Annual report and accounts

2019/20

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report and Accounts 2019/20

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a)
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PERFORMANCE REPORT

OVERVIEW OF PERFORMANCE

Statement from the Chief Executive

I am delighted to introduce the 2019/20 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 our 12 community-based services.

2019/20 has been a busy year for the Trust as we continued to experience high demand for our emergency and urgent care services, while undergoing a Care Quality Commission inspection, successfully implementing an electronic patient record system and, more recently, responding to the COVID-19 incident.

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

Our values

The Trust values are firmly embedded throughout our organisation. They outline the standard of care and experience 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

Reflecting on our achievements against our strategic priorities, I have highlighted a few of which we are particularly proud:

Our quality

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

Our values and strategic priorities drive us to continually improve and ensure that we put the quality and safety of care at the centre of everything we do.

We know that the staffing levels in clinical services have a direct impact on the quality and safety of care we are able to deliver to our patients, and I am proud to tell you that in 2019/20 we have achieved the lowest nurse vacancy rate in London at 5%. This has been the result of investment and innovative recruitment and retention strategies to support our nursing workforce.

The Trust has an embedded ward accreditation programme which is aligned to the domains and fundamental standards of the Care Quality Commission and used by our clinical teams to inform their improvement programmes. Clinical areas receive a rating of Gold, Silver, Bronze or White to inform the level of support and improvement required to enhance care. This year we saw an impressive 23% increase in areas receiving a Gold rating.

2019/20 saw the successful introduction of the medical examiner role, in line with national developments, and increased scrutiny of our approach to the mortality surveillance process. The Trust has successfully maintained both the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) below 0.8 throughout the year.

In November 2019 we welcomed the Care Quality Commission (CQC) to inspect our services, which included a well-led inspection and use of resources inspection by NHS Improvement. I am pleased to say that we maintained the rating of 'Good' overall, seeing an improvement in well-led rating from 'Good' to 'Outstanding', and maintaining the use of resources rating of 'Outstanding'. The Chelsea site improved the overall rating from 'Good' to 'Outstanding', and the West Middlesex site maintained the overall rating of 'Good'.

Critical care services at Chelsea site improved their overall rating from 'Good' to 'Outstanding', and maternity services at the Chelsea site were rated 'Outstanding' in the responsive domain. At the West Middlesex site, maternity services improved their overall rating to 'Outstanding', also being rated 'Outstanding' within the effective and responsive domains. The Trust received no 'must do' actions and the inspection report highlighted there were 31 examples of outstanding practice—a very impressive outcome for our organisation of which we are extremely proud.

Our people

Strategic priority 2: Be the employer of choice

As a Trust, we employ more than 6,000 staff. Over the past year, our focus on our people has, through a series of local, national and international workstreams, seen us achieve a marked reduction in our vacancy rates. At the time of writing we have a vacancy rate of 6.7%, one of the lowest in London. Linked to this, we have also reduced our reliance and expenditure on temporary staffing by more than £5m, which has directly impacted on our quality of care. We have strengthened our commitment to apprenticeships, with more than 150 in place and a growing agenda in the organisation.

The Trust's commitment to equality, diversity and inclusion was strengthened this year by the introduction of staff networks. For example, we established a staff-led Black, Asian and Minority Ethnic (BAME) network, an LGBTQ+ network and a Women's Network. These groups have developed workplans to inform the Trust's direction of travel and provide us with another opportunity to work in partnership with our staff. This year saw the Trust invest in economic equity by introducing the London Living Wage.

In the area of staff engagement and supporting our people, we maintained our top 20% staff engagement score in the national NHS staff survey. We implemented an employee relations training programme for our senior managers and we have seen a 30% reduction in formal disciplinary processes. Aligned to this, we have launched an extensive health and wellbeing programme which has significantly improved our approach to caring for and recognising the contributions of our staff.

I continue to be proud of the progress we are making in our volunteering programme, supported and championed by our chairman and Helpforce. We now have volunteers recognised and supported by our wards and departments and 2019/20 saw us increase the scope of the roles available to our volunteers.

Our sustainability

Strategic priority 3: Delivering better care at lower cost

Our excellent financial and operational performance continues to be of great pride to us, seeing us simultaneously achieving our financial plan while continuing to be one of the best performers against the national access standards. We could not have achieved this without an ambitious approach to improvement and innovation and working alongside our charity CW+.

The Trust achieved a 2019/20 surplus of £29.5m and delivered £21.7m of cost improvement programmes during the year. The Trust incurred additional expenditure during March 2020 relating to COVID-19, as well as a reduction in activity and income, which were reimbursed in full by NHS England and Improvement.

As of March 2020, the Trust has been placed into segment 1 of NHS Improvement's oversight framework, where 1 reflects providers with maximum autonomy. As previously mentioned, the Trust achieved an 'outstanding' rating for use of resources.

In 2019/20 the Trust invested £34.5m on capital which included £13.1m on the new NICU/ICU ward at the Chelsea site, £4.7m on the CernerEPR electronic patient record system, £4.7m on medical equipment and £2.8m on estates backlog maintenance.

The progression of the redevelopment of adult critical care and neonatal intensive care services was supported by a significant fundraising campaign by CW+, and I extend a personal thank you to every donor who contributed to this, as our patients are now being cared for in world class facilities.

2019/20 saw us continue with our electronic patient record (EPR) programme and undertake the largest and most complex implementation of the CernerEPR system in NHS history. This has improved the quality of our data and will inform our future strategy to improve population health.

Our drive to continually improve and seek out new ways of working continued this year by developing and launching CW Innovation with our charity CW+. This programme identifies and delivers new high-impact innovation initiatives and improvements which support the goal of delivering operational excellence, exceptional patient care and enhanced experience in a world-class clinical environment.

The Trust has embraced the digital world and the benefits which it offers to patient care. In partnership with CW+ we have established our Test Beds programme to seek out new and innovative ways to care for our patients. This has included improving how we share information between healthcare partners and a never-before-achieved digital solution which allows patients to self-book into ambulatory care services and manage their own appointments.

COVID-19

I cannot fail to acknowledge the emergence of the COVID-19 virus during 2019/20 and the impact which it has had on our patients, staff and wider communities.

On 30 January the first phase of the NHS's preparation and response to COVID-19 was triggered, with the declaration of a level 4 national incident. At the time of writing, it has been nearly three months since we began our response to COVID-19 and it is nothing short of incredible what we have achieved. As of the end of May 2020 some of our achievements included:

- Admitting 1,040 COVID-19 patients across the Trust
- Completely re-configuring our hospitals to respond safely and efficiently
- Tripling our critical care beds from 20 to 63
- Managing, at its peak, 284 COVID-19 inpatients with 61 on ICU
- Discharging 724 patients back to their homes
- Delivering more than 2,000 babies across our two maternity units
- Continuing to look after our non-COVID-19 patients with tens of thousands of outpatient attendances
- Introducing video conferencing tools and holding more than 3,000 virtual meetings with nearly 20,000 participants
- Providing 1,755 staff with COVID-related training
- Undertaking 241 hours of volunteering work by corporate staff in other departments
- Welcoming 400 staff daily to our health and wellbeing hubs to rest and refresh
- Completing 495 occupational health risk assessments

Despite our best efforts and exceptional care from our clinical teams, we have very sadly experienced a number of deaths in the organisation which will be confirmed as the pandemic eases.

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.

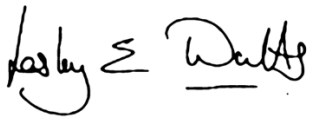
We should assume we will have a combination of a further outbreaks of the pandemic and increased non-COVID-19 emergency demand through winter. We have demonstrated our ability as an integrated care system to quickly repurpose and create surge capacity locally and regionally.

While we have seen a reduction in patients accessing non-elective care, we are now planning for the restart of our elective care programme across North West London. The key priority is that we ensure staff and patients are safe as the pandemic continues. Before we restart our elective activity, we must ensure we have appropriate stocks of associated medicines, personal protective equipment, blood, consumables, equipment and other needed supplies.

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 of 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 2020/21.



Lesley Watts
Chief Executive Officer

18 June 2020

The year in photos

April 2019

Opening of Tigerplay room at West Middlesex

Annual delivery of daffodils from Her Majesty The Queen

May 2019

300th anniversary of Westminster Hospital, celebrated at Westminster Abbey with supporters and staff, past and present

Opening of Reuben Maternity Centre with Mayor of London Sadiq Khan—part of the Critical Care project supported by CW+

June 2019

Windrush celebrations and launch of our BAME Network

Volunteers celebration events—pictured is Salma Abdi, Youth Volunteer

July 2019

Project SEARCH graduation—a yearlong internship at West Middlesex for young people with learning difficulties

Pride took place in the first week of July—we are PROUD to celebrate diversity within our organisation

August 2019

A group of our nurses took part in a 24-hour bike ride to raise funds for our charity, CW+

Ruth Cadbury (MP for Brentford and Isleworth) visited A&E at West Middlesex, accompanied by Dr Zul Mirza

September 2019

At our annual Open Day, we celebrated Marylin Stanton with an award for her 55 years of service at West Middlesex

CW Innovation launch—a programme that identifies and delivers new high-impact innovation initiatives and improvements

September 2019, continued…

Queen Mary Maternity Unit Antenatal Ward at West Middlesex achieves gold in their Ward Accreditation

October 2019

Our annual Staff Awards, held at the Twickenham Stoop

Marsha de Cordova (MP for Battersea) visited our Chelsea site to discuss the national bereavement care pathway

Halloween arts and crafts for patients on our Acute Frailty Unit

November 2019

We launched CernerEPR at Chelsea and Westminster Hospital

Recognising the vital contribution that ISS colleagues make to our organisation every single day by paying them the London Living Wage

December 2019

Tonie Neville (Deputy Head of Midwifery) receives an NHS gold award from Prof Jacqueline Dunkley-Bent (Chief Midwifery Officer for NHS England)

Annual Long Service Awards—celebrating the dedication and commitment of our staff

Christmas at the Trust events—pictured is West Middlesex Main Theatres, winner of the Best Dressed Ward/Department award, and our governors with Santa Claus.

