	£35,000	£146,000	£181,000

Reporting of compensation schemes—exit packages 2019/20

Exit package cost band (including any special payment element)	N° of compulsory redundancies	N° of other departures agreed	Total n° of exit packages
≤£10,000	4	-	4
£10,001–25,000	2	-	2
£25,001–50,000	1	1	2
£50,001–100,000	1	-	1
£100,001–150,000	-	-	-
£150,001–200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**8**	**1**	**9**
Total resource cost (£)	£142,000	£27,000	£169,000

Exit packages—other (non-compulsory) departure payments

	2020/21		2019/20	
Exit package cost band (including any special payment element)	**N° of payments agreed**	**Total value of agreements (£000)**	**N° of payments agreed**	**Total value of agreements (£000)**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARs) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	146	1	27
Exit payments following employment tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**2**	**146**	**1**	**27**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

NHS FOUNDATION TRUST CODE OF GOVERNANCE DISCLOSURES

Code of Governance compliance statement

Chelsea and Westminster Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis, including membership of Trust Board committees, their terms of reference and Trust Board performance assessments. The NHS Foundation Trust Code of Governance, most recently revised in Jul 2014, is based on the principles of the UK Corporate Governance Code which was last updated in 2016.

As a Trust, we are committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver mandatory goods and services. The Trust's governance arrangements are reviewed yearly against the provisions of the NHS Foundation Trust Code of Governance to ensure the application of the main and supporting principles of the code as a criterion of good practice. For the year ending 31 Mar 2021, Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by NHS Improvement (NHSI).

Governance arrangements

The Trust is led by a Board of Directors whose key responsibilities are to:

- Provide leadership to the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed
- Ensure the Trust complies with its licence, its constitution, requirements set by NHSI, and relevant statutory and contractual obligations
- Set the Trust's vision, values and standards of conduct
- Set the Trust's strategic aims and ensure that the necessary human and financial resources are in place to deliver these
- Ensure the quality and safety of the healthcare services provided by the Trust
- Ensure the Trust exercises its functions effectively, efficiently and economically

The Trust Board undertakes its responsibilities through a set business cycle which includes approving strategies and receiving monitoring reports on areas such as key risks and financial, operational and quality and safety performance. The Trust Board approves standing financial instructions, scheme of delegation and reservation of powers policies which outline the decisions that must be taken by the Trust Board and the decisions that are delegated to the management of the hospital. These include contracts, tendering procedures, security of the Trust's property, monitoring and ensuring compliance with Department of Health and Social Care directions on fraud and corruption, delegated approval limits, budget submission, annual reports and accounts, banking arrangements, payroll, borrowing and investment, risk management and insurance arrangements.

The Trust Board of Directors, collectively and individually, have a legal duty to promote the success of the Trust to maximise the benefits for the populations that it serves. They also have a duty to avoid conflicts of interest, not to accept any benefits from third parties and to declare interests in any transactions that involve the Trust.

Throughout the reporting period, the Nominations and Remuneration Committee have kept under review the overall size of the Trust Board and the balance of skills, experience and expertise of its members.

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:

- Appointment or removal of the chairman and other non-executive directors
- Approving the appointment (by non-executive directors) of the chief executive
- Deciding the remuneration, allowances and other terms and conditions of office of non-executive directors
- Appointment or removal of the Foundation Trust's financial auditors
- Reviewing and developing the Trust's membership strategy

A formal procedure is in place should there be a dispute between the Board and Council of Governors. During 2020/21, no issues of dispute arose, and the governors therefore did not exercise their power under paragraph 10(c) of schedule 7, NHS Act 2006.

Board of Directors

As at 31 Mar 2021, the Trust Board had five executive directors (including the chief executive) and six non-executive directors (including the chairman). The Trust Board comprises 33% female and 67% male directors. The skills, expertise and experience of each Trust Board director as at the end of Mar 2021 are detailed below and is appropriate to meet the requirements of an NHS foundation trust.

Executive directors

Lesley Watts, Chief Executive Officer

Lesley is chief executive of Chelsea and Westminster Hospital NHS Foundation Trust and also the chief executive of the North West London Integrated Care System (ICS). A nurse and midwife by training, Lesley has extensive executive managerial experience, having led the Trust since 2015 and was previously chief executive for East and North Hertfordshire Clinical Commissioning Group. In 2020, under her leadership the Trust was awarded a CQC rating of 'outstanding' for well-led and use of resources.

Dr Roger Chinn, Chief Medical Officer

Roger Chinn was appointed as chief medical officer in Dec 2020. He is a clinical radiologist who has been a consultant with the Trust since 1996. Previously, he has held senior leadership roles as deputy medical director and chief clinical information officer in the Trust and was the medical director at West Middlesex University Hospital for the year prior to its acquisition by the Trust.

Robert Hodgkiss, Deputy Chief Executive and Chief Operating Officer

Rob was appointed as chief operating officer in Mar 2016. He joined the Trust in Apr 2012 as divisional director of operations for women, neonatal, children and young people, HIV/GUM and dermatology services. Rob joined the NHS in 1992, initially working as a healthcare assistant before moving on to various junior, middle, senior management roles

across London and the Midlands. Rob has a great deal of experience in understanding the complexities of the modern NHS including emergency planning and response, and is the organisation's accountable emergency officer. Rob is also the interim chief operating officer lead for the North West London Integrated Care System.

Virginia Massaro, Chief Financial Officer

Virginia joined the Trust in 2010 as head of financial planning before progressing to assistant director of finance and deputy director of finance, having previously worked in finance teams across other NHS organisations in North West London. She has been chief financial officer since October 2019 and is a qualified chartered management accountant.

Pippa Nightingale, Chief Nursing Officer

Pippa joined the NHS in 1994, originally working as a maternity support worker. She qualified in 1998 and worked clinically for 10 years in maternity and neonates. On completion of her MSc in advanced clinical practice in 2007 she undertook a clinical academic role at the University of Hertfordshire. Pippa entered back into the acute setting as a matron and then as a consultant midwife. She has undertaken numerous professional leadership roles including deputy director of midwifery at Imperial Hospital, director of midwifery and clinical director at Chelsea and Westminster Hospital, and chief nurse and executive quality lead at the North West London Integrated Care System, responsible for quality, patient safety and safeguarding across the system.

Non-executive directors

Stephen Gill, Chairman (interim)

Steve was appointed as a non-executive director on 1 Nov 2017. He was chair of the People and Organisational Development Committee from Feb 2018 to Mar 2021. In Aug 2020 Steve was appointed as deputy chair and senior independent director (SID) and, in Mar 2021, was appointed as interim chairman. Steve has had an international executive career in the IT industry, including chief executive roles with Hewlett-Packard in the UK, Korea and China. He has held various non-executive director roles including advising the UK government on IT in education. Steve qualified as a chartered accountant with PwC in London and has extensive experience in mergers and acquisitions, strategic planning, talent and succession planning, organisational development, risk management and disaster recovery. Steve has been the chair of trustees of Age Concern (Windsor) since Jan 2018.

Sir Thomas Hughes-Hallett

Sir Tom is cofounder (with his friend Paul Marshall) and chair of the Marshall Institute within the London School of Economics and Political Science, chair of Chelsea and Westminster Hospital NHS Foundation Trust and founder and chair of Helpforce. He is a Trustee on the Board of the Westminster Abbey Foundation. He has been appointed a professor in practice at the London School of Economics.

Sir Tom has served the Department of Health as a chair and member of several advisory boards. He has held senior leadership positions within investment banking and the voluntary sector, including chair of the Michael Palin Centre for Stammering Children,

English Churches Housing Group, chief executive of Marie Curie Cancer Care and the Institute of Global Health Innovation at Imperial College London, among others.

Sir Tom has chaired commissions both for the government and independently on healthcare, end-of-life care and philanthropy. In 2012 he was awarded a knighthood for his services to philanthropy, in 2013 a beacon fellowship for philanthropic advocacy, a US Ferrari lifetime lectureship by Houston Methodist Medical School and an honorary degree by Anglia Ruskin University. Sir Tom is married to Juliet, the founder and chair of the charity Smart Works, and his great passions are choral music and family life.

He retired from the Trust in Mar 2021.

Aman Dalvi

Aman Dalvi has worked at very senior levels for many years and has been a chief executive of three organisations where he has led multidisciplinary teams. Aman has extensive experience in planning and regeneration and in his career, he was executive director of development and renewal in a major local authority. Aman Dalvi was also a ministerial appointee on the boards of English Partnerships and the Olympic Park Legacy Company. Aman has also served as a chair of several organisations which include the Anchor Trust and PA Housing. In addition, Aman Dalvi has been a statutory appointment on several large and diverse organisations. Aman Dalvi is currently working as a consultant for two major developers and is chair of a development company. Aman is a member of the Audit and Risk Committee and the Finance and Investment Committee.

Nilkunj Dodhia

Nilkunj, a non-voting Trust Board member since 1 Jul 2014, was appointed as a non-executive director on 27 Nov 2015. He has diverse experience as an executive and non-executive director with interests in telecommunications, healthcare and financial services. Nilkunj was previously with McKinsey and Company and also served as chairman of the South West London Elective Orthopaedic Centre (SWLEOC) and as non-executive director of Epsom and St Helier University Hospitals NHS Trust. Nilkunj has an MBA from INSEAD and is a fellow of the Institute of Chartered Accountants in England and Wales. Nilkunj is currently chair of the Finance and Investment Committee and is a member of the Quality Committee.

Nick Gash

Nick works as a consultant offering communications, policy and political advice, and training to a wide range of clients. He is an associate of public affairs company Westbrook Strategy. Nick was board chair of West Middlesex University Hospital until the acquisition in 2015, having been a non-executive director and deputy chairman before that. He chairs the North West London advisory panel for national clinical excellence awards and is a lay advisor to Health Education England (London and South East) for medical recruitment and annual reviews of trainee progression. He is a lay member of the school board of the London School of Anaesthetics. Until 2004 Nick was the chief executive of the National Union of Students, having previously been director of development and training. Nick was, for nine years, chair of the trustees of Watermans, a multicultural arts centre based in Brentford. Nick currently chairs the Audit and Risk Committee and is a member of the People and Organisational Development Committee. Nick is also the non-executive director lead for Freedom to Speak Up, and a trustee of our hospital charity, CW+.

Eliza Hermann

Eliza was appointed as a non-executive director on 1 Jul 2014. She spent 25 years in the oil and gas industry working for Amoco and BP on projects all over the world. She held commercial and strategy development roles and, for the last decade of her career, she was a vice president of human resources at BP's headquarters in London. Over the past 18 years, Eliza has served as a non-executive director on the boards of various private and public sector organisations. These include a NASDAQ-listed global logistics company, two UK arms-length public bodies, a charity, and NHS Hertfordshire which was, at the time, the second largest NHS commissioning body in England. She has chaired numerous board committees and is currently the chair of the Quality Committee and a member of the Audit and Risk Committee.

Ajay Mehta

Ajay is an organisational development specialist supporting the growth and sustainability of civil society organisations globally to increase their social impact. With significant contributions in the social impact and public sectors, he brings a breadth of experience in the areas of strategic planning, resource mobilisation and sustainability, community engagement, leadership and governance. Ajay's portfolio of work has ranged from large international institutions to smaller community-based organisations, supporting them to review and re-engineer their strategic interventions and maximise impact. Ajay has particular interests in human and environmental rights, a focus of his company em4, which engages with institutional funders to build the capacities of their grantees. He has held board-level positions with national and international charities, and was until recently a non-executive director of Hounslow and Richmond Community Healthcare NHS Trust. He currently heads up a charitable foundation that invests in the development of healthcare workers in communities, clinics and healthcare facilities across sub-Saharan Africa. Ajay is currently chair of the People and Organisational Development Committee and member of the Quality Committee.

Directors and others in regular attendance at Board meetings 2020/21

- Gubby Ayida, Equality, Diversity and Inclusion Specialist Advisor to Trust Board
- Chis Chaney, Chief Executive, CW+
- Kevin Jarrold, Chief Information Officer
- Martin Lupton, Associate Dean and Head of Undergraduate Medicine, Imperial College London
- Sue Smith, Interim Director of HR and OD[23]
- Serena Stirling, Director of Corporate Governance and Compliance

Key responsibilities of non-executive directors

For all non-executive directors, key responsibilities include:

- Challenging and supporting the executive directors in decision-making and on the Trust's strategy

[23] Joined the Trust Board in Oct 2020

- Holding collective accountability with the executive directors for the exercise of their powers and for the performance of the Trust

Independence of non-executive directors

The Trust Board has evaluated the circumstances and relationships of individual non-executive directors which are relevant to the determination of the presumption of independence and determines all its non-executive directors to be independent in character and judgement. Key changes on the Trust Board in 2020/21 were as follows:

- Dr Andrew Jones, Non-Executive Director—stepped down 4 Jul 2020
- Jeremy Jensen, Non-Executive Director—term expired 30 Sep 2020
- Sir Thomas Hughes-Hallett, Chairman—stepped down 31 Mar 2021

Performance evaluation of the Board

The annual appraisal of the chairman involved collaboration between the senior independent director and the lead governor of the Council of Governors. The views of non-executive directors, executive directors, external partners and governors were sought and contributed to the process. The performance of non-executive directors is evaluated annually by the chairman. Executive directors have an annual appraisal with the chief executive. All Trust Board committees reviewed their effectiveness during 2020/21 and provided assurance reports to the Audit and Risk Committee which, in turn, reported the effectiveness of the committees to the Trust Board.