December 2019, continued…

We were delighted to be visited by our local sports teams, including Harlequins RFC, England Rugby 7s, Chelsea Football Club and Brentford FC

World AIDS Day— the Trust runs the largest HIV service in the country and has a long association with the fight against HIV/AIDS

January 2020

We welcomed our latest Care Quality Commission (CQC) ratings which show the Trust is well-led and offers safe, caring, responsive and effective services—maternity at the West Middlesex site and Critical Care at the Chelsea site have been rated 'Outstanding'

We were delighted to welcome Professor Dame Elizabeth Anionwu to the BAME Network where she spoke about her life experiences

Graduates of the Trust's Established Leaders programme

February 2020

Macmillan Cancer trustees visit our information centre at Chelsea and Westminster Hospital

Major incident exercise in our theatres

March 2020

Celebrating Mouth Care Awareness Week with top tips for teeth by our Public Health team

The Trust was shortlisted in four categories in the BMJ Awards—pictured is the maternity team, shortlisted for Digital Innovation Team of the Year

The Trust responded to COVID-19, with great support from our local community

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 heart 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 development of the Health and Care Partnership (HCP) in both North West and South West London to drive improvements to care, and we are working innovatively with our partners to deliver integrated care in Hammersmith and Fulham, Hounslow and West London.

The Trust serves a catchment area in excess of one million people. The Trust's main health commissioning and social care partnerships cover two sustainability and transformation partnership (STP) footprints and the following areas:

- Brent
- Central London CCG
- Ealing CCG
- Hammersmith and Fulham CCG
- Harrow
- Hillingdon
- Hounslow CCG
- Richmond CCG
- Wandsworth CCG
- West London CCG (our statutory host)
- 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).

Key priorities, issues and risks for 2019/20

At the outset of 2019/20 the Trust Board reviewed the organisation's vision over the next five years and agreed that we wished to increase our contribution as a major health provider in North West London (and beyond), strengthen our position as a major university teaching hospital, drive internationally-recognised research and development, and establish ourselves as one of the NHS's primary centres for innovation. Alongside this, in light of the NHS long-term plan and the North West London STP, the Trust also aspires to have a leading role in supporting the development of integrated care systems and improving population health. To achieve the vision of extending clinical excellence for our patients our priorities are:

- **Extending excellence across acute hospital services:** We have successfully demonstrated our ability to deliver high-quality, low-cost hospital care. The strategy looks to grow and expand this model.

- **Establishing excellent services for population health:** We believe that the NHS long-term plan and existing STP strategies will incentivise population health management as the setting where we can deliver the best care at the lowest cost. The strategy seeks to explore this and the role we should play in the wider health system.

- **Achieving excellence in clinical, operational and financial performance driven by a process of research, discovery and innovation:** We believe that the guiding principles which underpin our organisation are our culture and the values, capabilities and development of our people. The strategy builds on this and, in partnership with our charity CW+, seeks to establish the Trust as one of the primary centres for innovation in the NHS.

To support delivery and consistency across all services provided by the Trust we plan to retain the Trust strategic priorities, which are recognised across the organisation and are integrated in to divisional, directorate, and ward/department plans:

- Deliver high-quality, patient-centred care
- Be the employer of choice
- Deliver better care at lower cost

The above priorities are a continuation of the previous year's areas of focus. The progress with each of these priorities will be monitored by key performance indicators (KPIs) to measure the success of their delivery. Subsequently, each of these priorities will be broken down into a number of strategic objectives and a range of measures established, through which assurance against delivery will be monitored.

The Trust Board has also endorsed two further strategic programmes which are added to the priorities:

- The continued delivery of the Electronic Patient Record (EPR) programme
- The continued development of our estate and, in particular, a long-term site master plan for the West Middlesex site.

The Trust's operating plan for 2019/20 was submitted to NHS Improvement in Apr 2019, in line with the national business planning timetable, and forms the underpinning planning and delivery support document detailing the key issues and risks facing the Trust. Specifically, the plan identifies the following key themes:

- **Quality planning and assurance:** Continuing to implement our existing quality strategy, including delivery on the existing quality priority areas and the maintenance of ward accreditation.

- **Activity planning and capacity demand:** Improving compliance with the key national performance standards for 4-hour A&E access, 18-week referral to treatment times (RTT), and cancer access times. Successful partnership programmes to reduce non-elective demand are seen as key complementary strategies in this area.

- **Workforce:** The Trust has developed a people and organisational development strategy which sets out what we will do to establish ourselves as an employer of choice. The strategy is underpinned by the following work streams:

    - Attracting and onboarding new staff
    - Engagement, culture and leadership
    - Health and wellbeing
    - Designing a workforce for the future
    - Workforce productivity

- **Financial planning and use of resources:** Identifying risks to our forecasts for activity, in addition to supporting budgets, contracts, performance against key national efficiency programmes and the Trust's own cost improvement programme (CIP). The Trust is coordinating this through a bespoke improvement programme.

Clinical services strategy

The Trust's key strategic plan is the Clinical Services Strategy 2015–20. At the heart of the strategy is our core aim to deliver the best possible experience and outcomes for our patients. This is supported by four key priorities:

- **Local acute and integrated care services:** Our priorities are integrated urgent and emergency care, efficient planned care and support for ageing well and for those with multiple and chronic conditions

- **Specialised services:** Our priorities are specialised women's and children's services delivered across all of North West London and specialised sexual health and HIV services delivered across London and more widely

- **Innovation and research:** Our priorities are translating research 'from bench to bedside', bringing the best evidence to bear in clinical care and patient experience and establishing the Trust as one of the primary centres for innovation in the NHS

- **Education and training:** Our focus is on multiprofessional training to recruit and retain the best staff to deliver our strategy

This overarching framework is supported by enabling and supporting plans such as:

- **Estates:** Ensuring that our sites and building solutions reflect the clinical vision

- **Clinical systems and Information Technology (IT):** Describing how the clinical and informatics systems and technology solutions enable the clinical services strategy to be delivered

- **People and organisational development:** Ensuring that the right people with the right skills, competencies, values and behaviours are working within the right culture and structure

The clinical services strategy and supporting plans are due to be refreshed in 2020 to reflect the evolving strategic vision for the Trust, and the changes in national and regional policy set out in the NHS long term plan.

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 2021/22. The impact of COVID19 in 2019/20, associated changes to the cash regime for 2020/21 (with block contract and top-up arrangements), in addition to the arrangements of NHS England/Improvement (NHSE/I) to fund specific COVID-19 expenditure, have been taken into account for the Trust's plans and projections, including cash flows, liquidity and income base.

As well as considering regulatory commitments, the directors have a reasonable expectation that the Trust has adequate plans and resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

PERFORMANCE ANALYSIS

How the Trust measures performance

The work of the Trust Board is underpinned by five key committees—namely 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 a number of key performance indicators (KPIs), with associated commentary to explain variances and detail the 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. Trend data is also provided for the last 12 months to enable the Trust Board to track progress over time.

During 2019/20, 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, RTT and cancer. The 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. This provides an opportunity for executive directors to have a more detailed discussion with divisional teams, exploring performance challenges, improvement plans and also to celebrate success and innovation. Divisional performance reviews are supported by the divisional performance information against the Board-level KPIs, supplemented by additional information relevant to divisional priorities.

A comprehensive programme of specialty-based deep dives introduced in 2017/18 are now fully embedded across the organisation. These reviews are executive-led and conducted with specialty multidisciplinary teams to review 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 regulatory performance metrics across both sites and to monitor data quality.

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.

In order to support effective operational performance, the Trust has invested in a team of specialist information professionals who provide analytical support to all in the organisation, and service the Trust's internal and external reporting obligations.

Operational performance

During 2019/20, the Trust has performed well against the key regulatory and contractual performance metrics, including quality and workforce KPIs. The Trust has experienced significant growth in demand, making this a significant achievement based on the national picture.

This year has seen the Trust go through the largest and most nationally ambitious electronic patient record (EPR) system implementation, including the successful deployment of the CernerEPR system on the Chelsea site in Nov 2019. The impact of this cannot be underestimated from a performance perspective, as safe implementation requires a complete cultural, operational and reporting shift to new ways of working. This has made sustaining performance even more difficult over what has been a challenging winter period and, more recently, managing the impact of COVID-19.

Urgent and emergency care

Urgent and emergency care continues to see growth year-on-year despite a number of pathway improvements promoting same-day and ambulatory care pathways, seeking to reduce admission to hospital and improve the length of stay for admitted patients. The Trust has consistently delivered one of the best levels of performance across London and one of the best nationally.