Board meetings

The Trust Board meets on average no less than six times per year. Special meetings are organised as and when required. There were five public meetings and one extraordinary private meeting in 2020/21. Director attendance is detailed below.

	Ordinary Board meeting attendance	Extraordinary Board meeting attendance
Executive directors		
Lesley Watts	5/5	1/1
Dr Roger Chinn	5/5	1/1
Rob Hodgkiss	5/5	0/1
Virginia Massaro	5/5	1/1
Pippa Nightingale	5/5	1/1
Thomas Simons[24]	3/3	0/1
Zoe Penn[25]	n/a	n/a
Non-executive directors		
Sir Tom Hughes-Hallett	5/5	1/1
Aman Dalvi	5/5	1/1
Nilkunj Dodhia	5/5	1/1
Nick Gash	5/5	1/1
Stephen Gill	5/5	1/1
Eliza Hermann	5/5	1/1
Jeremy Jensen	2/3	1/1
Dr Andrew Jones	1/2	1/1
Ajay Mehta	5/5	1/1

[24] Left the Trust Board in Oct 2020
[25] Left the Trust Board in Apr 2020

Committees of the Board of Directors

The Trust Board committee structure is set out below. Terms of reference detail the responsibilities of each committee and this structure monitors and provides assurance to the Trust Board on the delivery of our objectives and other key priorities.

Nominations and Remuneration Committee of the Board of Directors for the appointment of executive directors

The Nominations and Remuneration Committee is a committee of the Trust Board of Directors. It is appointed in accordance with the constitution of the Trust to decide the remuneration and allowances, and the other terms and conditions of office, of the chief executive and other executive directors. The committee comprises the chairman and all other non-executive directors.

The committee met on 13 Oct 2020 to consider and agree plans for the appointment of substantive chief financial officer and chief medical officer, including interim replacement of the director of HR and organisational development. Additionally, the committee met on 4 Feb 2021 to review and agree the committee's terms of reference, annual work plan, executive director and very senior manager pay, including formal approval of the appointment of the chief financial officer and chief medical officer.

Nominations and Remuneration Committee attendees	Attendance
Hughes-Hallett, Sir Tom (Chairman)	2/2
Gill, Stephen (Deputy Chairman)	2/2
Dalvi, Aman	2/2
Dodhia, Nilkunj	2/2
Gash, Nick	2/2
Hermann, Eliza	2/2
Mehta, Ajay	1/2
Jones, Dr Andrew	n/a
Jensen, Jeremy	n/a
In attendance	
Watts, Lesley	2/2
Smith, Sue	2/2
Stirling, Serena	1/2
Djelic, Vida	1/2

Nominations and Remuneration Committee of the Council of Governors for the appointment of non-executive directors

A separate Nominations and Remuneration Committee exists for the nomination, appointment and remuneration of the chairman and non-executive directors. This is a

committee of the Council of Governors and its membership comprises the chairman, the lead governor and five public- and patient-elected governors.

Reappointments

During 2020/21, on recommendation by the committee and agreement of the Council of Governors, it was agreed to extend the term of office of the non-executive directors Eliza Hermann and Nilkunj Dodhia for a further period to end on 30 Jun 2022.

Appointments

During 2020/21, on recommendation by the committee, the Council of Governors at its Jul 2020 meeting agreed to appoint Stephen Gill as the deputy chairman and senior independent director.

The Council of Governors at its Jan 2021 meeting agreed to appoint Stephen Gill as the interim chairman taking effect from 4 Mar 2021 until a substantive appointment is made.

Nominations and Remuneration Committee attendees	Attendance
Sir Tom Hughes-Hallett, Chairman	2/2
Richard Ballerand, Public Governor	2/2
Simon Dyer, Lead and Patient Governor	2/2
Minna Korjonen, Patient Governor	2/2
Anthony Levy Public Governor	2/2
David Phillips, Patient Governor	2/2
Laura Wareing, Public Governor	2/2
In attendance	
Lesley Watts, Chief Executive Officer	1/2
Thomas Simons, Director of HR and OD[26]	2/2
Serena Stirling, Director of Corporate Governance and Compliance	2/2

Quality Committee

The Quality Committee is mainly responsible for issues of quality and patient safety. It seeks assurance on systems, processes and outcomes relating to the safety and effectiveness of care which we deliver to our patients. This includes monitoring regulatory compliance with the standards set out by the Care Quality Commission (CQC).

People and Organisational Development Committee

The People and Organisational Development Committee is responsible for reviewing Trust performance on key workforce metrics (turnover, mandatory training and appraisal rates) while also reviewing key workforce and organisational development strategies on behalf of the Trust Board.

Finance and Investment Committee

The Finance and Investment Committee is responsible for seeking assurance as to the satisfactory management of the Trust's finances, cost improvement programme, cash

[26] Left the Trust Board in Oct 2020

management and capital programme. The committee also reviews and recommends to the Trust Board for approval those business cases with high-level strategic significance.

Audit and Risk Committee

The Audit and Risk Committee assures the Trust Board that probity and professional judgment are exercised in all financial matters. It advises on the adequacy and effectiveness of the Trust's internal control systems, risk management arrangements, counter-fraud measures and governance processes, and on ways of maximising efficiency and effectiveness. In doing this, the Audit and Risk Committee primarily utilises the work of internal audit (provided by KPMG in 2020/21), external audit (provided by Deloitte in 2020/21) and other external bodies. The committee approves the annual work plans of internal and external audit as well as the local counter-fraud specialist (provided by KPMG in 2020/21).

The chief executive is the Trust's designated accounting officer who has the duty of preparing the accounts in accordance with the NHS Act 2006. Nick Gash chaired the Audit and Risk Committee in 2020/21, which includes two other non-executive directors. The committee met five times in 2020/21.

Audit and Risk Committee attendees	Attendance
Nick Gash (Chair)	5/5
Aman Dalvi	2/2
Eliza Hermann	5/5
Dr Andrew Jones[27]	2/2

Significant issues considered by the Audit and Risk Committee in relation to the financial statements, operations and compliance

During the year, the Audit and Risk Committee received several reports from the internal auditors KPMG. These covered several areas including working from home infrastructure, financial controls, research governance, management of joint ventures, corporate records management, employee relations, workforce data, serious incidents, estates project management, data security and protection (DSP) toolkit, pharmacy and Cerner projects review. For the period 1 Apr 2020–31 Mar 2021, six high-risk recommendations were identified by our internal auditors.

Following the year end, the committee considered the draft annual report and accounts 2020/21 and received the ISA 260 report from the Trust's external auditors.

During 2020/21, in addition to non-executive directors and those executive directors in attendance, the Trust's internal and external auditors and counter-fraud specialist attended the committee meetings. When relevant, other senior managers attended meetings to provide a deeper level of insight into certain key issues within their respective areas of expertise including all areas of significant risk.

The committee has engaged regularly with the external auditors over the financial year. External audit matters discussed have included consideration of the external audit plan, matters arising from the audit of the Trust's financial statements, implementation of

[27] Left the Trust in Jul 2020

adoption of international reporting standards and any recommendations on control and accounting matters proposed by the auditor.

Policy for safeguarding the external auditors' independence

The Trust carried out an Official Journal of the European Union (OJEU) tender for statutory audit services in Oct 2016 and reappointed Deloitte LLP on a three-year contract with an option to extend for a further two years. It was agreed by the Audit and Risk Committee during 2019/20 to extend the contract for two years. As part of the procurement process, the independence of applicants was assessed. The external auditor has not provided non-audit services in the year.

Internal audit

From Apr 2018, following a competitive tender, the Trust has awarded the contract to provide internal audit and counter-fraud services to KPMG on a two-year contract with an option to extend for a further year. It was agreed by the Audit and Risk Committee during 2019/20 to extend the contract for one year. The internal audit plan covered the Trust's risk management, governance and internal control processes, both financial and non-financial, across the Trust. Through detailed examination, evaluation and testing of the Trust's systems, internal audit plays a key role in the Trust's assurance processes. The committee reviews the findings of internal audit's work against the annual plan at each of its meetings. The head of internal audit reports to the committee and has a right of direct access to committee members. The internal audit function is managed by the chief financial officer.

Council of Governors

The role, powers and composition of the Council of Governors is outlined earlier in this report and is also set out within the Trust's constitution. The Council of Governors meets at least quarterly and held four meetings in 2020/21. Executive and non-executive directors of the Trust Board are invited to attend. Both elected and appointed governors normally hold office for a period of three years and are eligible for re-election or reappointment at the end of that period. The details of the governors holding office as at Mar 2021 are provided within the following table.

Last name	First name	Constituency	Organisation	Date elected or appointed	Term	Attendance at council meetings 2020/21
Anderson	Nowell	Public	Hounslow	Nov 2018	2	4/4
Ballerand	Richard	Public	Kensington and Chelsea	Nov 2020	2	4/4
Bauer	Juliet	Patient	–	Nov 2018	2	4/4
Booth	Jeremy	Patient	–	Nov 2020	1	0/1
Boulliat	Caroline	Public	Wandsworth	Nov 2019	1	4/4
Cass-Horne	Cass J.	Public	City of Westminster	Nov 2019	1	4/4
Church	Tom	Patient	–	Nov 2018	3	4/4
Davies	Nigel	Public	Ealing	Nov 2018	2	4/4
Digby-Bell	Christopher	Patient	–	Nov 2020	3	4/4
Dyer	Simon	Patient/Lead Governor	–	Nov 2018	2	4/4
Grinham	Jodeine	Staff	Contracted	Nov 2017	n/a	1/3
Hodson-Pressinger	Anna	Patient	–	Nov 2018	n/a	3/3
Hutton	Elaine	Public	Wandsworth	Nov 2018	2	4/4
Jackson	Richard	Staff	Support, Admin and Clerical	Nov 2019	1	4/4

Last name	First name	Constituency	Organisation	Date elected or appointed	Term	Attendance at council meetings 2020/21
Kanodia	Kush	Patient	–	Nov 2018	n/a	4/4
Kitchener	Paul	Public	Kensington and Chelsea	Nov 2019	3	4/4
Korjonen	Minna	Patient	–	Nov 2018	1	3/4
Leka	Thewodros	Staff	Allied Health Professionals, Scientific and Technical	Nov 2019	1	3/4
Levy	Anthony	Public	City of Westminster	Nov 2019	1	4/4
Levy	Rose	Public	Hammersmith and Fulham	Nov 2020	1	1/1
Mayerhofer	Johanna	Public	Richmond upon Thames	Jan 2018	1	4/4
Nelson	Mark	Staff	Medical and Dental	Nov 2020	2	3/4
Nunes	Nicole	Staff	Contracted	Nov 2020	1	1/1
O'Farrell	Fiona	Public	Richmond upon Thames	Jan 2018	1	3/4
Phillips	David	Patient	–	Nov 2018	2	4/4
Quigley	Cllr Patricia	Local Authority	Hammersmith and Fulham	July 2018	1	4/4
Sands	Catherine	Staff	Management	Nov 2019	1	1/1
Scott	Jacquei	Staff	Nursing and Midwifery	Nov 2018	1	2/4
Walsh	Dr Desmond	University	Imperial College	Oct 2018	1	4/4
Wareing	Laura	Public	Hounslow	Nov 2018	2	3/4
Yardley	Trusha	Public	Hammersmith and Fulham	Nov 2019	1	4/4

Council of Governors elections held during 2020/21

An election was held in Nov 2020 to fill vacant seats in the public and staff constituencies. The results were as follows:

- Patient: Jeremy Booth (elected) and Christopher Digby-Bell (re-elected)
- Public—London Borough of Hammersmith and Fulham: Rose Levy (elected unopposed)
- Public—Royal Borough of Kensington and Chelsea: Richard Ballerand (re-elected)
- Staff—Management Class: Catherine Sands (elected)
- Staff—Medical and Dental Class: Mark Nelson (re-elected)
- Staff—Contracted Class: Nicole Nunes (elected unopposed)

Council of Governors' register of interests

Governors are required to sign a code of conduct, declare any relevant interests annually and confirm they meet the fit and proper person condition as set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The register of governors' interests is published annually—a copy can be downloaded from the Trust website at www.chelwest.nhs.uk/cog or requested by emailing chelwest.ft.secretary@nhs.net, calling 020 3315 6716 or writing to:

Board Governance Manager
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH

Contacting the governors

Governors welcome the views and suggestions of members and the wider public. Please see www.chelwest.nhs.uk/cog for governors' details and biographies. If you would like to contact any of the governors, email chelwest.ft.secretary@nhs.net or call 020 3315 6716.

How the Board of Directors and Council of Governors have acted to understand the views of governors and Foundation Trust members

The Trust Board interacts regularly with the Council of Governors to ensure that it understands their views and those of members. Governors can attend the Trust's public Board meetings. Non-executive directors and governors also meet twice a year to discuss a range of topics in an open and informal manner. A rolling programme of non-executive director chairs of Trust Board committees presenting at each Council of Governors meeting takes place to enable governors to hold the non-executive directors to account.

Foundation Trust membership

As a Foundation Trust we are accountable to our local community, patients and staff, who all have the right to become members. Trust members play an active role in helping us to understand the views and needs of the population we serve. Membership is open to anyone over the age of 16. The membership has three constituencies—patient, public and staff—as defined in the Trust constitution and summarised below.

Patient membership

Anyone who has attended any of the Trust's hospitals as either a patient or as the carer of a patient within the last three years.