The Trust has played a part in developing modified KPIs for urgent care with the national NHS team. For the latter part of the year and the forward look, the Trust is working to understand what the new normal will be in terms of pathways and managing demand post-COVID-19, working across North West London to continue to deliver high-quality and timely care.

Referral to treatment (RTT)

Throughout 2019/20, RTT performance was delivered each month up until the CernerEPR implementation in Nov 2019, where performance deteriorated. This is in keeping with the Trust's learning from the CernerEPR implementation at the West Middlesex site in May 2018. This was due to an increase in the waiting list and data quality challenges presented with any system migration.

The Trust remains in the top quartile nationally for RTT performance and the stabilisation period post-CernerEPR implementation continues to support recovery. During 2019/20, there were no reportable patients waiting more than 52 weeks to be treated on either site and this is expected to continue. However, the challenges posed with suspension of the elective programme as a result of COVID-19 will make this incredibly challenging.

Cancer

Trust compliance with the two-week wait standard has been excellent. Both of our sites have experienced significant growth in demand with increased referrals compared to 2018/19, yet the organisation has responded well to deliver timely care for our patients.

Performance in relation to the 62-day cancer wait target (GP referral to first treatment) has been the single biggest performance challenge of 2019/20, with a number of months below the national standard.

Reasons were multifaceted and a comprehensive recovery plan delivered near-compliant performance for Q4. This is one of the Trust's key priorities and a significant amount of resource has been prioritised in this area to not only recover performance, but to sustainably deliver a high level of care to our patients for the year ahead.

Diagnostics

The diagnostic standard (ensuring patients receive their diagnostic test within six weeks) has been delivered throughout the majority of 2019/20, with a small number of challenging months.

Although the aggregate position for the year has been impacted by COVID-19 in month 12, the Trust remained on track to exceed the 99% target. However, as a result of the impact of COVID-19 in Mar 2020, the Trust delivered a final position of 98.26%.

Statement on performance—COVID-19

The likely and sustained impact on traditional measures of performance has been well documented in recent months. The Trust has worked extremely hard to ensure that all patients receive appropriate and timely care despite the COVID-19 incident.

The approach to treating patients will change as local and national guidance emerges, and the Trust will continue to respond to that guidance and any return or change to national expectations.

At the time of writing the Trust is working with the North West London sector to understand the impact of COVID-19 on performance—in particular, on elective care pathways. The sector is building a recovery plan which ensures continuity of care for this patient group in the likelihood of further surges of the virus.

Financial performance

The Trust achieved a surplus of £29.5m for the year before reversal of impairments relating principally to land and buildings of £11.4m. This resulted in an adjusted surplus of £10.4m, against the control total of £11.8m surplus. This £1.4m difference is an agreed and NHSE/I-approved adjustment to plan, relating to additional annual leave carried forward at the end of 2019/20 due to COVID-19.

The Trust received provider sustainability and marginal rate emergency tariff funding of £17.8m, this was £0.9m higher than expected.

The Trust delivered £21.7m of cost improvement programmes during the year.

The following table shows the 2019/20 financial outturn against the plan for 2019/20 under NHS Improvement's reporting definitions:

	2019/20 outturn (£m)	2019/20 plan (£m)
Operating revenue	£709.9m	£682.2m
Employee expenses	(£401.4m)	(£363.7m)
Other operating expenses	(£264.2m)	(£283.9m)
Non-operating income and expenses	(£14.8m)	(£16.8m)
Net reversal of impairments and other non-current asset gains/(losses)	(£11.4m)	£0m
Donated asset income (and other prior year income)	(£7.8m)	(£6.0m)
Adjusted surplus on a control total basis	**£10.4m**	**£11.8m**
Net surplus %	1.5%	1.7%

Total operating revenue for EBITDA	£702.7m	£675.9m
Total operating expenses for EBITDA	(£658.9m)	(£629.8m)
EBITDA	**£43.8m**	**£46.1m**
EBITDA margin %	6.2%	6.8%

Year-end cash	**£117.2m**	**£88.4m**

The Trust's finance rating is scored from 1–5 (with 1 being the best) against five metrics set out by NHS Improvement. The Trust's performance and overall score is as follows:

Metric	2019/20 outturn	2019/20 plan
Capital service rating	2	2
Liquidity rating	1	1
I&E margin rating	1	1
I&E variance from plan rating	2	Not included in plan
Agency rating	1	1
Overall use of resources rating	**1**	**1**

During the year, the balance of cash and cash equivalents increased from £100.3m (31 Mar 2019) to £117.2m (31 Mar 2020).

In 2019/20 the Trust invested £34.5m on capital which included £13.1m on the new NICU and ICU wards at the Chelsea site, £4.7m on the CernerEPR system, £4.7m on medical equipment and £2.8m on estates backlog maintenance.

Statement on finance—COVID-19

The Trust incurred additional expenditure during 2019/20 relating to COVID-19 and a reduction in activity and income during Mar 2020 (£3.9m in total), which were reimbursed in full by NHS England and Improvement. The NHS funding and cash regime has changed in the first part of 2020/21 to provide financial support during COVID-19, with block contract, top up arrangements and additional funding of specific COVID-19 expenditure.

Statement on workforce—COVID-19

Keeping our employees safe and well both physically and mentally has never been more important and more challenging in the unprecedented scenario in which they have been working. During the start of the incident there was a clear focus on the physiological needs of staff, such as health and wellbeing hubs, accommodation, travel plans to work, the

introduction of sleep pods across both sites and numerous risk assessments to ensure our vulnerable staff were protected and as safe as possible.

Many staff have been redeployed to wards caring for patients with COVID-19 and ICU, being reskilled through training in short timeframes to contribute to surge staffing plans. Many staff have undertaken roles that look very different to their day job including volunteering to be redeployed from corporate services to the frontline and externally to the NHS Nightingale hospital. The adaptability of our staff has been incredible throughout this period.

Pre-COVID-19, the Trust's sickness level was at 3%, however, at the end of Mar 2020 sickness levels increased to 6%.

Despite the extraordinary circumstances it is clear staff have felt valued with the increased number of health and wellbeing initiatives. The recognition staff have received has been overwhelming, creating a positive work and team culture, with many staff working in new teams. The Trust continues to review the impact on our staff and increase the psychological and emotional wellbeing support, as teams enter the recovery phase, to ensure staff continue to be supported to have the space to rest and recover.

Environmental and sustainability performance

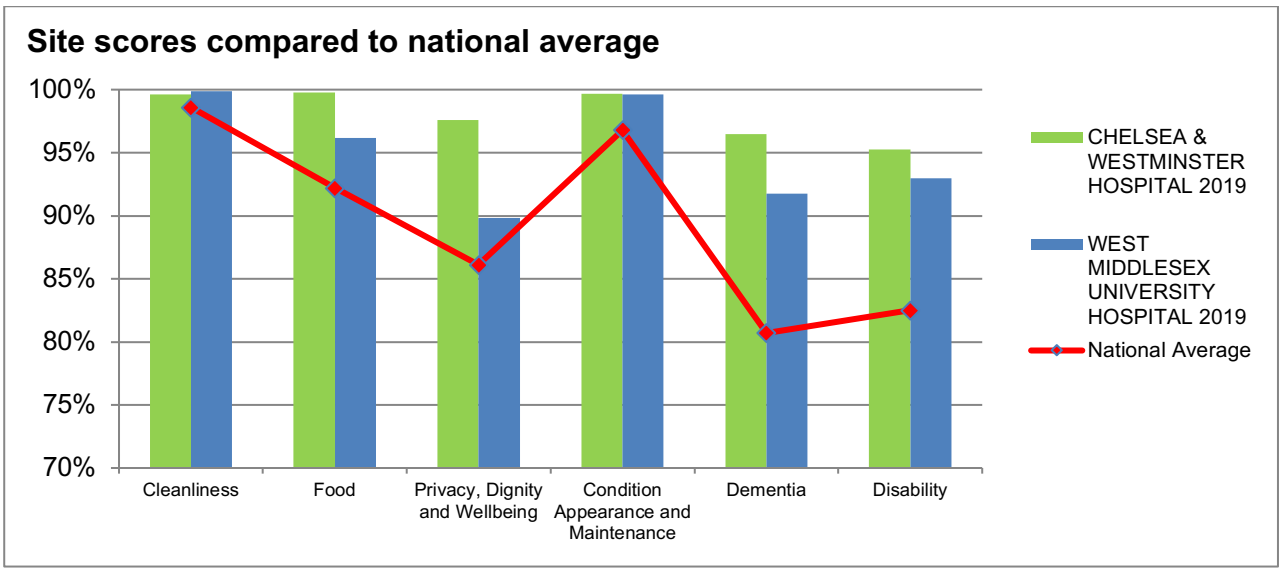
Environmental

The Trust has a growing sustainability programme which continues to minimise our environmental impact. Guided by our sustainability strategy, we are seeking to be a leader in sustainable healthcare, with the aim to further develop our carbon reduction plans.

The ongoing programme includes savings through the efficient use of resources and utilities. In particular, the generation of electricity on each of the main sites, via combined heat and power plants, contributes to an annual energy saving in excess of £1.4m. Further energy reduction schemes include the rollout of LED lighting across all sites, introduction of solar reflective films and a waste heat recovery system.

Patient-led assessments of the care environment (PLACE)

Following the annual PLACE assessments completed in Oct 2019, an action plan was developed to make further improvements to the patient environment. The PLACE scores achieved in Oct 2019 placed the Trust, as a whole, within the upper quartile compared to the London acute teaching hospital peer group across all six domains.



Further improvements are expected with a planned refurbishment of the Nell Gwynne Ward which will significantly enhance the PLACE scores in 2020/21. In particular, this will improve the needs of patients with dementia—for example, corridor handrails, colour schemes, signage and flooring compliant with the latest dementia guidance.

Patient environment

Capital investment and developments continue to improve the hospital environment for patients, including:

- Ambulatory care expansion at both sites—£107,000
- NICU/ICU critical care expansion—£13.1m
- Distribution lift upgrades—£448,000
- Labour suite refurbishment—£603,000

Waste

The Trust, in conjunction with Bouygues Energies & Services Facilities Management Ltd, have 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 at landfill, but will now be processed on site, reducing the carbon transportation to landfill. The waste is used as fuel for biomass energy. Segregating this waste using the behavioural change programme and creating new waste streams will reduce clinical waste volumes and save around £25,000 in the first year.

Water—environmental/legislative

To Trust's target was to reduce water consumption by 15% by the end of the calendar year 2020, based on the 2014 baseline figure of 360,860m^3. The following table highlights a current water consumption reduction to date of 16.4% against the target of 15%.

Water consumption (m^3)	2017/18	2018/19	2019/20
Chelsea and Westminster Hospital	235,344	196,808	123,277
West Middlesex University Hospital	107,014	134,257	186,674
Trustwide	**342,358**	**331,065**	**309,951**

Greenhouse gas (GHG) emissions—financial/environmental

Target: 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 the calendar year 2020 and 80% reduction by 2050.

The Trust has achieved a 41% 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 waste heat recovery system.

Carbon emissions	2015/16	2016/17	2017/18	2018/19	2019/20
Chelsea and Westminster Hospital tCO_2 (from EUETS submissions)	15,212	15,510	10,930	8,904	9,382
West Middlesex University Hospital tCO_2 (from CRC submissions)	7,284	6,815	6,525	5,608	3,934
Trustwide tCO_2	**22,496**	**22,325**	**17,455**	**14,512**	**13,316**

Emissions reduction	**Base year**	(170)	(5,040)	(7,983)	(9,180)
		1%	22%	35%	41%

Social, community, anti-bribery and human rights issues

Engagement with our patients and the wider community continues to be of upmost importance to the Trust and contributes to our understanding of what people need and expect from the services we provide.

We are proactive in our engagement with our patients and the wider community and have active patient groups who help codesign our services, such as the Maternity Voices Partnership Group. Open days are held at both main hospital sites as part of the Trust's community engagement activities. We continue to promote key initiatives such as offering work experience opportunities for students with autism from our local communities. Our Council of Governors are a valuable partner in our engagement activities, offering patients and members of the public regular opportunities, such as 'meet a governor' sessions on both of our main hospital sites.

Community

The Trust is committed to supporting national campaigns to improve the health and wellbeing of our patients and local communities. Working in partnership with various external partners, we have been able to reach out to patients on a range of health issues. For instance, this year the Trust has been working closely with partner organisations, such as the charitable foundation of Chelsea Football Club, to identify ways of supporting young people with mental health needs in the community. A variety of community activities were hosted in our organisation, such as World AIDS Day and Windrush Celebrations at both hospital sites.

Equality and diversity

During 2019/20 the Trust's work on embedding equality, diversity and inclusion for patients and staff has continued to develop in line with national developments. Highlights from the year include:

- Agreed patient equality objectives for 2019–21
- Trust support to implement the 'improving race equality through promoting fairness' action plan
- Trust Board and senior managers attended a race equality development session administered by the national Workforce Race Equality Standard (WRES) team
- Launch of the Black, Asian and Minority Ethnic (BAME) staff network on International Windrush Day in Jun 2019
- Developed a methodology to ensure a 'check and challenge' process is used when investigations and disciplinary action is being considered
- Refreshed recruitment training to ensure sufficient emphasis on diversity, culture and inclusion issues
- Identified and trained interview experts from diverse backgrounds to support and participate in interview panels for senior management roles
- Our women's network appointed new joint chairs to take forward the group, including specific actions relating to the gender pay gap
- An LGBTQ+ staff network was launched in Jan 2020 following staff focus groups in Nov/Dec 2019
- The Trust continues to work towards full compliance with the accessible information standard, identifying and supporting patients' specific communication needs and raising awareness to all staff
- The Trust established an accessibility working group with the aim to identify the accessibility needs for disabled staff, patients and members of the public using our services, and to prioritise these against an evidence-based framework.

Learning disabilities

The Trust has continued to work with people who have learning disabilities to improve their access to and experience of care. The lead nurse for learning disabilities has developed a network of nurses across the organisation who have had additional training to support patients with learning disabilities in our care.

In line with the national direction, there continues to be a focus on learning from deaths for patients with learning disabilities. Mortality and morbidity reviews are undertaken for every patient and the learning from these reviews shared widely throughout the organisation and nationally.

The deployment of CernerEPR, the new electronic patient record system, has provided the opportunity to redefine the information collected in relation to learning disabilities and improve the central recording of patient specific needs to individualise care delivery. The Trust continues to use the learning disability passport, which gives staff information about patient preferences for care.

The Trust is currently exploring the addition of a Changing Places facility at the West Middlesex site to complement the facility offered at the Chelsea site. The facility supports patients with disabilities and their carers to have personal care in a private and dignified environment.

The Trust has an active programme of learning disability staff training and a learning disabilities steering group involving staff, the local authority, third-sector organisations, patients and carers.

The Trust has been engaged with Project Search, placing young people with learning disabilities into intern positions throughout the organisation to gain a wide range of work experience and life skills. Of the eight students supported in 2019/20, five have been offered substantive roles within the organisation, with continuing support in place for the remaining three students.

Safeguarding

The Trust actively engages with Local safeguarding adult and safeguarding children boards. The Trust has a dedicated team of professionals who work to protect vulnerable adults and children. The Trust has named executive leads responsible for safeguarding adults and children. There are named lead individuals for both safeguarding children and adults who report regularly through the governance structure to the Trust's Quality Committee. The Trust has a team of Independent domestic violence advisors to support patients and staff who are affected by domestic abuse. The Trust has also invested in mental health leads to support the care of these patients while they are in our hospitals.

The safeguarding teams deliver extensive training programmes throughout the organisation to support frontline staff. The Trust offers a range of mandatory and additional training in all areas of safeguarding for both children and adults which are well-attended and positively evaluated by Trust staff.

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 2019/20 to provide local counter-fraud specialist services in accordance with secretary of state directions. The 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

The Trust is committed to developing a leading volunteer service within healthcare and launched a volunteer services strategy in 2019. Volunteers do not replace roles within the substantive workforce but focus on adding value to the experience of staff and patients. The Trust serves a large, diverse local population who largely form our volunteering teams. Volunteers have a clear identity, role and remit within the organisation. They are recognised for their contribution and work across all areas to augment and enhance the experience of care for our patients. Volunteers undergo appropriate screening and receive high-quality, relevant orientation and training appropriate to their roles. Furthermore, they are supported to feel part of the team at the Trust.

The Board is fully committed to the volunteer services strategy, along with our official charity CW+, supporting the integration of volunteers into all areas of our services. The Board champions the role of volunteers within the organisation, recognising their contribution to our patients, families and our staff. This year our volunteer service has decreased the time to recruit and deploy volunteers into a range of services. This has included a pilot in end-of-life care, and the ward helper role in adult inpatient areas.

The Trust aspires to be a centre of excellence for volunteering within healthcare. The use of volunteers within our services transforms the way in which care is provided, the experience of care by our patients, and the role satisfaction felt by our staff and volunteers. To achieve this, we will:

- Recruit, train and deploy 900 volunteers by 2021
- Support, develop and celebrate the contribution of our volunteer team
- Develop a volunteer services infrastructure which will evolve and develop with the service across our sites
- Expect and actively encourage all departments to embrace volunteers and their contribution
- Contribute to the body of literature on the impact and value of volunteering within healthcare
- Continue to contribute to and learn from the national agenda in relation to volunteering and through our association with Helpforce

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 a number of directors of the Trust Board are CW+ Trustees. During 2019/20 these included the Trust's Chief Executive Officer Lesley Watts, Chief Medical Officer Zoë Penn[1] and two Trust non-executive directors, Nick Gash and Liz Shanahan[2]. This shared governance arrangement is designed to ensure clear alignment between the strategic priorities of the Trust and the charity. The most significant areas of support provided to the Trust by CW+ during 2019/20 are summarised below.

[1] Left the Trust Board in Apr 2020
[2] Left the Trust Board in Nov 2019

Transforming our Estate

The Trust and CW+ are now in the third year of our significant capital redevelopment programme to transform both the adult and neonatal intensive care units at the Chelsea site. Once fully completed in 2021, we will be able to offer 2,000 critically ill patients exceptional care each year, using the latest equipment and technology, in world-class environments. These new units will offer families and staff much-improved facilities, which we hope will act as a blueprint in healing and clinical design throughout the NHS. CW+ completed a £12.5 million fundraising campaign towards this project last year and are also leading on the creation of a new 'sky garden' adjacent to the adult intensive care unit on the 5th floor of the hospital. This new area will create a quiet, tranquil space with nature for patients, families and staff outside of the unit and a destination for rehabilitating patients. The charity has also been conducting a broad array of research, including funding a new psychology service, to explore how the environment can affect patients in intensive care, and how best to support patients to prevent delirium (a very common condition for patients who have received critical care support).