Public membership

Any member of the public over the age of 16 who lives in the area the Trust serves, divided into six constituencies based on local government boundaries:

- Royal Borough of Kensington and Chelsea
- City of Westminster
- London Borough of Hammersmith and Fulham
- London Borough of Wandsworth
- London Borough of Hounslow
- London Borough of Richmond upon Thames
- London Borough of Ealing

Staff membership

Individuals employed by the Trust under a contract of employment with the Trust, divided into six constituencies:

- Support, administrative and clerical staff
- Allied health professionals, scientific and technical staff
- Contracted staff

- Medical and dental staff
- Nursing and midwifery staff
- Management staff

All staff automatically became members unless they choose to opt out of membership.

Membership engagement and strategy

The Trust's membership strategy focuses on recruitment, communication and engagement with members. In 2020/21, the Trust continued focusing on developing the communication and engagement with members and the public albeit virtually due to the COVID-19 pandemic.

This has included the annual members' meeting, *Your Health* seminars, and regular 'meet a governor' sessions. Governors participated in all public and member engagement events organised by the Trust throughout the year.

We engage and keep our members updated by distributing a monthly e-newsletter with links to e-newsletters on the Trust's website. This is currently sent out via the membership database to our public and patient members who have provided us with their email addresses.

Our overall membership for 2020/21 is 18,502. Demographic information provided by members shows our membership is broadly representative of the population we serve. The following table shows our membership profile as at 31 Mar 2021.

	Public	Patient	Staff	Total
Age	**7,086**	**5,585**	**5,831**	**18,502**
0–16	4	0	0	4
17–21	80	6	3	89
22+	6,336	3,801	5,827	15,964
Not stated	666	1,778	1	2,445
Age 22+	**6,336**	**3,801**	**5,827**	**15,964**
22–29	380	63	799	1,242
30–39	658	372	1,804	2,834
40–49	1,077	831	1,470	3,378
50–59	1,305	942	1,156	3,403
60–74	1,521	949	583	3,053
75+	1,395	644	15	2,054
Gender	**7,086**	**5,585**	**5,831**	**18,502**
Unspecified	127	52	0	179
Male	2,520	2,078	1,405	6,003
Female	4,438	3,454	4,426	12,318
Transgender	0	0	0	0
Ethnicity	**7,071**	**5,556**	**5,818**	**18,445**
White—English, Welsh, Scottish, Northern Irish, British	3,422	2,142	1,982	7,546
White—Irish	189	116	197	502
White—Gypsy or Irish Traveller	0	0	0	0
White—Other	911	527	666	2,104
Mixed—White and Black Caribbean	99	56	44	199
Mixed—White and Black African	24	11	39	74
Mixed—White and Asian	56	25	45	126
Mixed—other mixed	91	69	86	246
Asian or Asian British—Indian	328	129	470	927
Asian or Asian British—Pakistani	127	53	90	270
Asian or Asian British—Bangladeshi	49	38	38	125
Asian or Asian British—Chinese	42	35	70	147
Asian or Asian British—other Asian	220	139	548	907
Black or Black British—African	310	225	513	1,048
Black or Black British—Caribbean	122	83	235	440
Black or Black British—other Black	69	38	72	179
Other ethnic group—Arab	11	1	0	12
Other ethnic group—any other ethnic group	78	53	255	386
Not stated	923	1,816	468	3,207
Total membership	**7,086**	**5,585**	**5,831**	**18,502**

Directors' responsibilities for preparing the accounts

The directors have undertaken their responsibility for preparing the accounts under directions issued by NHS Improvement, the independent regulator of Foundation Trusts under the National Health Service Act 2006, and as detailed in the *Statement of Accounting Officer's Responsibilities* from page 83.

The Trust has ensured that the annual accounts of the organisation have met the accounting requirements of the NHS Improvement *Annual Reporting Manual*, Department of Health *Group Accounting Manual* and HM Treasury *Financial Reporting Manual*. The accounting policies contained in these manuals fall within the remit of the Financial Reporting Advisory Board (FRAB) to the extent that they are meaningful and appropriate to the NHS.

The directors consider 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.

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust's website. Legislation in the UK governing the preparation and dissemination of financial statements differs from legislation in other jurisdictions.

REGULATORY RATINGS

NHS oversight framework

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

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

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

Segmentation

The Trust has been placed into segment 1. This segmentation information is the Trust's position as at 31 Mar 2021.

Current segmentation information for NHS Trusts and foundation trusts is published on the NHS Improvement website www.improvement.nhs.uk.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Chelsea and Westminster Hospital NHS Foundation Trust

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

NHSI, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require Chelsea and Westminster Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, 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 NHSI, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis

- Make judgements and estimates on a reasonable basis state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the Department of Health and Social Care *Group Accounting Manual*) have been followed and disclose and explain any material departures in the financial statements

- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

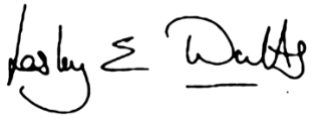
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy

- Prepare the financial statements on a going concern basis

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 him/her to ensure that the accounts comply with requirement 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*.



Lesley Watts
Chief Executive Officer

24 June 2021

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while 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*.

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 Trust's policies, aims and objectives, evaluate the likelihood of those risks being realised and the impact should they be realised. This enables us to manage them efficiently, effectively and economically. The system of internal control has been in place at Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 Mar 2021 and up to the date of approval of the annual report and accounts.

COVID-19 and internal control

As with all healthcare providers in the UK, the coronavirus pandemic fundamentally altered the day-to-day operations of the Trust during the response period. These changes affected both our clinical response and our systems of internal control. Following guidance from NHS England and NHS Improvement the Trust established interim internal control arrangements designed to release capacity for clinical duties, provide clear decision-making processes, steer activity and internal control activities during the pandemic response.

During this period:

- Trust Board committee meetings were held virtually with agendas predominantly focused on pandemic management assurance
- Trust Board committee agendas were refocused to core items only, allowing sufficient time for discussion and shorter meeting packs separated into system and Trust themes, mandatory assurances, decisions, and associated risks
- All non-operationally critical meetings were cancelled
- Use of e-governance was expanded to ensure decision-makers remained informed and accountable for their internal control responsibilities
- Daily gold briefing and decision-making meetings were established to ensure clarity of leadership and information exchange

Internal audit arrangement in place throughout 2020/21 provided assurance in the systems, processes, and controls in place for the management of key activities underpinning the organisation internal control arrangements. COVID-19-specific internal control arrangements have been stood down for financial year 2021/22.

Capacity to handle risk

The Trust is committed to a comprehensive, integrated Trustwide approach to the management of risk based upon the support and leadership offered by the Board of Directors and the committees of the Trust Board.

The Trust's risk management process is designed to provide a systematic method of identifying risks and determining the most effective means to minimise or remove them following risk analysis and evaluation. Practice is supported through the maintenance of an organisation-wide risk register—the register is a management tool that promotes visibility and escalation, and provides a repository from which assurance can be offered that risks are being identified and appropriately managed.

The risk management strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as a mechanism to highlight areas they believe require improvement.

The executive directors have responsibility for the management and coordination of strategic and operational risk within their areas of control. These responsibilities include the maintenance of risk registers, the promotion of risk management activity, the development of strategic and business plans required to address risk, and the escalation of principle risks and associated assurance to Trust Board. Responsibility for the implementation of risk management activity has been delegated to the executive directors as follows:

- The chief nursing officer has responsibility for quality governance, clinical governance, patient safety, staff safety, regulatory compliance and associated risks
- The chief medical officer has responsibility for research and development, service development, clinical effectiveness, public health and associated risks
- The chief financial officer has responsibility for financial governance and associated risks
- The director of human resources and organisational development has responsibility for learning and development, workforce management, staff wellbeing and associated risks
- The deputy chief executive officer has responsibility for site development, business development, digital innovation and associated risks
- The chief information officer is responsible for information management, information technology, information security and associated risks

Executive and non-executive directors receive training as part of a scheduled risk and board assurance development session. All staff receive risk management training on various aspects of risk as part of the Trust's induction programme. This training forms part of the mandatory courses provided by the Trust, which all staff undertake on a regular basis. The organisation's quality and clinical governance directorate also provides one-to-one and group risk management training as required. The risk assurance framework is scrutinised by the following committees of the Trust Board:

- Audit and Risk Committee
- Quality Committee
- People and Organisational Development Committee
- Finance and Investment Committee

The committees and their sub-groups ensure risks and the associated mitigation actions are recognised and good practice is supported across all areas.

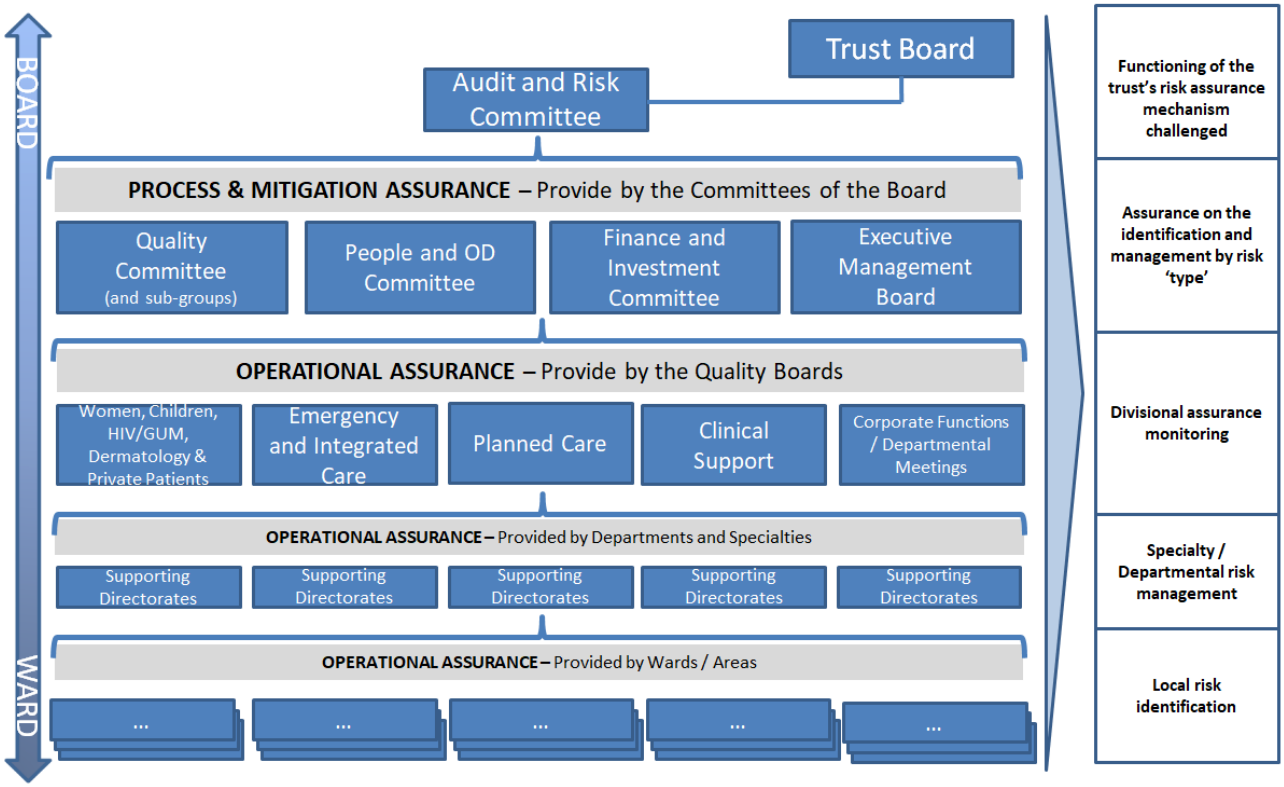
The Trust risk management policy is accessible to all staff via the intranet and aims to provide guidance on the conduct of risk identification, assessment and the escalation, as appropriate, in accordance with each staff member's level of authority and duties.

Risk and control framework

The Trust's risk management process is designed to provide a systematic method of identifying risks and determining the most effective means to minimise or remove. Practice is supported through the maintenance of an organisation-wide risk register.

Operational risk assurance is provided via the divisional boards—these groups ensure the risk register process is embedded and mitigation actions are undertaken within appropriate timescales.

Management and mitigation assurance is provided via the committees of the board and their subgroups. All items recorded within the risk register system are categorised according to the risk 'subject'—each categorisation is aligned to a committee or subgroup responsible for measuring risk assurance and supporting mitigation action where required.



While the Trust Board retains overall responsibility, detailed scrutiny of specific areas of the Trust's work, including relevant risks, is provided by Trust Board subcommittees:

- **Quality Committee:** Assures the Trust Board that quality and safety within the organisation is being delivered to the highest possible standards, and that there are appropriate policies, processes and governance in place to continuously learn and improve care.

- **People and Organisation Development Committee:** Assures the Trust Board on matters related to staff, considering the work areas of people and organisational development strategy and planning, leadership development and talent management, education, skills and capability (clinical and non-clinical, statutory and mandatory), performance, reward and recognition, culture, values and engagement, and health and wellbeing. The committee ensures that there are robust processes in place to identify risks and issues and manage them accordingly.

- **Finance and Investment Committee:** Assures the Trust Board on financial and investment policy, capital, information management and technology, and commercial development issues, ensuring the Trust operates in an economic and efficient manner against agreed income and expenditure positions.

- **Audit and Risk Committee:** Assures the Trust Board that probity and professional judgement is exercised by providing independent and objective review of financial and corporate governance, assurance processes, risk management across the Trust's clinical and non-clinical activities, and fraud and corruption. In addition, the committee scrutinises the output of all audits undertaken by the Trust's internal and external auditors, reporting any risks identified to the Trust Board accordingly, and has an explicit role to assure the Trust Board on the appropriateness and effectiveness of the Trust's risk assurance framework.

- **Nominations and Remuneration Committee:** Oversees all aspects of the appointment process for executive directors and very senior managers, including the approval of arrangements for the termination of directorships, determining the remuneration, allowances, pensions, gratuities and other major contractual terms, and evaluating the performance of individual executive directors.

The Trust control framework ensures the transmission of risk information from ward to board—this process is supported by:

- **Risk appetite statement:** Describes the amount of risk the Trust Board is prepared to take in the pursuit of its objectives. The Trust's risk appetite varies between objectives and risk type and is reviewed by the Trust Board (via its committees) at least annually to ensure it reflects changes in strategy, appetite, and tolerance to risk.

- **Risk management strategy:** Describes the systems of internal controls in place to oversee, monitor and manage risk within the Trust.

- **Risk registers:** Documents risks at each level of the Trust, alongside actions to control, mitigate or resolve each risk.

- **Board assurance framework (BAF):** Records the principal risks that could substantially impact on the achievement of the Trust's strategic objectives.

The risk management framework informs objective setting, business planning, service delivery, and the routine functioning of the organisation and ensures risk management is an integral part of routine management.

The Trust will be reviewing any gaps in controls in the process of declaration of interests to rectify any disclosure process issues as part of risk management and internal control systems.

The overall head of internal audit opinion for the period 1 Apr 2020 to 31 Mar 2021 is that 'significant assurance with minor improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

Identification of risk

There are four principal methods of risk identification used by the Trust:

- Known ongoing inherent risks of which the Trust is aware, which are controlled and managed
- Foreseeable local risks which are inherent and identified proactively by competent persons
- Strategic risks identified by the Trust Board (including the risks associated with complying to the Trust's foundation trust licence)
- Retrospectively realised risks from risk sources

As per the fourth method of risk identification detailed above, risks can be identified from several sources, including but not restricted to:

- Recommendations from incident investigations and themes/trends arising from cumulative analysis of incident data
- Risks arising as a result of an external review or inspections
- Recommendations from internal audit reports or other internal or external monitoring reviews, audits, assessments or reports
- Clinical risk assessments
- Non-clinical risk assessments (security, health and safety, health and wellbeing etc)
- Patient surveys
- Staff surveys
- PALS and complaints key themes
- Risk shared by other NHS organisations and/or other stakeholders/duty holders or authorities

In some cases, through the processes described above, the Trust Board may identify complex risks that affect or involve external organisations, such as local stakeholders within the local healthcare community (local authorities, CCGs). Where this is the case, the Trust adopts a collaborative approach to its risk mitigation plans, ensuring a transparent and 'joined-up' approach to managing risk, recognising that in some cases the Trust will be limited in the degree of risk mitigation it can achieve as an individual organisation.

Risk assessment

The purpose of undertaking risk assessments is to effectively manage and control significant risks which are/have been identified/inherited or which are foreseeable in nature, as required by health and safety legislation. Risks are evaluated to determine the level of exposure and provide input to decisions on where responses to reduce, accept or avoid risks are necessary/acceptable or likely to be worthwhile.

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:

Likelihood	Consequence				
	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1 (Low)	2 (Low)	3 (Low)	4 (Medium)	5 (Medium)
2 Unlikely	2 (Low)	4 (Medium)	6 (Medium)	8 (High)	10 (High)
3 Possible	3 (Low)	6 (Medium)	9 (High)	12 (High)	15 (Extreme)
4 Likely	4 (Medium)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
5 Almost certain	5 (Medium)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)

In addition, the risk register process involves a set of risk metrics pertaining to risk impact and likelihood which helps to improve the robustness of the calculation of risk assessments taking place within the Trust:

Impact level	Descriptor	Risk type			
		Injury	Service delivery	Financial	Reputation/publicity
1	Insignificant	No injuries or injury requiring no treatment or intervention	Service disruption that does not affect patient care	Less than £10,000	Rumours
2	Minor	Minor injury or illness requiring minor intervention <7 days off work if staff	Short disruption to services affecting patient care or intermittent breach of key target	Loss of between £10,000 and £100,000	Local media coverage
3	Moderate	Moderate injury requiring professional intervention RIDDOR reportable incident	Sustained period of disruption to services/ sustained breach of key target	Loss of between £100,001 and £500,000	Local media coverage with reduction in public confidence
4	Major	Major injury leading to long-term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant under-performance of a range of key targets	Loss of between £500,001 and £5m	National media coverage and increased level of political/public scrutiny, total loss of public confidence
5	Catastrophic	Incident leading to death Serious incident involving a large number of patients	Permanent closure/ loss of a service	Loss of >£5m	Long term or repeated adverse national publicity Removal of chair/ CEO or executive team

Likelihood Level	Descriptor	Range
5	Almost certain	>50%
4	Likely	10–50%
3	Possible	1–10%
2	Unlikely	0.1–1%
1	Rare	<0.1%

Alongside the general risk assessment process that the Trust employs, there are also patient- and staff-specific risk assessment forms used at ward/department level in relation to specific risks, for example:

- Falls
- Pressure ulcers
- Moving and handling
- Venous thromboembolism
- Nutrition
- Workstation assessment

The risk register record is structured in a way that requires the recording of a ‘current risk rating’ and a ‘target risk rating’. This allows the Trust to track changes in risk, from risk recognition through to an assessment of risk post-mitigating actions. In each case, the Trust’s risk ‘appetite’ is determined by the target risk rating—ie once the mitigating actions have been implemented successfully and the risk has reduced to the target, the Trust accepts this residual level of risk. However, each time a risk is reviewed and updated, the determination of the Trust’s risk appetite is also reviewed, particularly after new mitigating actions have been identified.

Principal risks

The board assurance framework (BAF) records the principal risks that could substantially impact compliance with NHS Foundation Trust licence and achievement of the Trust’s strategic objectives. It provides a framework for reporting key information to the Trust Board by identifying primary controls in place to manage strategic objectives, assurance about effectiveness of controls, and any gaps in the controls or assurances.

The executive management team prepares and approves the BAF as a means of communicating principal risk. The committees of the Trust Board receive the BAF at least twice a year to support understanding of principal risks, controls, assurance evidence and assess outcomes of management activity.

Compliance with the NHS provider licence is routinely monitored through the NHS oversight framework but, on an annual basis, the licence requires the Trust to self-certify as to whether the organisation has effective systems, governance arrangement, and the resources required to ensure compliance. The 2020/21 self-certification processes concluded that the organisation had taken the necessary precautions as were necessary to comply with the conditions of the licence, any requirements imposed on it under the NHS acts and have had regard to the NHS constitution. Principle risks were considered as part of this review and informed by the BAF—no principle risks to compliance were identified.

As of Mar 2021, the following principal risks that could act as barriers to the organisations strategic objectives were reported to the Audit and Risk Committee:

The North West London Health and Care Partnership System recovery plan

The Trust is responsible for supporting the improvement of care and patient experience across North West London through the development of a sustainable portfolio of outstanding acute and specialised services. Though the Trust has robust development and improvement plans in place that are aligned to meet this ambition, the delivery could be impacted in part by a lack of a standardised approach to change and governance with external stakeholders. The Trust is working closely with the NWL Integrated Care System and other stakeholders to develop and deliver the operating plan for 2021/22. This risk is monitored by the Trust Board and the Finance and Investment Committee.

Achievement of quality, performance and regulatory standards

The provision of safe, high-quality and patient-centred care is of paramount importance to the Trust. The Trust was subject to a Care Quality Commission (CQC) inspection in Nov 2019 and received a ‘Good’ rating for West Middlesex University Hospital and an ‘Outstanding’ rating for Chelsea and Westminster Hospital. The Trust received no ‘must do’ recommendations and the inspection report highlighted 31 examples of ‘Outstanding’ practice. The Trust has an embedded quality monitoring and improvement process designed to support continuous development and regularly undertakes self-assessment against the CQC well-led framework in-year.

Becoming the employer of choice

The organisation is committed to provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers—and to recruit and retain the people needed to deliver high-quality services to our patients. During 2020/21, the Trust has continued to develop its culture and values to support its ambition to become the ‘employer of choice’ within the local NHS economy. During 2021/22 the Trust will continue to deliver its equality, diversity and inclusion action plan and further develop its recovery, retention and recruitment workstreams to ensure that any barriers to the achievement of this strategic objective are addressed. This risk is monitored by the People and Organisational Development Committee.

Financial sustainability

The Trust has a robust financial strategy—risk and barriers to the delivery of this strategy are reported quarterly to the Finance and Investment Committee. If there was a failure to maintain the organisations financial sustainability, this would reduce the Trust’s capacity to respond to growth in activity, continue to invest in the workforce and infrastructure, and make investment and other decisions within the relevant regulatory frameworks, policies and guidance. Detailed planning and budget control mechanisms have been established within the 2021/22 financial plan to ensure controls to this risk are in place and effective. This risk is monitored by the Finance and Investment Committee.

Embedding innovation and improvement

The Trust has an ambitious quality improvement plan designed to deliver an 'Outstanding' CQC rating. The improvement process is well-embedded, based around the Trust PROUD values and the improvement framework. The organisations dedicated quality improvement team works to support colleagues to develop ideas, grow their skills and deliver changes to improve patient care. During 2020/21 the Trust has supported collaborative working across the research, digital and innovation and improvement departments to facilitate ensure new ideas are well supported and benefit from the collective skills across these three teams. During 2021/22 the Trust will continue to focus on the alignment of support across research, innovation and improvement and will be increasing patient and public engagement directly in the improvement programme.

Estate development

During 2020/21, the Trust continued to deliver the estates strategy designed to ensure high-quality, effective and efficient care can be delivered across all sites—the strategy is overseen and supported by the Finance and Investment Committee and the Trust Board. During this financial year the Trust and our patients have benefited from the successful development of new, state-of-the-art ICU and NICU facilities at Chelsea and Westminster Hospital. Ambitious development plans have also been commenced at West Middlesex University Hospital to ensure that our patients receive long-term benefit from sustainable estates development. Risks associated with the estates development strategy are monitored by the executive management Board.

Implement our digital strategy

The Trust is committed to the provision of innovative technology to support improvement in patient care, patient experience and the running of our hospitals. During 2020/21 the Trust has continued to embed and extent its use of the new electronic patient record (EPR) system and has introduced new approaches designed to enable patients to take control of their own healthcare, such as booking appointments, accessing their electronic health record, and remotely monitoring and reporting their symptoms. Risks associated with the digital innovation strategy are overseen by the Digital Transformation Board and the Finance and Investment Committee.

Responding to the COVID-19 pandemic

As with all healthcare providers in the UK, the coronavirus pandemic has fundamentally altered the day-to-day operations of the Trust during the response period. We are prioritising emergency and urgent care on our main site, and we are working within nationally approved clinical guidelines to ensure patients requiring priority cancer treatments or time-sensitive urgent treatments receive these through designated hubs on sites that are not directly treating patients with COVID-19 or have defined separate pathways for this care.

The limited scope of activity during the response period will severely prolong waiting times for patients already referred on routine pathways. Once the restrictions on routine services are lifted, newly referred cases could also experience delays for treatments due to lack of sufficient capacity to treat this enhanced level of demand within usual timescales. There is also risk to clinical outcomes as we may not quickly identify routine cases which should be

upgraded to urgent pathways, as well as to patients who defer their attendances and then must be rebooked. This major disruption to service provision will have consequential financial impact as well through 2020/21. We are carrying out a strategic and operational review of the situation daily.

EU exit

Throughout 2020/21 the Trust continued to review and mitigate the impact of the EU exit. The Trust established an operational group to manage risks and ensure the hospital continues operating in a safe, efficient and effective manner. This includes consideration of the potential impact of all possible risks, including staffing and the supply of drugs and consumables. The operational group has continued to meet on a regular basis, chaired by a divisional director, and reports to an executive director. This group provides regular updates to the executive management Board. These risks continue to be monitored and mitigated wherever possible. The Trust has also continued to support and advise all staff who are EU nationals in relation to applying for settled/pre-settled status.

Data security and protection toolkit (DSPT) attainment levels

Information governance is the way organisations process or handle information. It covers information relating to patients and staff, as well as corporate information, and helps ensure the information is handled appropriately and securely with particular emphasis on managing personal data within the data protection legislation.

The DSPT is an online self-assessment tool that enables NHS organisations and their partnering bodies to measure how well they are complying with Department of Health standards on the correct and secure handling of data, and how well they are protecting data from unauthorised access, loss, and damage. It aims to demonstrate how we are implementing the 10 data security standards recommended by the late Dame Fiona Caldicott, the national data guardian for health and adult social care. Approximately 70% of the DSPT is related to IT-related cyber security.

The attainment level assessed within the DSPT provides an overall measure of the quality of data systems, standards and processes. The DSPT sets out specific criteria that enable performance to be assessed based on submitted evidence and assertions, resulting in four possible outcomes—standards exceeded, standards met, standards not fully met (plan agreed), and standards not met. For more information about the DSPT please visit www.dsptoolkit.nhs.uk.

Assessment outcome: For 2019/20 the Trust achieved ‘standards met’ and we believe we will again achieve this standard for 2020/21.

We have already achieved IG training compliance of 96% within the time period and have therefore complied, although there has been a reduction during the COVID-19 pandemic.