Thanks to the generosity of the Reuben Foundation, CW+ transformed the environment of the maternity unit at Chelsea and Westminster Hospital, which was officially opened in May 2019 by mayor of London Sadiq Khan. The new maternity centre offers adaptable environments with bespoke digital artwork, adjustable lighting levels and the ability to play personalised birthing playlists, both in delivery rooms and in our state-of-the-art operating theatres.

The CW+ Sun and Stars Appeal to transform the children's wards at the West Middlesex site successfully met a £150,000 fundraising target. A new teenage space and children's playroom have been created which young patients are currently enjoying, with the remainder of the renovations to be completed by the end of the calendar year 2020.

Grants and innovation

CW+ continues to offer a discretionary grants programme, funding £500,000 to projects which support patient care and experience. The majority of grants are applied for by staff, many of which are innovative projects aiming to improve the quality of care for patients, alongside increased efficiency and cost savings for the Trust. The charity hosted a special 'nurses and midwives' funding call in 2019 which was very successful and resulted in a number of innovative staff-led projects receiving funding. CW+ also launched a new fund to support staff wellbeing.

In partnership with CW+, we were delighted to officially launch our innovative programme CW Innovation in 2019. Our vision is to become a global leader in healthcare innovation. We want to deliver the best possible care and experience for patients in our hospitals, across the NHS and beyond.

Working with a range of partners, including Sensyne, Nova and the DigitalHealth London Accelerator, CW Innovation is the only programme of its kind in a UK acute organisation which identifies and tests high-impact innovations to improve patient care, patient experience and operational efficiency. CW Innovation now has a pipeline of more than 70 health innovation projects for the Trust, including sensor technologies, remote wearable monitors, new clinical devices, digital rehabilitation, virtual clinics, smartphone apps and many more.

Arts in Health

The charity published a new book in June 2019, *The Healing Arts*, celebrating their pioneering arts in health programme which has been running for more than 25 years. CW+'s award-winning Arts in Health programme continues to combine digital, visual and performing arts, with innovative design to transform the environment of our hospitals and the experience for our patients, families and staff.

The charity's participation programme, Arts for All, has expanded at both our hospital sites, offering patients a diverse variety of creative opportunities to improve their health and wellbeing. CW+ funded a PhD thesis, published in Jul 2019, to evaluate this programme. This research was the first of its kind in the UK and demonstrated that engagement with art can reduce isolation, increase quality of life, improve wellbeing and lower anxiety.

CW+ were chosen as Charity of the Year by the Mayor of the Royal Borough of Kensington and Chelsea Cllr Will Pascall. With support from the mayor, the charity aims to expand their Arts for All programme to reach beyond the hospital walls to support people in the community to stay well, connect with others and live independently.

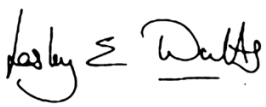
Another exciting part of CW+'s Arts in Health programme is exploring how new technologies, including companion robots, virtual reality and personalised digital environments can reduce anxiety and support staff in the delivery of care.

Celebrating our history

2019 saw us celebrate the 300th anniversary of Chelsea and Westminster Hospital's predecessor, the Westminster Hospital. To mark this historic occasion, together with CW+ we held a commemorative service on 23 May at Westminster Abbey, attended by past and current staff, patients, volunteers, supporters, MPs and NHS dignitaries. This special service recognised the pioneering forefathers who founded the Westminster Hospital in 1719, the first hospital in the world funded by charitable giving, which continued to grow and become Chelsea and Westminster Hospital in 1993.

To honour our remarkable history, CW+ also installed a heritage timeline and permanent public exhibition at the Chelsea site. Thanks to support from the National Lottery Heritage Fund, this exhibition includes artefacts from the hospital archives, oral accounts and memories from past staff, and a variety of film footage and photographs documenting the Trust's history.

We are looking forward to marking the 100th anniversary of West Middlesex University Hospital throughout 2020, with a heritage exhibition and celebration event for the local community.



Lesley Watts
Chief Executive Officer

18 June 2020

SECTION 2

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Names of Trust directors during 2019/20

Name	Title	Period	Unexpired term
Sir Tom Hughes-Hallett	Chairman	1 Feb 2020–present	2 year 10 months
Aman Dalvi	Non-executive Director	1 Dec 2019–present	2 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	Non-executive Director	1 Nov 2017–present	0 year 7 months
Eliza Hermann	Non-executive Director	1 Jul 2014–present	0 year 3 months
Jeremy Jensen	Deputy Chairman and Senior Independent Director	1 Jul 2014–present	0 year 3 months
Dr Andrew Jones	Non-Executive Director	1 Jul 2014–present	0 year 3 months
Ajay Mehta	Non-Executive Director	1 Dec 2019–present	2 year 8 months
Liz Shanahan	Non-Executive Director	1 Jul 2014– 30 Nov 2019	n/a
Lesley Watts	Chief Executive Officer	14 Sep 2015–present	n/a
Sandra Easton	Chief Financial Officer	7 Apr 2016–30 Sep 2019	Left 30 Sep 2019
Robert Hodgkiss	Deputy Chief Executive and Chief Operating Officer	7 Apr 2016–present	n/a
Virginia Massaro	Acting Chief Financial Officer	1 Oct 2019–present	n/a
Pippa Nightingale	Chief Nursing Officer	18 Jul 2016–present	n/a
Zoë Penn	Chief Medical Officer	1 Mar 2013–3 Apr 2020	Left 3 Apr 2020
Thomas Simons	Director of HR & OD	4 Mar 2019–present	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 ft.secretary@chelwest.nhs.uk 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 2019/20.

The 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	2019/20 n°	2019/20 £000
Non-NHS payables		
Total non-NHS trade invoices paid in the year	94,251	260,264
Total non-NHS trade invoices paid within target	89,542	221,086
Percentage of non-NHS trade invoices paid within target	**95.0%**	**84.9%**
NHS payables		
Total NHS trade invoices paid in the year	3,860	54,368
Total NHS trade invoices paid within target	2,946	47,172
Percentage of NHS trade invoices paid within target	**76.3%**	**86.8%**
Totals		
Total trade invoices paid in the year	98,111	314,632
Total trade invoices paid within target	92,488	268,257
Percentage of total trade invoices paid within target	**94.3%**	**85.3%**

Well-led framework

It is of paramount importance to ensure that the Trust is well-led so that the services are safe and patient-centred.

In Nov 2019 we welcomed the Care Quality Commission (CQC) to inspect our services, which included a well-led inspection and a use of resources inspection by NHS Improvement. The Trust maintained the rating of 'good' overall, seeing an improvement in well-led rating from 'good' to 'outstanding', and maintaining the use of resources rating of 'outstanding'. The Chelsea site improved the overall rating from 'good' to 'outstanding', and the West Middlesex site maintained the overall rating of 'good'.

Critical care services at Chelsea site improved their overall rating from 'good' to 'outstanding', and maternity services at the Chelsea site were rated 'outstanding' in the responsive domain. At the West Middlesex site, maternity services improved their overall rating to 'outstanding', being rated 'outstanding' within the effective and responsive domains. The Trust received no 'must do' actions and the inspection report highlighted 31 examples of outstanding practice.

The inspection identified 22 'should do' action for the organisation which have been embedded in our quality improvement processes. Progress is monitored by the Quality Committee and the Trust Board. The organisation undertakes annual self-assessments against the CQC well-led framework and has regular peer observers at Board meetings to inform our development, including the CQC and NHS Improvement.

An overview of the arrangements in place to govern service quality are included in the annual governance statement and will be included in the quality report which will be published separately as per the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The arrangements include a clear 'ward to board' assurance framework, which includes quality, workforce, performance and finance. The Quality Committee seeks assurance on systems, processes and outcomes relating to quality (safety, clinical effectiveness and patient experience) on behalf of the Trust Board.

To the best of the directors' knowledge, there are no known material inconsistencies between:

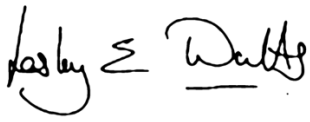
- The annual governance statement
- The corporate governance statement and annual report
- Reports arising from the CQC inspections and the Trust's consequent action plans

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

18 June 2020

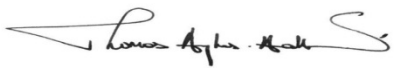
REMUNERATION REPORT

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 2019/20, the committee met on one occasion to consider a number of 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.

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.



Sir Thomas Hughes-Hallett
Chairman of Nominations and Remuneration Committee

18 June 2020

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 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 2019/20.

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 also 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 on page 49.

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 the 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

	Salary/fees	Taxable benefits	Annual performance-related bonus	Long term-related bonus	Pension-related benefits
Framework used to assess performance	Trust appraisal system	none disclosed	n/a	n/a	n/a
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 table *Names of Trust directors during 2019/20* on page 41.

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 2019/20.

Nominations and Remuneration Committee

The executive Nominations and Remuneration Committee is chaired by Sir Thomas Hughes-Hallett, 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 that 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 2019/20 may be found in the section *NHS Foundation Trust Code of Governance Disclosures* from page 78.