IG incidents reported to the DSPT

Information governance incidents of a certain severity need to be reported to the UK data protection regulator, the Information Commissioner’s Office (ICO), within 72 hours of discovery. The mechanism for doing this is normally through the incident reporting section of the DSPT, where you also report other serious incidents below the level of ICO involvement.

There were four incidents reported on the DSPT from Apr 2020, two of which were reported to the ICO. This compares to seven and four in 2019/20. The ICO decided that no further action was needed for the first incident and have asked for further evidence for the later incident.

Freedom of information (FOI)

For the 2020 calendar year there were 604 FOI requests received with a compliance rate of 90% against the acceptable level of 90%. For financial year 2020/21 we received 470 FOIs to 31 Jan 2021 (10 months) with a compliance rate of 91%.

During the pandemic we wrote to FOI requesters explaining the current situation with regards to COVID-19 and impact to out teams and staffing. We asked if they were willing to withdraw their request, withdrawing automatically if there was no response within a week—these requests were included in the figures.

General data protection regulation (GDPR)

GDPR came into force on 25 May 2018 along with the UK interpretation of this legislation, the Data Protection Act 2018. As required by law we have appointed a data protection officer and are compliant with the core aspects, led in part by work on the DSPT and various other streams.

The Trust is currently implementing data protection compliance software which will centralise the main tasks required for compliance and enable consistent reporting.

Quality governance and performance

Ensuring safe staffing

Safe staffing metrics have been reported throughout the pandemic, however decisions supported by the regional and national teams and professional bodies were implemented. These included changing the ICU and ward nurse and medical ratios to provide effective care but expand the ICU capacity to manage the demand. More than 50% of the nursing workforce was redeployed to critical care or acute medicine areas, and all staff were provided with skills training before deployment into the areas.

Data assurance

The Trust assures the quality and accuracy of elective waiting times data through a combination of regular daily and weekly meetings, and review and sign-off procedures for performance data. The review and sign-off process includes review at the elective access group, Trust Executive team meetings, Quality Committee and Trust Board.

We have an advanced feed from the patient administration system (PAS) which is available throughout the Trust and updated daily. Divisional staff and the information team regularly review a suite of reports including more advanced information for elective waiting times and patient-level information. The Trust will establish a minimum frequency requirement for completing refresher training on data entry into the PAS.

A manual data validation process is undertaken by the information team to review the information entered into the PAS and to investigate the data that underlies reported performance. Identified data issues are logged by the performance team, then investigated and corrected. Recurring issues are subject to root cause analyses, from which corrective action plans are developed to support the relevant services to improve the quality of inputted and reported data.

We have invested significantly in data quality improvement via the electronic patient record (EPR) system. The Trust has had several external bodies auditing our data quality performance which has outlined that we are in line with our peers. A Trustwide data quality group is in place, chaired by the director of performance. This group provides oversight of data quality policies, strategies and reviews. The data quality group reports into the executive management Board to enable prompt escalation of emerging issues to the Trust Board when required.

All Trust sites use the Datix database system for reporting incidents, which provides a unified approach to aid the review of the information governance (IG) incident management process. IG incidents are summarised and reported to the information governance steering group. The IG team assists IG incident investigations as required and advises on lessons learned from these incidents at departmental meetings and/or via Trustwide communication tools.

Corporate governance

Details of the corporate governance structure can be found within the *Accountability Report* from page 37. It is a fundamental part of our Trust's governance structure that all material risks and issues are scrutinised and monitored by the executive management Board, in addition to being reported to Trust Board committees. This includes the key areas of quality, workforce, performance and finance, giving further assurance that the Trust is fully compliant with the CQC registration requirements.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure compliance with all employer obligations contained within the scheme regulations. 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. There are control measures in place to ensure that the organisation complies with obligations under equality, diversity and human rights legislation. The Trust has implemented several equity and diversity programmes to support openness, honesty and transparency. The policy and procedure is maintained by the human resources team and compliance is monitored by the People and Organisational Development Committee.

Conflicts of interest

The Trust has an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the managing conflicts of interest in the NHS guidance. This can be viewed at www.chelwest.nhs.uk/corporate-publications. The Trust is currently reviewing the process of declaration of interests as part of risk management and internal control systems.

Climate change

The Trust recognises and understands the pressing and immediate need to reduce carbon emissions and to address sustainability issues as part of the climate emergency. With the backing of society, patients and staff, the Trust recognises and supports efforts to move to a sustainable health system. The Trust will continue to develop an ongoing strategy to achieve the national challenges outlined in the NHS green plan and commit to net zero by 2040.

The Trust will adopt the wider commitments to achieve the scope 1 direct emissions and scope 2 indirect emissions control, with an ambition to reach an 80% reduction by 2028 to 2032 of our 2019 baseline and net zero by 2040.

The Trust will further adopt the scope 3 indirect supply chain emission target with an ambition to reach an 80% reduction by 2036 to 2039 and net zero by 2045.

Our green plan (formerly carbon reduction strategy) is in response for NHS healthcare services to act on climate change. This strategy is in support of the mandate by the NHS as a whole to implement our strategy across every aspect of the Trust's activity to clearly identify our impacts, in line with the greenhouse gas protocol (GHGP) direct scope 1 and indirect scope 2, and develop and engage with suppliers and the wider community to measure indirect aspects of our scope 3 carbon impacts.

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

The Trust Board keeps a monthly review of the Trust's use of resources through the integrated performance report in addition to the monthly finance report, which allows the Trust Board to maintain a 'grip' on financial performance, cost-effectiveness and allows the triangulation of quality, performance, workforce and financial data.

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

The oversight roles of the Trust Board and Finance and Investment Committee 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 executive management Board provides opportunities through the divisional boards for divisional and operational performance to be reviewed, and monthly reviews with the chief financial officer and divisional triumvirate teams allow for regular oversight of the performance within the respective clinical services they provide. The cost improvement programme is monitored through the improvement board and this is further supplemented by specialty deep dives, which is in addition to the internal audit work undertaken throughout 2020/21.

The detail of the key actions of the internal audit programme can be found in the *Review of effectiveness* section on page 100.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Following an update from NHS Improvement it was confirmed that foundation trusts are not required to submit quality reports for 2020/21 and that auditor-led assurance work on the quality reports could cease. There would also be no formal requirement for a limited assurance opinion or governors' report.

To provide scrutiny to the core subjects covered within the quality report an abridged version of the document will be submitted to the committees of the Trust Board and published on the Trust website.

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 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 actions taken to address any identified risks and improve the quality of healthcare that is provided.

The role of the Trust Board, Audit and Risk Committee, Quality Committee, Finance and Investment Committee and People and Organisational Development Committee in maintaining and reviewing the Trust's systems of internal control is described above.

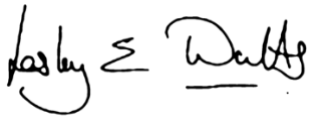
The internal audit programme provides a further mechanism for doing this. KPMG, the Trust's internal auditors, identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker, and reviewed frequently by the executive team.

In 2020/21 there were six high-risk recommendations identified by our internal auditors.

The overall head of internal audit opinion for the period 1 Apr 2020–31 Mar 2021 is that 'significant assurance with minor improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

Conclusion

In conclusion, to the best of my knowledge, no significant internal control issues have been identified within 2020/21.



Lesley Watts
Chief Executive Officer

24 June 2021

SECTION 3

AUDITOR'S REPORT

Independent auditor’s report to the Council of Governors and Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust (the ‘foundation trust’):

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

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 37.

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the table of pay multiples and related narrative notes; and
- the table of exit packages and related narrative notes.

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

Basis for opinion

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

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

Conclusions relating to going concern

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.

- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

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

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

- accruals and deferred income recorded at 31 March 2021 and the timing of their recognition at year-end is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2021; we tested a sample of deferred income items to supporting documentation and evaluated management's assessment as to whether the criteria for revenue recognition had been met as to 31 March 2021 and the value to be deferred.

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

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

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

- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;

- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;

- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and

- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

Report on other legal and regulatory requirements

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

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

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

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

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

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

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

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

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

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

Annual Governance Statement and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or

- proper practices have not been observed in the compilation of the financial statements.

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of, the audit; or

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

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the *Matters on which we are required to report by exception—Use of resources* section of our report).

We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

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

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

24 June 2021

Audit certificate issued subsequent to opinion on financial statements

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 24 June 2021 we reported that, in our opinion, the financial statements:

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

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

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

As at the date of issue of our audit report for the year ended 31 March 2021 on 24 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

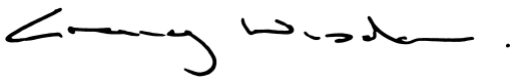
Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 24 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

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

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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



Craig Wisdom (Key Audit Partner)

For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom

8 July 2021

SECTION 4

FINANCE

ANNUAL ACCOUNTS 2020/21

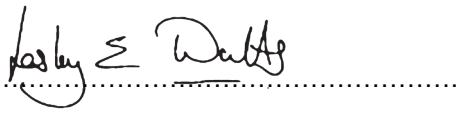
Chelsea and Westminster Hospital NHS Foundation Trust

Annual accounts for the year ended 31 Mar 2021

Foreword to the accounts

Chelsea and Westminster Hospital NHS Foundation Trust

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

Signed 

Name **Lesley Watts**
Job title **Chief Executive**
Date **24-Jun-21**

Statement of Comprehensive Income

For the year ended 31 March 2021

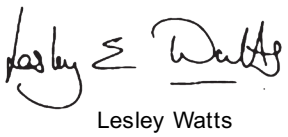
	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2	631,632	603,795
Other operating income	3	120,902	106,115
Operating expenses	5, 7	(755,818)	(665,596)
Operating surplus/(deficit) from continuing operations		**(3,284)**	**44,314**
Finance income	10	-	927
Finance expenses	11	(5,759)	(5,712)
PDC dividends payable		(9,674)	(10,456)
Net finance costs		**(15,433)**	**(15,241)**
Other gains / (losses)	12	8	(444)
Profit on assets and liabilities transferred in respect of the discontinued operations of the investment in Joint Ventures	12	(1,480)	-
Share of profit / (losses) of associates / joint arrangements	17	357	909
Surplus / (deficit) for the year from continuing operations		**(19,832)**	**29,538**
Surplus / (deficit) for the year		**(19,832)**	**29,538**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(643)	13,309
Fair value gains / (losses) on equity instruments designated at fair value through OCI	18	4,416	(3,242)
Total comprehensive income / (expense) for the period		**(16,059)**	**39,605**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(19,832)	29,538
Remove net impairments not scoring to the Departmental expenditure limit		24,702	(11,352)
Remove I&E impact of capital grants and donations		(2,482)	(6,868)
Remove 2018/19 post audit PSF reallocation (2019/20 only)			(910)
Remove net impact of inventories received from DHSC group bodies for COVID response		(798)	
Adjusted financial performance surplus		**1,590**	**10,408**

Statement of Financial Position

As at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	13	39,332	42,663
Property, plant and equipment	14	454,198	451,257
Investments in associates and joint ventures	17	-	2,185
Other investments / financial assets	18	5,774	1,357
Receivables	20	1,933	1,673
Total non-current assets		**501,237**	**499,135**
Current assets			
Inventories	19	12,960	7,784
Receivables	20	45,244	60,496
Cash and cash equivalents	21	141,646	117,161
Total current assets		**199,850**	**185,441**
Current liabilities			
Trade and other payables	22	(103,162)	(87,740)
Borrowings	24	(6,610)	(6,744)
Provisions	27	(7,104)	(7,265)
Other liabilities	23	(22,322)	(14,229)
Total current liabilities		**(139,198)**	**(115,978)**
Total assets less current liabilities		**561,889**	**568,598**
Non-current liabilities			
Borrowings	24	(80,390)	(86,696)
Provisions	27	(5,698)	(4,919)
Total non-current liabilities		**(86,088)**	**(91,615)**
Total assets employed		**475,801**	**476,983**
Financed by			
Public dividend capital		277,017	262,141
Revaluation reserve		118,962	119,637
Financial assets reserve		1,252	(3,165)
Income and expenditure reserve		78,570	98,370
Total taxpayers' equity		**475,801**	**476,983**

The notes on pages 9 to 63 form part of these accounts.



Name Lesley Watts
Position Chief Executive
Date 24 June 2021

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**262,141**	**119,637**	**(3,165)**	**98,370**	**476,983**
Surplus/(deficit) for the year	-	-	-	(19,832)	**(19,832)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(32)	-	32	**-**
Impairments	-	(643)	-	-	**(643)**
Fair value gains on equity instruments designated at fair value through OCI	-	-	4,416	-	**4,416**
Public dividend capital received	14,876	-	-	-	**14,876**
Taxpayers' and others' equity at 31 March 2021	**277,017**	**118,962**	**1,252**	**78,570**	**475,801**

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**259,845**	**106,342**	**77**	**68,818**	**435,082**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2019 - restated	**259,845**	**106,342**	**77**	**68,818**	**435,082**
Surplus/(deficit) for the year	-	-	-	29,538	**29,538**
Impairments	-	13,309	-	-	**13,309**
Transfer to retained earnings on disposal of assets	-	(14)	-	14	**-**
Fair value losses on equity instruments designated at fair value through OCI	-	-	(3,242)	-	**(3,242)**
Public dividend capital received	2,296	-	-	-	**2,296**
Taxpayers' and others' equity at 31 March 2020	**262,141**	**119,637**	**(3,165)**	**98,370**	**476,983**

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.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

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

Statement of Cash Flows

For the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,284)	44,314
Non-cash income and expense:			
Depreciation and amortisation	5.1	21,309	18,059
Net impairments	6	24,702	(11,352)
Income recognised in respect of capital donations	3	(3,281)	(7,250)
(Increase) / decrease in receivables and other assets		14,742	34,156
(Increase) / decrease in inventories		(5,176)	(1,121)
Increase / (decrease) in payables and other liabilities		21,234	(5,799)
Increase / (decrease) in provisions		618	(1,262)
Other movements in operating cash flows		-	223
Net cash flows from operating activities		**70,864**	**69,968**
Cash flows used in investing activities			
Interest received		35	952
Proceeds from sales of investments		1,061	-
Purchase of intangible assets		(3,254)	(11,781)
Purchase of PPE and investment property		(38,672)	(28,368)
Sales of PPE and investment property		36	22
Receipt of cash donations to purchase assets		1,197	7,250
Net cash flows used in investing activities		**(39,597)**	**(31,925)**
Cash flows used in financing activities			
Public dividend capital received		14,876	2,296
Movement on loans from DHSC		(3,673)	(3,673)
Movement on other loans		(1,278)	(1,247)
Capital element of finance lease rental payments		(28)	(180)
Capital element of PFI, LIFT and other service concession payments		(1,252)	(1,132)
Interest on loans		(1,150)	(1,240)
Other interest		(77)	(1)
Interest paid on finance lease liabilities		(17)	(27)
Interest paid on PFI, LIFT and other service concession obligations		(4,724)	(4,460)
PDC dividend paid		(9,459)	(11,478)
Net cash flows(used in financing activities		**(6,782)**	**(21,142)**
Increase in cash and cash equivalents		**24,485**	**16,901**
Cash and cash equivalents at 1 April - brought forward		**117,161**	**100,260**
Cash and cash equivalents at 31 March	21	**141,646**	**117,161**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

The Trust has a draft plan for the first half of 2021/22 to generate a breakeven position. The Trust will receive block NHS funding in the first 6 months of 2021/22 as part of the revised NHS funding arrangements over the COVID pandemic. As at the 31 March 2021 the Trust holds £142m of cash reserves and has a forecast cash balance of £102m at 31 March 2022.

The directors are confident that there is a reasonable expectation that the Trust will continue to have adequate cash resources to service its operational activities in cash terms for the next 12 months and into 2022/23. The impact of COVID and associated changes to the cash regime for the first half of 2021/22 (with block and top up arrangements) have been taken into account for the Trust's plans and projections, including cash flows, liquidity and income base.

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

Note 1.3 Interests in other entities

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

Note 1.4 Revenue from contracts with customers

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

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

For the whole of 2020/21 payments for contract income was made 1 month in advance to aid Trusts cash flow issues, these had no material impact on contract balances.

Revenue from NHS contracts

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

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

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

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

For 2020/21 and 2019/20

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

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

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the 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 1.6 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS 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 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, structure, fit-out, and mechanical & electrical services, a weighted life of these components are used and depreciated over the asset's useful life.

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

- Land and non-specialised buildings – market value for existing use
- Specialised land & buildings – depreciated replacement cost on a modern equivalent asset basis.
- Non property assets – depreciated historic cost
- Residential accommodation – existing use value for social housing

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

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

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

Depreciation

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

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

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

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

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

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

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

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.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

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

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16 - Property, Plant & Equipment.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17 - Leases.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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
Buildings, excluding dwellings	4	60
Dwellings	40	50
Plant & machinery	5	15
Transport equipment	5	5
Information technology	3	10
Furniture & fittings	5	10

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

Note 1.9 Intangible assets

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

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

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

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation has been charged using the straight line method.

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

	Min life Years	Max life Years
Information technology	2	10
Software licences	3	10

Note 1.10 Inventories

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

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

Note 1.11 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure with the exception of Sensyne Health PLC Shares.

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

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income: Sensyne Health PLC Shares.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

Credit losses is recognised in line with IFRS 15. Injury costs recovery (ICR) credit losses are recognised as advised by the Compensation Recovery Unit (CRU) at 22.43% for 2020-21. The credit losses for receivables is recognised in line with IFRS 9 of the simplified approach, using probabilities of default applicable to the whole term of the financial assets. In some cases a specific credit losses applied consider the relevant credit quality of relevant financial assets.

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

Finance leases

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

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	(0.02%)
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 28.2 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 in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, 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 Third party assets

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

Note 1.19 Losses and special payments

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

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

Note 1.20 Gifts

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

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

Note 1.23 Critical judgements in applying accounting policies

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

Property Valuations

Gerald Eve LLP were instructed to carry out an interim update valuation of all land and buildings at the Chelsea and West Middlesex sites as at 31 December 2020. The valuation was prepared under the requirements of the DHSC Group Accounting Manual and the RICS Valuation – Global Standard 2020 and the national standards and guidance set out in the UK national supplement (November 2018), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). Specialised assets such as hospitals for which no market exists are valued at Depreciated Replacement Cost (DRC) valuation method to arrive at the Modern Equivalent Asset. Other assets are valued at Existing Use Value (EUV) in Current Use.

A majority of the buildings owned by the Trust are specialised assets which have been valued on a Modern Equivalent Asset basis. This requires assumptions to be made about the design of a modern asset with equivalent service potential to the existing asset:

- reviewing the Useful Economic Life of the asset and the residual value at the end of that life;
- revising the areas excluded from the valuation of the Chelsea site (as used by Imperial College rather than the Trust) to reflect current usage, and reassessing the overall layout of an equivalent modern asset
- excluding recoverable VAT when revaluing PFI buildings on the West Middlesex site reflecting the cost at which the service potential would be replaced by the PFI operator; and
- adopting an “alternative site” basis of valuation for the Chelsea site, and at West Middlesex reducing the area of the site required for the modern equivalent asset on the basis that it would be more efficiently arranged as part of a single holistic design.

Non-specialised assets and land such as the Trust’s residential staff accommodation have been valued on an Existing Use Value basis with assessed in line with the Group Accounting Manual.

Note 1.24 Sources of estimation uncertainty

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

Disputes with Commissioners

As set out in note 26.1, Management considers the extent to which contractual revenue can be collected. Where the Trust considers there is a risk of non-payment of monies owed Management has made an assessment of the potential recoverability and where it believes there is a risk of dispute it records a provision for contractual dispute. Provisions for the disputes are £0.4m at 31 March 2021 (31 March 2020 £0.9m). Disputes relate to challenges on activity recording and charging that it has not been possible to settle by reference to the contract, under which the Trust has been entitled to the income. The Trust has recognised the income in relation to the disputes in its Statement of Comprehensive Income. The Trust has determined the level of provision on a basis that reflects settlement of the issue for the financial year in which the issue was raised and any subsequent years. Given the Trust has a contract in place the Trust is legally owed the money the Trust has chosen to provide a contractual dispute provision.

Recoverability of NHS and Local Authority Debt

The Trust has £5.0m of debt with NHS bodies at 31 March 2021 (2020 £17.0m) and £8.0m of debt with Local Authorities (2020 £5.4m). Management has considered the recoverability of this debt as at 31 March 2021 and has established a level of bad debt provision which is felt adequate to cover the risk of non-recovery.

The Trust has signed contracts with Local Authorities within London which it accounts for under IFRS 15. For contracts with Local Authorities outside of London the Trust also recognises income in accordance with IFRS 15 as it has an implied contact albeit not a signed explicit one.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 2.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	556,402	398,364
High cost drugs income from commissioners (excluding pass-through costs)	19,675	59,110
Other NHS clinical income	-	76,216
Community services		
Block contract / system envelope income*	2,210	2,495
All services		
Private patient income	10,588	18,883
Additional pension contribution central funding**	15,159	14,616
Other clinical income	27,598	34,111
Total income from activities	**631,632**	**603,795**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.
**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	171,560	154,233
Clinical commissioning groups	423,434	394,196
Other NHS providers	1,285	2,062
NHS other	8	159
Local authorities	22,952	28,068
Non-NHS: private patients	10,588	18,883
Non-NHS: overseas patients (chargeable to patient)	537	3,588
Injury cost recovery scheme	866	1,361
Non NHS: other	402	1,245
Total income from activities	**631,632**	**603,795**
Of which:		
Related to continuing operations	631,632	603,795

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21 £000	2019/20 £000
Income recognised this year	537	3,588
Cash payments received in-year	1,082	2,236
Amounts added to provision for impairment of receivables	-	1,534
Amounts written off in-year	893	943

Note 3 Other operating income

	2020/21			2019/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	4,952	3,566	**8,518**	3,343	3,373	**6,716**
Education and training	24,605	-	**24,605**	24,440	-	**24,440**
Non-patient care services to other bodies	12,093	-	**12,093**	12,093	-	**12,093**
Provider sustainability fund (2019/20 only)	-	-	**-**	11,374	-	**11,374**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	6,385	-	**6,385**
Reimbursement and top up funding	49,525	-	**49,525**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	8,279	-	**8,279**	9,080	-	**9,080**
Receipt of capital grants and donations	-	3,281	**3,281**	-	7,250	**7,250**
Charitable and other contributions to expenditure	-	7,128	**7,128**	-	282	**282**
Support from the Department of Health and Social Care for mergers	-	924	**924**	-	11,040	**11,040**
Rental revenue from operating leases	-	710	**710**	-	736	**736**
Other income	5,839	-	**5,839**	16,719	-	**16,719**
Total other operating income	**105,293**	**15,609**	**120,902**	**83,434**	**22,681**	**106,115**
Of which:						
Related to continuing operations			120,902			106,115
Related to discontinued operations			-			-

Reimbursement and top up funding consists of: £13.3m in a 'top up' payment to reflect the difference between the expected baseline net costs and block contract and other income, where modelling of the expected cost base is higher for M1-6 2020/21; £22.8m in 'retrospective top-up' payments to fund additional costs and/or loss of revenue where the block and top-up payments do not equal the actual costs of genuine and reasonable additional marginal costs due to COVID during M1-6 2020/21; £3m of funding for costs related to the vaccination programme and other COVID related costs not covered by other funding arrangements; and £10.5m of funding to replace reduced income from non-NHS sources (primarily Local Authorities, Private Patients, and Overseas Visitors).

Most of other income from NHS commissioners was included in the block payments as these were set based on 19/20 M9 AoB. Other income of £5.8m (2019/20 £16.7m) includes ED funding £0m (2019/20 £2.5m), maternity funding for modular building £1.5m (2019/20 £1.5m, as maternity lease), staff accommodation rental £1.7m (2019/20 £2.4m), car parking income £1.4m (2019/20 £2.6m), Clinical Excellence Award £0.4m (2019/20 £0.9m), Sexual Health E-Services £1.4m (2019/20 £0.9m) and other various departmental schemes. Adjustments were made here for deferral of PPE stock and Independent Sector Providers.

Note 4.1 Income from activities arising from commissioner requested services

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

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	594,994	548,429
Income from services not designated as commissioner requested services	36,638	55,366
Total	**631,632**	**603,795**

Note 5.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,850	3,903
Purchase of healthcare from non-NHS and non-DHSC bodies	9,550	8,492
Staff and executive directors costs	420,914	398,117
Remuneration of non-executive directors	102	140
Supplies and services - clinical (excluding drugs costs)	75,776	71,895
Supplies and services - general	56,708	43,635
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	62,769	70,187
Inventories written down	1,232	383
Consultancy costs	386	721
Establishment	3,506	2,572
Premises	16,147	14,191
Transport (including patient travel)	5,022	3,325
Depreciation on property, plant and equipment	14,809	13,862
Amortisation on intangible assets	6,500	4,197
Net impairments	24,702	(11,352)
Movement in credit loss allowance: contract receivables / contract assets	130	(2,345)
Movement in credit loss allowance: all other receivables and investments	7	(141)
Increase/(decrease) in other provisions	1,230	(1,346)
Audit fees payable to the external auditor		
audit services- statutory audit	156	142
Internal audit costs	186	146
Clinical negligence	30,672	22,436
Legal fees	281	253
Insurance	287	221
Research and development	3,549	3,327
Education and training	1,300	1,546
Rentals under operating leases	2,609	3,066
Redundancy	27	109
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	11,577	11,808
Car parking & security	1,034	930
Hospitality	3	20
Losses, ex gratia & special payments	1,122	446
Other services, eg external payroll	422	473
Other	253	237
Total	**755,818**	**665,596**
Of which:		
Related to continuing operations	755,818	665,596

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 6 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price*	24,702	(11,352)
Total net impairments charged to operating surplus / deficit	**24,702**	**(11,352)**
Impairments charged to the revaluation reserve	643	(13,309)
Total net impairments	**25,345**	**(24,661)**

* The position includes Impairments of £24.7m arising from the annual valuation exercise of the Trust's estate (based on industry standard indices). Although this has worsened the deficit position it does not impact the control total, which the Trust is measured against.

Note 7 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	331,398	311,983
Social security costs	35,274	33,056
Apprenticeship levy	1,577	1,503
Employer's contributions to NHS pensions	49,809	47,836
Pension cost - other	38	37
Temporary staff (including agency)	9,071	15,248
Total gross staff costs	**427,167**	**409,663**
Total staff costs	**427,167**	**409,663**
Of which		
Costs capitalised as part of assets	2,704	8,219

Note 7.1 Retirements due to ill-health

During 2020/21 there were no early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is 0k (0k in 2019/20).