Disclosures required by Health and Social Care Act

The Trust is governed by a Board of Directors. At 31 Mar 2020, the Board comprised nine non-executive directors (including the chairman) and six executive directors (including the chief executive). There are 30 governor positions (29 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
2019/20			
Governors	27	7	1.59
Directors	15	6	2.05
2018/19			
Governors	26	3	0.37
Directors	14	3	0.62

Senior manager remuneration tables

Senior manager remuneration 2019/20[3]

Name and title	Salary	Expense payments (taxable)	Performance related bonuses	All pension related benefits	Total	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 Mar 2020	Lump sum at pension age related to accrued pension at 31 Mar 2020	Cash equivalent transfer value at 1 Apr 2019	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 Mar 2020
	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000	£000	£000
Executive directors[4]												
Lesley Watts, Chief Executive[5]	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[6]	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 Exec/Chief Operating Officer[5]	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[5, 7]	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[8]	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

3 NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement. During the year, the government announced that public sector pension schemes will be required to provide indexation on the guaranteed minimum pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

4 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

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

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

7 Left the Board on 30 Sep 2019

8 Appointed to the Board on 1 Oct 2019

Name and title	Salary	Expense payments (taxable)	Performance related bonuses	All pension related benefits	Total	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 Mar 2020	Lump sum at pension age related to accrued pension at 31 Mar 2020	Cash equivalent transfer value at 1 Apr 2019	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 Mar 2020
	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000	£000	£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
Steve 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[9]	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[9]	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[10]	5–10	0	0	n/a	5–10	n/a	n/a	n/a	n/a	n/a	n/a	n/a

[9] Appointed to the Board 1 Dec 2019
[10] Left the Board 30 Nov 2019

Senior manager remuneration 2018/19

Name and title	Salary	Expense payments (taxable)	Performance related bonuses	All pension related benefits	Total	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 Mar 2019	Lump sum at pension age related to accrued pension at 31 Mar 2019	Cash equivalent transfer value at 1 Apr 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 Mar 2019
	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000	£000	£000
Executive directors												
Lesley Watts, Chief Executive[11]	255–260	0	0	n/a	255–260	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Karl Munslow-Ong, Deputy Chief Executive[12]	95–100	0	0	27.5–30	125–130	0–2.5	0–2.5	30–35	65–70	340	84	424
Zoë Penn, Chief Medical Officer[13]	195–200	0	0	115–117.5	310–315	5–7.5	5–7.5	85–90	155–160	1,380	254	1,634
Rob Hodgkiss, Chief Operating Officer[11]	185–190	0	0	n/a	185–190	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sandra Easton, Chief Financial Officer[11]	175–180	0	0	n/a	175–180	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pippa Nightingale, Chief Nursing Officer	145–150	0	0	132.5–135	280–285	5–7.5	10–12.5	40–45	95–100	491	177	670
Thomas Simons, Director of Human Resources and Organisational Development[14]	10–15	0	0	52.5–55	60–65	2.5–5	0.00	20–25	0	182	57	240
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
Steve 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

[11] Figures for CETV are not available as the individuals are no longer part of the NHS pension scheme
[12] Left the Board on 4 Nov 2018
[13] The remuneration of the Chief Medical Officer includes £52,500 in respect of her clinical role
[14] Appointed to the Board on 4 Mar 2019

Name and title	Salary	Expense payments (taxable)	Performance related bonuses	All pension related benefits	Total	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 Mar 2019	Lump sum at pension age related to accrued pension at 31 Mar 2019	Cash equivalent transfer value at 1 Apr 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 Mar 2019
	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000	£000	£000
Non-executive directors, continued (2018/19)												
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
Liz Shanahan, 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
Gary Sims, Non-Executive Director[15]	0–5	0	0	n/a	0–5	n/a	n/a	n/a	n/a	n/a	n/a	n/a

[15] Left the Board on 30 May 2018

Fair pay multiple

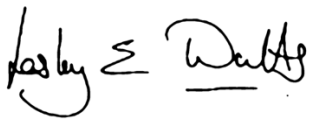
The banded remuneration of the highest paid director in the Trust in the 2019/20 financial year was £275,000–280,000 (2018/19: £255,000–260,000). This was 6.95 times the median remuneration of the workforce (2018/19: 6.56 times), which was £40,270 (2018/19: £39,239).

In 2019/20, zero employees received remuneration in excess of the highest paid director (2018/19: zero). Remuneration ranged from £12,000 to the highest paid director banded remuneration of £275,000–280,000 (2018/19: £12,000 to the highest paid director banded remuneration of £255,000–260,000).

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

Definition of 'senior managers'

The definition of 'senior managers' for the purpose of this 2019/20 report is those persons in voting executive director or non-executive director roles within the organisation.



Lesley Watts
Chief Executive Officer

18 June 2020

STAFF REPORT

Analysis of staff costs

Employee expenses	2019/20 total £000	2019/20 permanently employed total £000	2019/20 other total £000
Salaries and wages	311,983	268,244	43,739
Social security costs	33,056	30,132	2,924
Apprenticeship levy	1,503	1,503	0
Pension cost—defined contribution plans (employer's contributions to NHS pensions)	33,220	31,563	1,657
Pension cost—employer contributions paid by NHSE on provider's behalf (6.3%)	14,616	13,887	729
Pension cost—other	37	37	0
Temporary staff—agency/contract staff	15,248	0	15,248
Total staff costs	**409,663**	**345,366**	**64,297**

Analysis of average staff numbers

Average number of employees (WTE basis)

Employee	Substantive	Other	2019/20 total	2018/19 total
Medical and dental	1,193	120	**1,313**	1,256
Ambulance staff	0	0	**0**	0
Administration and estates	1,198	200	**1,398**	1,364
Healthcare assistants and other support staff	762	206	**968**	995
Nursing, midwifery and health visiting staff	2,224	334	**2,558**	2,508
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical staff	549	49	**598**	573
Healthcare science staff	0	0	**0**	0
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**5,926**	**909**	**6,835**	**6,696**
Of which:				
Number of employees (WTE) engaged on capital projects	63	43	**106**	138

Breakdown of employees

The following chart provides information of the gender split between the different staff groups as at 31 Mar 2020:

Employee	Female	Male	Total
Executive director	4	2	6
Non-executive director	1	8	9
Senior manager	85	83	168
Other	4,723	1,487	6,210
Total	**4,813**	**1,580**	**6,393**

Sickness absence

The chart below details the Trust's sickness absence data for 2019/20:

Sickness absence	2019/20 (n°)	2018/19 (n°)
Total days lost	67,935	55,317
Total staff	5,763	5,530
Average working days lost per whole time equivalent	12	10

Staff health and wellbeing

The Trust recognises that there is clear evidence supporting the link between staff health and wellbeing and safe patient care and is committed to continually working to improve the health and wellbeing of staff. We believe individuals should be treated fairly in all aspects of their employment, including training, career development and promotion, regardless of disability or any other protected characteristic. We aim to create a culture which respects and values individual differences and encourages individuals to develop and maximise their true potential.

The Trust has devised a staff health and wellbeing (HWB) plan which consists of five objectives. These are:

- Ensure visible Board and executive ownership of staff health and wellbeing
- Develop a framework which provides a focus for staff HWB activities
- Continue to work in partnership with a range of stakeholders to deliver existing HWB commitments and develop new innovations
- Develop a comprehensive evaluation framework to monitor the effectiveness of this plan
- Work with Trust leads to review and refresh organisation policies relevant to staff HWB

The plan's objectives and activities incorporate feedback from staff about the HWB interventions that they value as reported in the 2018 NHS staff survey—for example, access to emotional/psychological support. It has also been developed in light of guidance and good practice arising from the NHS Health and Wellbeing Framework 2018. An evaluation of the activities which took place during the Trust's health and wellbeing week from 1–5 Jul 2019 have also informed the development the Trust's plan.

The Trust has 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.

In accordance with the Trust policies on sickness absence and equality and diversity, the occupational health department offers advice to both managers and staff on appropriate working arrangements, which may include reasonable adjustment or modifications to working hours to accommodate a medical condition. Reasonable adjustments are specific to individuals and could include making adjustments to premises, duties, working hours or acquiring or modifying equipment. The Trust also seeks guidance from specialist external agencies, such as Access to Work, where necessary.

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

The Trust established a Health and Wellbeing Committee to develop a framework and plan to provide a focus on wellbeing activities. As a result, a wide range of targeted and innovative wellbeing programmes are available for staff. These include regular health and wellbeing events, access to physiotherapy, ongoing exercise classes, staff benefit platforms, mental health awareness and support, mindfulness and counselling services. Work is underway to introduce a network of 'mental health at work' first aiders and health and wellbeing champions to support our strategy.

The Trust has achieved foundation level status for the London healthy workforce charter in 2019 and is working towards achievement and excellence status. This is a way for the Trust to focus on priorities using an evidence-based framework and recognition of good practice through accreditation.

Staff engagement

The Trust recognises that an engaged workforce will provide improved quality of care and was pleased to see that staff engagement scores improved in this year's staff survey.

Our approach is wide-ranging, including engagement events, such as a monthly Team Briefing, where staff present their improvement work within the organisation. The executive team continues to play an important role in the corporate welcome for new joiners. 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.

Other events have been held to raise awareness of opportunities for staff, such as apprenticeship week, where we hosted a tea party for existing apprentices, and awareness days for other staff to explore available opportunities.