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

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

NEST is the workplace pension set up by the Government. The Trust offers employees the NEST pension scheme alongside the two NHS Pension Schemes. NEST is a defined contribution workplace pension scheme backed by the UK Government. In 2020/21 the Trust paid £42,645 into NEST.
Staff are automatically enrolled into the NHS pension scheme or the NEST scheme unless staff opt out.

Note 9 Operating leases

Note 9.1 Chelsea and Westminster Hospital NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Chelsea and Westminster Hospital NHS Foundation Trust is the lessor.

The Trust has three lessor agreements on Trust buildings and land. Imperial College lease the Renal Unit and charges are made with regard to actual costs associated with the premises. Alliance Medical lease land for their MRI unit and a contract has been agreed in respect of lease charges that takes into consideration charges from the company to the Trust for MRI scans. Hounslow and Richmond Community Healthcare NHS Trust lease land and building for the Urgent Care Centre (UCC).

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	710	736
Total	**710**	**736**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year.	710	736
Total	**710**	**736**

Note 9.2 Chelsea and Westminster Hospital NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Chelsea and Westminster Hospital NHS Foundation Trust is the lessee.
The site has a number of property operating leases to run its operations. These include leased properties predominantly from private companies but also from NHS Property Services. The rent reviews are either at a five year or other agreed intervals.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	3,010	3,463
Less sublease payments received	(401)	(397)
Total	**2,609**	**3,066**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	2,795	2,879
- later than one year and not later than five years;	5,798	6,403
- later than five years.	3,889	5,273
Total	**12,482**	**14,555**

Note 10 Finance income

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	-	832
Other finance income	-	95
Total finance income	**-**	**927**

Note 11.1 Finance expenditure

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

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	915	980
Other loans	223	254
Finance leases	17	27
Interest on late payment of commercial debt	2	1
Main finance costs on PFI and LIFT schemes obligations	2,373	2,463
Contingent finance costs on PFI and LIFT scheme obligations	2,154	1,984
Total interest expense	**5,684**	**5,709**
Unwinding of discount on provisions	-	3
Other finance costs	75	-
Total finance costs	**5,759**	**5,712**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21 £000	2019/20 £000
Total liability accruing in year under this legislation as a result of late payments	295	367
Amounts included within interest payable arising from claims made under this legislation	2	1

Note 12 Other gains / (losses)

	2020/21 £000	2019/20 £000
Gains on disposal of assets	39	22
Losses on disposal of assets	(31)	(466)
Losses on disposal of other financial assets / investments	(1,480)	-
Total gains / (losses) on disposal of assets	**(1,472)**	**(444)**
Total other gains / (losses)	**(1,472)**	**(444)**

Note 13.1 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**6,408**	**57,523**	**1,345**	**65,276**
Transfers by absorption	-	-	-	**-**
Additions	76	-	3,093	**3,169**
Reclassifications	467	3,490	(3,957)	**-**
Valuation / gross cost at 31 March 2021	**6,951**	**61,013**	**481**	**68,445**
Amortisation at 1 April 2020 - brought forward	**3,595**	**19,018**	**-**	**22,613**
Transfers by absorption	-	-	-	**-**
Provided during the year	777	5,723	-	**6,500**
Amortisation at 31 March 2021	**4,372**	**24,741**	**-**	**29,113**
Net book value at 31 March 2021	**2,579**	**36,272**	**481**	**39,332**
Net book value at 1 April 2020	**2,813**	**38,505**	**1,345**	**42,663**

Note 13.2 Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**5,186**	**34,483**	**16,955**	**56,624**
Additions	-	-	10,283	**10,283**
Reclassifications	1,222	24,671	(25,893)	**-**
Disposals / derecognition	-	(1,631)	-	**(1,631)**
Valuation / gross cost at 31 March 2020	**6,408**	**57,523**	**1,345**	**65,276**
Amortisation at 1 April 2019 - as previously stated	**3,004**	**16,577**	**-**	**19,581**
Provided during the year	591	3,606	-	**4,197**
Disposals / derecognition	-	(1,165)	-	**(1,165)**
Amortisation at 31 March 2020	**3,595**	**19,018**	**-**	**22,613**
Net book value at 31 March 2020	**2,813**	**38,505**	**1,345**	**42,663**
Net book value at 1 April 2019	**2,182**	**17,906**	**16,955**	**37,043**

Note 14.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**95,749**	**302,957**	**12,645**	**25,761**	**77,559**	**121**	**14,401**	**3,635**	**532,828**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	-	-	33,499	2,084	-	7,539	-	**43,122**
Impairments	-	(38,967)	-	-	-	-	-	-	**(38,967)**
Reversals of impairments	8,292	4,326	1,004	-	-	-	-	-	**13,622**
Revaluations	-	(11,890)	(528)	-	(158)	-	-	-	**(12,576)**
Reclassifications	(8)	34,958	16	(40,735)	5,734	-	-	35	**-**
Disposals / derecognition	-	-	-	-	(1,023)	-	-	-	**(1,023)**
Valuation/gross cost at 31 March 2021	**104,033**	**291,384**	**13,137**	**18,525**	**84,196**	**121**	**21,940**	**3,670**	**537,006**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**6,152**	**312**	**-**	**58,212**	**121**	**13,669**	**3,105**	**81,571**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	9,924	292	-	4,084	-	337	172	**14,809**
Revaluations	-	(11,890)	(528)	-	(158)	-	-	-	**(12,576)**
Disposals / derecognition	-	-	-	-	(996)	-	-	-	**(996)**
Accumulated depreciation at 31 March 2021	**-**	**4,186**	**76**	**-**	**61,142**	**121**	**14,006**	**3,277**	**82,808**
Net book value at 31 March 2021	**104,033**	**287,198**	**13,061**	**18,525**	**23,054**	**-**	**7,934**	**393**	**454,198**
Net book value at 1 April 2020	**95,749**	**296,805**	**12,333**	**25,761**	**19,347**	**-**	**732**	**530**	**451,257**

The Trust has received £1,813k COVID response equipment from Department of Health and Social Care (DHSC) and £270k imaging equipment from NHS England and Improvement (NHS&I), these are recorded in Trusts' accounts as donations.

Note 14.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**92,302**	**273,504**	**13,319**	**23,454**	**72,381**	**121**	**14,406**	**3,579**	**493,066**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2019 - restated	**92,302**	**273,504**	**13,319**	**23,454**	**72,381**	**121**	**14,406**	**3,579**	**493,066**
Additions	-	-	-	24,170	-	-	-	-	**24,170**
Impairments	-	(3,285)	(305)	-	-	-	-	-	**(3,590)**
Reversals of impairments	3,394	24,857	-	-	-	-	-	-	**28,251**
Revaluations	-	(8,076)	(372)	-	-	-	-	-	**(8,448)**
Reclassifications	53	15,957	3	(21,640)	5,568	-	(5)	64	**-**
Disposals / derecognition	-	-	-	(223)	(390)	-	-	(8)	**(621)**
Valuation/gross cost at 31 March 2020	**95,749**	**302,957**	**12,645**	**25,761**	**77,559**	**121**	**14,401**	**3,635**	**532,828**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**5,355**	**386**	**-**	**54,491**	**121**	**13,293**	**2,909**	**76,555**
Provided during the year	-	8,873	298	-	4,111	-	376	204	**13,862**
Revaluations	-	(8,076)	(372)	-	-	-	-	-	**(8,448)**
Disposals / derecognition	-	-	-	-	(390)	-	-	(8)	**(398)**
Accumulated depreciation at 31 March 2020	**-**	**6,152**	**312**	**-**	**58,212**	**121**	**13,669**	**3,105**	**81,571**
Net book value at 31 March 2020	**95,749**	**296,805**	**12,333**	**25,761**	**19,347**	**-**	**732**	**530**	**451,257**
Net book value at 1 April 2019	**92,302**	**268,149**	**12,933**	**23,454**	**17,890**	**-**	**1,113**	**670**	**416,511**

Note 14.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	104,033	219,674	13,061	18,125	20,281	7,934	393	**383,501**
Finance leased	-	1,497	-	-	-	-	-	**1,497**
On-SoFP PFI contracts and other service concession arrangements	-	53,913	-	-	-	-	-	**53,913**
Owned - donated/granted	-	12,114	-	400	2,773	-	-	**15,287**
NBV total at 31 March 2021	**104,033**	**287,198**	**13,061**	**18,525**	**23,054**	**7,934**	**393**	**454,198**

Note 14.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	95,749	230,798	12,333	15,657	18,666	732	530	**374,465**
Finance leased	-	1,965	-	-	-	-	-	**1,965**
On-SoFP PFI contracts and other service concession arrangements	-	55,810	-	-	-	-	-	**55,810**
Owned - donated/granted	-	8,232	-	10,104	681	-	-	**19,017**
NBV total at 31 March 2020	**95,749**	**296,805**	**12,333**	**25,761**	**19,347**	**732**	**530**	**451,257**

Note 15 Donations of property, plant and equipment

The Trust has received donations of £3,280k in the year.

- £2,084k donation of physical plant and equipment received from DHSC and NHSE/I.
- £1,197k cash donation, within it £400k for the construction of property (CW+), plant and equipment, £434k for COVID equipment purchase (CW+) and £363k for development of intangible assets (Various).

Note 16 Revaluations of property, plant and equipment

The Trust instructed Gerald Eve LLP to carry out a revaluation of its property portfolio as at 31 December 2020. The revaluation was predominantly based on modern equivalent asset values using the alternative site approach where appropriate. This exercise resulted in a decrease in the value of the relative assets of £25.3m, this represents £24.7m impairment charged to the I&E and £0.6m decrease in revaluation reserves in accordance with the Trust's accounting policies and NHS Improvement guidance.

Note 17 Investments in associates and joint ventures

	2020/21	2019/20
	£000	£000
Carrying value at 1 April - brought forward	**2,185**	**1,276**
Share of profit / (loss)	357	909
Disposals	(2,542)	-
Carrying value at 31 March	**(0)**	**2,185**

The joint venture, Sphere, owned by the Trust and Royal Marsden Hospital was dissolved as at 31 March 2021. At the time of termination the Trust had recognised £2.5m in profit sharing.

Note 18 Other investments / financial assets (non-current)

	2020/21	2019/20
	£000	£000
Carrying value at 1 April - brought forward	**1,357**	**4,599**
Movement in fair value through OCI	4,416	(3,242)
Carrying value at 31 March	**5,774**	**1,357**

The Trust recognises Sensyne Health PLC shares as Fair Value through OCI. As at 31 March 2021 the Trust recognised the shares at the AIM listed valuation, reduced for a discount to reflect they are not completely liquid as the Trust is subject to an up to 3 year locked in period.

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	3,778	3,880
Consumables	8,965	3,635
Energy	138	216
Other	79	53
Total inventories	**12,960**	**7,784**

Inventories recognised in expenses for the year were £65,701k (2019/20: £67,220k). Write-down of inventories recognised as expenses for the year were £1,232k (2019/20: £383k).

In response to the COVID pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £6,774k of items purchased by DHSC.

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

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables (IFRS 15)	39,164	56,116
Allowance for impaired contract receivables / assets	(8,493)	(9,691)
Allowance for other impaired receivables	(453)	(446)
Prepayments (non-PFI)	5,856	10,042
Interest receivable	-	35
PDC dividend receivable	269	484
VAT receivable	1,924	812
Other receivables	6,977	3,144
Total current receivables	**45,244**	**60,496**
Non-current		
Other receivables	1,933	1,673
Total non-current receivables	**1,933**	**1,673**
Of which receivable from NHS and DHSC group bodies:		
Current	13,866	27,782
Non-current	1,933	1,673

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. The primary changes in the reduction in contract receivables relates to cash collection in year and changes for marginal rate for over performance.

Non-current receivables includes Clinician Pension tax of £1.9m (2019/20 £1.7m) provided by NHSE, using information provided by the Government Actuaries Department and NHS Business Services Authority. A separate provision is recognised in Payables.

Note 20.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**9,691**	**446**	**13,618**	**589**
New allowances arising	746	7	3,054	40
Reversals of allowances	(616)	-	(5,399)	(181)
Utilisation of allowances (write offs)	(1,328)	-	(1,582)	(2)
Allowances as at 31 March 2021	**8,493**	**453**	**9,691**	**446**

The total balance for allowances contract credit losses includes £3,769k for Overseas patients credit losses, £1,277k for NHS, £1,073k for Local Authorities, £189k for Private Patient, £1,407k for Road Traffic Accident (RTA) and £778k for Others . Each year the Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the RTA income, for 2020/21 this figure is 22.43%. The total balance for allowances for non-contract credit losses is for salary overpayment of £453k.

Note 21 Cash and cash equivalents movements

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

	2020/21	2019/20
	£000	£000
At 1 April	**117,161**	**100,260**
Net change in year	24,485	16,901
At 31 March	**141,646**	**117,161**
Broken down into:		
Cash at commercial banks and in hand	49	191
Cash with the Government Banking Service	141,597	116,970
Total cash and cash equivalents as in SoFP	**141,646**	**117,161**
Total cash and cash equivalents as in SoCF	**141,646**	**117,161**

Note 22 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	14,390	17,224
Capital payables	8,294	6,013
Accruals	62,257	48,741
Social security costs	5,052	4,773
Other taxes payable	4,772	4,139
Other payables	8,397	6,850
Total current trade and other payables	**103,162**	**87,740**
Of which payables from NHS and DHSC group bodies:		
Current	15,339	16,505

Note 23 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities (IFRS 15)	22,173	14,229
Deferred grants	149	-
Total other current liabilities	**22,322**	**14,229**

Note 24.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	3,771	3,781
Other loans	1,315	1,285
Obligations under finance leases	30	28
Obligations under PFI, LIFT or other service concession contracts	1,494	1,650
Total current borrowings	**6,610**	**6,744**
Non-current		
Loans from DHSC	44,504	48,177
Other loans	7,049	8,359
Obligations under finance leases	218	248
Obligations under PFI, LIFT or other service concession contracts	28,619	29,912
Total non-current borrowings	**80,390**	**86,696**

The Trust has four loans outstanding at the end of the financial year. Three loans are from the Department of Health and Social Care and comprise of one working capital loan and two separate capital investment loans. The working capital loan balance at the end of the year is £32.8m with an interest rate of 1.8%. The capital investment loans have balances of £7.1m, with an interest rate of 1.46%, and £8.3m, with an interest rate of 2.2%.