National NHS staff survey 2019

Towards the end of 2019, questionnaires were sent to 5,996 staff, of which 2,758 staff took part in this survey, giving us a response rate of 46%. This was a 5% increase in participation from 2018. An additional theme—teamworking—has been added to the benchmark report. The 11 key themes are listed below:

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

The following table shows the Trust and the average scores in 2019 as well as the results for the last two years.

Indicator	Trust score 2019	Average for acute trusts 2019	Trust score 2018	Average for acute trusts 2018	Trust score 2017	Average for acute trusts 2017
Equality, diversity and inclusion	8.6	9.0	8.7	9.1	8.7	9.1
Health and wellbeing	5.8	5.9	5.8	5.9	6.1	6.0
Immediate managers	6.9	6.8	6.9	6.7	6.9	6.7
Morale	6.0	6.1	6.1	6.0	n/a	n/a
Quality of appraisals	6.3	5.6	6.0	5.4	6.1	5.3
Quality of care	7.8	7.5	7.7	7.4	7.7	7.4
Safe environment (bullying and harassment)	7.6	7.9	7.7	7.9	7.7	8.0
Safe environment (violence)	9.3	9.4	9.3	9.4	9.3	9.4
Safety culture	6.9	6.7	6.9	6.7	6.9	6.6
Staff engagement	7.3	7.0	7.3	7.0	7.3	7.0
Teamworking	6.9	6.6	6.8	6.5	6.8	6.5

Headlines

The overall results of the 2019 staff survey show that the Trust has not moved significantly in the majority of the 11 themes, with the exception of quality of appraisals, where there has been a statistically significant increase from 6.0 in 2018 to 6.3 in 2019. The Trust results are above average on six of the themes and below average for the other five. The Trust has an extensive action plan in place aligned to the findings of the survey.

Areas of strength

- Topics above the national average were also above the national average in 2018 and therefore have been maintained—these are staff engagement, immediate managers, quality of appraisals, quality of care, safety culture and teamworking

- While the quality of appraisals demonstrated the largest improvement, there were also improvements to the quality of care and teamworking

- While the Trust is below national average for health and wellbeing, within this topic it is now above national average with regard to the opportunities for flexible working patterns

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 10% of staff who participated in the survey stated that in the last 12 months they had personally experienced discrimination at work from their manager/team leader or other colleagues

- Morale is a key priority for improvement, as more than 26% 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, a 1% increase from 2018.

- Within the topic of safe environment (bullying and harassment), more than 20% of staff who participated in the survey stated that they had experienced at least one episode of harassment, bullying or abuse at work from other colleagues.

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 information for 2018/19 is published at www.chelwest.nhs.uk/edi.

Workforce gender split

As at 31 Mar 2020 the total relevant paid workforce was 6,393 staff across all sites and staff groups.

Gender	Number of staff	% split of the workforce
Male	1,577	24.67% of the total workforce
Female	4,816	75.33% 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 %	**17.72%**	**11.04%**

The gender pay gap when expressed as a mean average shows that female staff earn 17.7% 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 11.0% 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 2019 there were 482 consultants at the Trust of which 51% were male and 49% female.

Gender	Average pay	Median pay
Male	14,726.24	9,048.00
Female	11,306.26	9,048.00
Difference	3,419.98	0
Pay gap %	**23.22%**	**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	75.06	24.94
2	1,290	310	80.63	19.38
3	1,297	292	81.62	18.38
4	997	613	61.93	38.07

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 2018 to 31 Mar 2019.

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	21
Number of full-time equivalent employees as at 31 Mar 2019	6,180

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

	2019/20
0%	10
1–50%	10
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	£83,000
Total pay bill	£372,019,000
% 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	0.86%

Workforce improvement activity

Recruitment and retention

The Trust has continued with a number of activities to reduce vacancy rates. This has included several initiatives to maximise opportunities such as local, national and international recruitment drives, as well as guaranteed job offers for student nurses, a process for fast-tracking temporary staff to permanent roles and the launch of the Capital Nurse Project. The main focus has been to reduce the qualified nursing vacancy rate to 10% which, as at 31 Mar 2020, is 4.93% with an overall Trust vacancy rate of 6.77%.

Following a review of the recruitment process, a number of initiatives have also been introduced to improve the robustness of the overall recruitment and selection process. These include equality, diversity and inclusion (EDI) programmes such as introducing diversity and inclusion champions to the Trust, rolling out EDI-based interview skills training and developing comprehensive guidance, interview documents and scoring mechanisms for hiring managers.

Recruitment time to hire has continued to reduce across all non-medical staff groups from 15 weeks in previous years to an average of 8 weeks in 2019/20 and currently stands at 8.4 weeks as of Mar 2020, which is within the Trust target of 9 weeks.

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

Retention of our staff remains one of the key priorities for the Trust. The Trust is putting actions in place to reduce turnover to 13%. This focuses on the following key themes:

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

As at the end of Mar 2020 the Trust had reduced overall turnover in the year from 19.10% to 17.96% and voluntary turnover from 14.3% to 13.7%.

Pre-retirement and mid-year financial planning programmes continue to be available as part of our retention strategy, assisting staff to identify how they can retire and return to the Trust to continue service.

So far, we have introduced a manager training programme to supplement our leadership training programmes and offer additional extended skills training, career clinics and an enhanced staff benefits package.

Performance and development reviews (PDRs)

The Trust continues to recognise the value of PDRs and this was acknowledged in the staff survey this year with a rise from 6.0 to 6.3 out of 10 staff stating that they have experienced an improvement in the quality of appraisals (PDRs) in the Trust. In response to 'The values of my organisation were discussed as part of the appraisal process', 48.5% of staff selected 'Yes, definitely'. This is nearly 10% above the national average score of 37.8%.

We continue to have an annual PDR rate of 88% of staff having had a PDR in the past 12 months. From Apr 2020, PDRs will be completed on the anniversary of joining to link with the new terms and conditions.

Professional development

Core training (statutory and mandatory) compliance was 93% as at the end of Mar 2020 compared to the required target of 90% (95% for information governance). Additional (non-core) topics have also been made available via our eLearning platform over the past year with positive feedback from staff regarding flexibility of access.

In support of the Trust's wellbeing strategy, the Trust continues to provide resilience training utilising the Insights Discovery model and emotional intelligence sessions to support staff in managing day-to-day challenges. During 2019/20 an additional 358 staff attended a resilience workshop—in total, almost 20% of staff have attended a session since this training was offered. Resilience training is integral to the leadership and preceptorship programmes with additional provision made for team-specific interventions.

Other department specific support offered during the year include coaching skills for managers, communication skills and customer service training.

In 2019/20 the Trust has built an in-house offering for quality improvement training in line with the Trust's Quality Strategy 2019–24 to build improvement capability and capacity across the organisation. The central quality improvement team has trained 335 staff as 'improvement participants', and 24 staff have attended 2-day 'improvement leaders' training.

Leadership development

The emerging leaders and established leaders development programmes have been evaluated and updated to reflect Trust priorities and continue to be delivered to multidisciplinary cohorts of staff. Our emerging leaders development programme in particular continues to prove popular and has been undertaken by 221 staff from multiple

disciplines, while our established leaders programme has been undertaken by 160 staff in senior roles.

Through both programmes we have seen transformation projects implemented, combined with learning around leadership principles. As their careers have progressed, 16 staff have completed both programmes.

The Trust concluded its 4-year partnership with Healthskills for the delivery of our established leaders programme, and we will be utilising the apprenticeship levy in the future for this population (levels 6 and 7 qualifications). The success of the partnership with Healthskills resulted in being shortlisted for an *HSJ* Partnership Award in 2019.

Late in the year we introduced a new management fundamentals programme to ensure new and existing managers are equipped with the necessary skills and knowledge at the earliest opportunity.

Clinical development

The new clinical education programmes delivered this year address the changes in the standards of supervision and assessments for all students and staff. The Trust was actively involved and participated in the transformation of the local and national standards of practice. Clinical skills training has been updated, encompassing combined learning methods to ensure we address learning and development needs. The Nursing and Midwifery Council proficiencies for nurses will upskill all existing staff to meet the national requirements. The clinical learning and development team has also been very active supporting the implementation of new clinical devices across the Trust, which includes the implementation of the CernerEPR system.

The Trust has continued to deliver preregistration, undergraduate and postgraduate training for nursing, midwifery, medicine and allied health professionals. Supporting our students across disciplines is essential to securing an effective, competent workforce and nurtures our future employees. Following the introduction of the apprenticeship programme this year we have seen an increase of nursing associates, registered nurse degree apprenticeships, midwifery apprentices and allied health programmes. Workforce development is a key strategy for retention of competent staff. Over the past year the Trust, in collaboration of Health Education England, has supported staff members to attain continuous personal development for academically accredited qualifications.

The clinical learning and development department has also embarked in supporting the advanced care practitioner programme with our staff progressing to become advanced practitioners, either through the master's degree level or through the apprenticeship route. We also saw an increase in the numbers of non-medical prescribers. The new nurse preceptorship programme outlines the framework of the pan-London capital nurse programme in supporting our newly qualified nurses with their skills, competencies and confidence. The newly formatted multidisciplinary simulation training was introduced to improve team working, quality care and patient safety. We also trained more than 350 international nurses and are very proud to say our colleagues have a 100% pass rate with their objective structured clinical examinations (OSCEs). The strategy for our clinical development is aligned to sustainability and transformation partnership priorities to meet the changing demands of our communities and services.