In 2018/19 the Trust took out a further loan with Natwest Plc for £10.9m, with an interest rate of 2.44% to purchase the Maternity Modular building on the West Middlesex Site. The outstanding loan at end of year is £8.4m.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**51,958**	**9,644**	**276**	**31,562**	**93,440**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,673)	(1,278)	(28)	(1,252)	**(6,231)**
Financing cash flows - payments of interest	(925)	(225)	(17)	(2,570)	**(3,737)**
Non-cash movements:					
Application of effective interest rate	915	223	17	2,373	**3,528**
Carrying value at 31 March 2021	**48,275**	**8,364**	**248**	**30,113**	**87,000**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**55,637**	**10,891**	**456**	**32,707**	**99,691**
Prior period adjustment	-	-	-	-	**-**
Carrying value at 1 April 2019 - restated	**55,637**	**10,891**	**456**	**32,707**	**99,691**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,673)	(1,247)	(180)	(1,132)	**(6,232)**
Financing cash flows - payments of interest	(986)	(254)	(27)	(2,476)	**(3,743)**
Non-cash movements:					
Application of effective interest rate	980	254	27	2,463	**3,724**
Carrying value at 31 March 2020	**51,958**	**9,644**	**276**	**31,562**	**93,440**

Note 26 Finance leases

Note 26.1 Chelsea and Westminster Hospital NHS Foundation Trust as a lessee
Obligations under finance leases where the Trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**310**	**355**
of which liabilities are due:		
- not later than one year;	45	45
- later than one year and not later than five years;	178	179
- later than five years.	87	131
Finance charges allocated to future periods	(62)	(79)
Net lease liabilities	**248**	**276**
of which payable:		
- not later than one year;	30	28
- later than one year and not later than five years;	138	131
- later than five years.	80	117

The Trust had one finance lease arrangements during 2020/21. MRI building. The outstanding period for this lease is 7 years.

Note 27.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Contractual Disputes	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020	**1,590**	**1,025**	**788**	**889**	**523**	**7,369**	**12,184**
Arising during the year	174	70	803	892	-	3,291	**5,230**
Utilised during the year	(193)	(65)	(188)	(420)	(9)	(37)	**(912)**
Reversed unused	(104)	-	(357)	(937)	(514)	(1,788)	**(3,700)**
At 31 March 2021	**1,467**	**1,030**	**1,046**	**424**	**-**	**8,835**	**12,802**
Expected timing of cash flows:							
- not later than one year;	179	65	1,046	424	-	**5,390**	**7,104**
- later than one year and not later than five years;	763	261	-	-	-	**1,146**	**2,170**
- later than five years.	525	704	-	-	-	**2,299**	**3,528**
Total	**1,467**	**1,030**	**1,046**	**424**	**-**	**8,835**	**12,802**

Contractual disputes relate to challenges from Commissioners on pricing, charging and penalties. Other provisions include NHS Resolution LTPS Claim of £88k (2019/20 £99k), dilapidations £1,512k (2019/20 £879k), contractual pay claims £815k (2019/20 £2,311k), clinician pension tax £1,933k (2019/20 £1,673k), potential liability for Sphere Joint Venture £2,080k and other contractual claims £2,407k (2019/20 £2,407k).

Note 27.2 Clinical negligence liabilities

At 31 March 2021, £445,921k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Chelsea and Westminster Hospital NHS Foundation Trust (31 March 2020: £375,367k).

Note 28 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(40)	(36)
Net value of contingent liabilities	**(40)**	**(36)**
Net value of contingent assets	**-**	**-**

Note 29 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	7,501	6,792
Intangible assets	65	504
Total	**7,566**	**7,296**

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

Note 30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

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

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**51,108**	**54,930**
Of which liabilities are due		
- not later than one year;	3,770	4,024
- later than one year and not later than five years;	13,160	13,341
- later than five years.	34,178	37,565
Finance charges allocated to future periods	(20,995)	(23,368)
Net PFI, LIFT or other service concession arrangement obligation	**30,113**	**31,562**
- not later than one year;	1,494	1,650
- later than one year and not later than five years;	4,992	4,803
- later than five years.	23,627	25,109

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**260,594**	**275,335**
Of which payments are due:		
- not later than one year;	15,025	14,741
- later than one year and not later than five years;	62,998	61,632
- later than five years.	182,571	198,962

Note 30.3 Analysis of amounts payable to service concession operator

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

The Trust paid £18.6m in the year which represents £3.2m in excess of the contractually committed amount. The Trust expects to incur a comparable spend in addition to the contractual liability presented above for 2020-21. Beyond this range, it is not possible to reliably estimate any variances to the contracted amount which might be incurred. (The Trust also paid £2.9m for London Living Wage, although outside the PFI contract value).

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**18,585**	**18,626**
Consisting of:		
- Interest charge statement of financial position	2,373	2,463
- Repayment of obligation	1,252	1,132
- Service element and other charges to operating expenditure	11,577	11,808
- Capital lifecycle maintenance	1,229	1,239
- Contingent rent	2,154	1,984
Total amount paid to service concession operator	**18,585**	**18,626**

The Trust has a PFI scheme with Bywest Limited for a 33 year period which commenced in 2004. At the end of this period the Trust takes possession of the buildings and equipment funded and maintained by Bywest over the duration of the scheme. The Trust makes an annual unitary payment to cover liabilities management, lifecycle maintenance and finance costs. Unitary payments may vary in the future and are dependent on the Retail Price Index. Facilities management services are subject to market testing every five years. The market testing and formal tender of these services was last carried out in 2019/20. A new contract for soft facilities management services commenced in July 2019, which covers hotel services including building cleaning. The PFI scheme transferred to the Trust on 1 September 2015 following the merger with West Middlesex University Hospital NHS Trust.

Under IFRIC 12 the asset is treated as an asset of the Trust. The substance of the contract is that the Trust has finance lease and payments comprise imputed finance lease charges and service charges.

Note 31 Financial instruments

Note 31.1 Financial risk management

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship the Trust has with healthcare commissioners and the way those healthcare commissioners are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

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

Liquidity Risk

The Trust's net operating costs are mainly incurred under legally binding contracts with commissioners, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long-term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust finances its capital programme through agreed loan facilities with the Independent Trust Financing Facility. The Trust has a working capital facility as at 31 March 2021 but has not drawn down against it.

Credit Risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer of counterparty.

The policy reflects the position on the causes of debt, the implications of compliance and the need to identify trading counterparties correctly and the varied level of risk associated with them along with the requirement to maintain an adequate bad debt provision. The Trust maintains a bad debt provision rule set which is flexible and reflects the monthly movements on the sales ledger, however it also requires that a line by line review of items to be provided is carried out regularly.

Trade debtors consist of high value transaction with NHS England and CCG commissioners under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health and local authorities under contractual terms although these are subject to individual negotiation. Other trade debtors include private and overseas patients, spread across diverse geographical areas.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

The maximum exposure of the Trust to credit risk is equal to the total trade and other receivables within Note 20.

Interest rate risk

The Trust's borrowings comprise fixed rate loans or interest free loans; the Trust is not therefore exposed to interest rate risk.

Note 31.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018. Comparative disclosure have been prepared under IAS 39 and the measurement categories is consistent to those in prior year

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	37,195	-	-	**37,195**
Other investments / financial assets	-	-	5,774	**5,774**
Cash and cash equivalents	141,646	-	-	**141,646**
Total at 31 March 2021	**178,841**	**-**	**5,774**	**184,615**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	50,831	-	-	**50,831**
Other investments / financial assets	-	-	1,357	**1,357**
Cash and cash equivalents	117,161	-	-	**117,161**
Total at 31 March 2020	**167,992**	**-**	**1,357**	**169,349**

The Trust recognises Sensyne Plc shares as Fair Value through OCI. As at 31 March 2021 the Trust recognised the shares at the AIM listed valuation reduced for a discount to reflect they are not completely liquid as the Trust is subject to an up to 3 year locked in period.

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	48,275	-	**48,275**
Obligations under finance leases	248	-	**248**
Obligations under PFI, LIFT and other service concession contracts	30,113	-	**30,113**
Other borrowings	8,364	-	**8,364**
Trade and other payables excluding non financial liabilities	88,015	-	**88,015**
Provisions under contract	3,371	-	**3,371**
Total at 31 March 2021	**178,386**	**-**	**178,386**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	51,958	-	**51,958**
Obligations under finance leases	276	-	**276**
Obligations under PFI, LIFT and other service concession contracts	31,562	-	**31,562**
Other borrowings	9,644	-	**9,644**
Trade and other payables excluding non financial liabilities	78,705	-	**78,705**
Provisions under contract	4,500	-	**4,500**
Total at 31 March 2020	**176,645**	**-**	**176,645**

Note 31.4 Maturity of financial liabilities

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

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less;	101,236	93,874
In more than one year but not more than five years;	36,077	37,289
In more than five years.	70,714	79,150
Total	**208,027**	**210,313**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 32 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	26	16	31	2
Bad debts and claims abandoned	327	1,106	912	1,137
Stores losses and damage to property	26	1,065	26	383
Total losses	**379**	**2,187**	**969**	**1,522**
Special payments				
Ex-gratia payments	34	58	30	62
Total special payments	**34**	**58**	**30**	**62**
Total losses and special payments	**413**	**2,245**	**999**	**1,584**

Losses and special payments are charged to the relevant headings on an accrual basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risk.

There was one individual case over £300,000 in the year (2019/20 none).
In 2020/21 there was £515k of Trust purchased PPE consumables that are currently in quarantine, whilst the quality is assessed and are thus not available stock.

Note 33 Operating segments

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purpose of operating segments disclosure. IFRS 8 requirements were considered and the Trust has determined that the Chief Operating Decision Maker is the Trust Board of Chelsea and Westminster Hospital NHS Foundation Trust. It is the responsibility of the Trust Board to formulate financial strategy and approve budgets. Significant operating segments that are reported internally are the ones that are required to be disclosed in the financial statements. There is no segmental reporting for revenue, assets or liabilities to the Trust Board. Expenditure is reported by segment to the Trust Board, however, those segments fully satisfy the aggregation criteria to be one reportable segment as per IFRS 8. Therefore all activities of the Trust are considered to be one segment, 'Healthcare', and there are no individual reportable segments on which to make disclosures.

Note 34 Academic Health Partnership

The Trust has continued to be a partner in Imperial College Healthcare Partners Limited, a company limited by guarantee, with Imperial College and a number of other local trusts. The company provides central services for the Imperial Academic Health Science Partnership, in which the Trust participates. The Trust's initial investment was £1, and the Trust's contribution to the costs of the company for the year was £48k (2019/20 £48k).

Note 35 North West London Pathology
In 2017/18 the Chelsea and Westminster Hospital NHS Foundation Trust (CW), Imperial College Healthcare NHS Trust (ICHT) and The Hillingdon Hospitals NHS Foundation Trust (THH) entered into an agreement to restructure their pathology services by establishing North West London Pathology (NWLP). NWLP is jointly governed by the 3 organisations ICHT (61.2%), CW (19.92%) and THH (18.88%).

NWLP, hosted by Imperial College Healthcare NHS Trust, is defined as a joint operation, per IFRS 11, and each Trust accounts for its share of the operating costs based on activity and hosting costs apportioned on the relative percentage of ownership. The Trust's initial contribution is reflected as a working capital loan and is included in other current receivables.

Note 36 Related parties

The Trust is a public benefit corporation and has been authorised pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. The Department of Health and Social Care is the parent department.

During the year an entity (Travill Construction Ltd) related to a Trust Board member had transactions with the Trust to the value of £388k (£74k 2019/20).

During the year the Trust has had a significant number of material transactions with the following Whole Government bodies:
– NHS England
– NHS Clinical Commissioning Groups
– NHS Foundation Trusts
– NHS Trusts
– Department of Health and Social Care
– Health Education England
– NHS Pension Scheme
– NHS Property Services
– Local Authorities
– Ministry of Defence
– London School of Hygiene & Tropical Medicine

In addition to the above the Trust has a number of transactions with Sphere and CW+ (the official charity partner of the Trust).

	2020/21	2019/20
CW+	**£000s**	**£000s**
Receivables	63	513
Payables	0	52
Income	1,631	7,285
Expenditure	49	111
Sphere	**£000s**	**£000s**
Receivables	0	520
Payables	0	15
Income	596	397
Expenditure	14,646	7,484

Note 37 Events after the reporting date

None.

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

369 Fulham Road
London
SW10 9NH

Main Switchboard
+44 (0)20 3315 8000

Website
www.chelwest.nhs.uk

fb.com/chelwest
fb.com/westmidhospital

@chelwestft
@westmidhospital

@chelwestft