The medical education teams continue to deliver quality education interventions for medical students and junior doctors in training across our sites. This is supported by simulation training on both main sites and Medical Mondays on the West Middlesex site. A junior and senior leadership programme has been developed and successfully delivered for doctors in training. A PACES course was delivered at the West Middlesex site this year and mock OSCE programmes continue to be delivered for medical students. Other programmes include communication skills, 'train the trainer', 'teach the teacher' and interview practice sessions for junior doctors. The Trust's risk fellow is an individual who continues to support juniors involved in incidents and works with teams to reduce risks and learn from errors.

The education fellows have developed their skills and undertake PGCerts while in post with some of their work being recognised internationally with poster presentations. The fellows have also run a 'make me a medic' course on both main sites encouraging young people who are considering a career in medicine. Finally, the grand round has been refreshed on both main sites which has improved attendance and engagement.

Recognition schemes

The Trust continues to recognise staff each month with the PROUD awards and we have seen many staff recognised for going above and beyond in their contribution to the Trust. The annual staff awards were held in November with many staff recognised for their outstanding contribution to the Trust. In December the long service awards were presented to many staff serving the Trust from 10–50 years' service.

Apprenticeships

Clinical and non-clinical apprenticeships continue to be used in the Trust to support and develop staff in their roles. More than 2.3% of Trust staff are currently completing an apprenticeship which meets the national target. The Trust is now working with STP partners and recently procured for human resources apprenticeships and a master's degree level senior leaders programme. We have maintained our registration as an apprenticeship training provider for the HCA Apprenticeship. National Apprenticeship Week was an opportunity to celebrate the contribution of existing apprentices in the Trust, while also raising the organisation's awareness about the available apprenticeship opportunities.

Work experience

This was another great year for the work experience programme in the Trust as we saw an increase in the number of young people taking part in placements across our sites. We witnessed increased growth and engagement from young people exploring the variety of careers within the NHS, both clinical and non-clinical.

In 2019, 382 young people took part through work placements, career days/events and school visits. Year on year there has been increased engagement and interest from students hoping to observe within the Trust, but also a growth in non-clinical placements.

With the increased demand for placements there was a need to change the application process and make it more centralised to ensure the Trust has a focus on serving the local communities and boroughs. The Trust is in the process of partnering with several other

London Trusts to create a community of practice and widen participation from students within the communities which are served by each organisation. We recognise that some Trusts may not have placement opportunities in some areas/specialities and this is a great opportunity to support those students through a network approach.

The impact of this, particularly at the age and point at which young people are making career decisions, will promote the NHS as a potential employer with students becoming to be the future workforce.

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 is 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 2019/20, of which 14 related to the Chelsea site, 8 to the West Middlesex site and 1 to a satellite clinic. 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.

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 2019/20, 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 2019/20, the Trust incurred £0.7m (2018/19 £1.0m) on consultancy costs which included procurement consultancy costs to support elements of the Trust's contract portfolio, consultancy support for the estates and facilities team, ongoing support for the soft services contract (referred to as the Fulham Road collaborative) and costs for private finance initiative expert advice.

Off-payroll engagements as at 31 Mar 2020 for more than £245 per day and that last for longer than 6 months

	Total	Revenue	Capital
N° of existing engagements as at 31 Mar 2020	19	4	15
Of which the number that have existed:			
For less than one year at the time of reporting	2	2	0
For between one and two years at the time of reporting	11	2	9
For between two and three years at the time of reporting	5	0	6
For between three and four years at the time of reporting	1	0	1
For four or more years at the time of reporting	0	0	0

New off-payroll engagements, or those that reached 6 months in duration, between 1 Apr 2019 and 31 Mar 2020, for more than £245 per day and that last for longer than 6 months

	Total	Revenue	Capital
N° of new engagements or those that reached 6 months in duration, 1 Apr 2019–31 Mar 2020	38	5	33
Of which the number that have existed:			
N° assessed as within scope of IR35	0	0	0
N° assessed as not within scope of IR35	38	5	33
N° engaged directly (via PSC contracted to department) and on departmental payroll	0	0	0
N° of engagements reassessed for consistency/assurance purposes during the year	0	0	0
N° of engagements that saw a change to IR35 status following consistency review	0	0	0

Exit packages

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

Reporting of compensation schemes—exit packages 2018/19

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	-	-	-
£50,001–100,000	1	-	1
£100,001–150,000	1	-	1
£150,001–200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**2**	**1**	**3**
Total resource cost (£)	199,000	20,000	219,000

Exit packages—other (non-compulsory) departure payments

	2019/20		2018/19	
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	1	27	1	20
Exit payments following employment tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**1**	**27**	**1**	**20**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

Awards and achievements

Internal awards

CW+ PROUD to care winners

April 2019
- Dr Dharmik Vora
- Jamie Gibson
- Melissa Marinaro
- Nikhil Pawa
- Dr Simon Lee
- Peter Chamberlain
- Cancer Services MDT coordinators

May 2019
- Neima Kailondo
- Nicola Burton
- Greg Szwedo

June 2019
- Grace Collins
- Tracey Virgin-Elliston
- Sally Farthing
- Kate Israel
- Alexandra Antoniou-Fenwick
- Aideen Millar
- Gordon Mitchell

July 2019
- Sima Sheth
- Dr Ravi Patel
- Dr Mohammed Mitwali
- Geri Choo
- Iilya kantsedikas
- ISS Catering Team
- Katey Hewitt
- Birju Pujara

August 2019
- Rachel Madelin
- Syon 2 Staff Nurses
- Rachael Jones
- Parviz Khan
- James Oppong-Bimpeh
- Stan Grutzmacher

September 2019
- Bernard Arguelles
- Carmel McCullough
- Giri Prasad Budhathoki
- Navpreet Jhawer & the Phlebotomy team
- Frank and Lynn Greenland

October 2019
- Elspeth Pickering
- Chloe Buckle
- Ahmed Khan
- Eleanor Long
- Douglas Payne

November 2019
- Planned Care Cerner Leads
- Sinead Pritchard
- IT and the Cerner project team
- Anna Letchworth
- Frankie Rose

December 2019
- Dariana Murphy
- Sally Kelly
- Federica Guerra
- Sowntharya Sachchi
- Breastfeeding Peer Supporter Volunteers

January 2020
- Aphra Stewart
- Medical Workforce Team
- Alivia Kent
- Graham Burton
- Neil D'Silva

Please note: Due to the COVID-19 pandemic the awards for Feb/Mar 2020 were postponed.

Staff Awards 2019

- **Allied health professional of the year:** Fionn MacLauchlan
- **Clinical support worker of the year:** Alam Choudhary
- **Pharmacist of the year:** Emily Ward
- **Corporate employee of the year:** Katie Thomson
- **Support service employee of the year:** Anthoula Kanaris
- **Volunteer of the year:** Oliver Nickalls & Salma Abdi
- **Nurse of the year:** Bridgette Fraser
- **Midwife of the year:** Sarah Sandhu
- **Doctor of the year:** Dr Osaeloke Osakwe
- **Team of the year:** Mental Health team
- **Inspiring leadership award:** Cathy Hill
- **Lifetime achievement award:** Tracey Virgin-Elliston
- **Quality improvement award:** Unicompartmental Knee Replacement team
- **CW+ Proud to Care annual award:** Dr Sanjay Krishnamoorthy
- **CW+ special award:** Christine Catlin
- **Council of Governors quality improvement award:** Nightingale Acute Frailty Unit and Daniel Board
- **Chief Executive's special award:** Maternity and Obstetrics Teams and Olga Sleigh

External Awards

Gold Standards Framework (GSF) Quality Hallmark Award 2019

- Nell Gwynne Ward, Chelsea and Westminster Hospital
- Ron Johnson Ward, Chelsea and Westminster Hospital
- Kew Ward, West Middlesex Hospital
- Lampton Ward, West Middlesex Hospital

HSJ Value Awards 2019

- Chelsea and Westminster and the Royal Marsden shared procurement service won the Financial or Procurement Initiative of the Year 2019 award.

HSJ Awards 2019

- The Trust was shortlisted for the prestigious 'Acute or Specialist Trust of the Year' category at the *HSJ* Awards, which recognises outstanding contribution to healthcare.

Providers Deliver

- NHS Providers launched a major new programme of work, Providers Deliver, and recognised the Trust for responding to feedback from the Care Quality Commission (CQC) in a positive and systematic way and encouraging great ideas from staff that have made a real difference to patients and service users.

National Helpforce Awards

- Salma Abdi, youth volunteer at our West Middlesex site, was highly commended for Young Volunteer of the Year at the Helpforce Champions Awards 2019. Salma was highly commended for her outstanding contribution to supporting West Middlesex University Hospital. She has been an activity volunteer on our care of the elderly wards, has supported patients in clinical imaging, and was part of a continued pilot project supporting women attending a gynaecology outpatient clinic.

NHS Gold Award

- Deputy Head of Midwifery Tonie Neville received a prestigious NHS Gold Award from Professor Jacqueline Dunkley-Bent, the Chief Midwifery Officer for England, for outstanding achievement and exceptional contributions within her distinguished career in midwifery

Queen's Birthday Honours List 2019

- **Dr Na'eem Ahmed**—British Empire Medal (BEM) for his outstanding contribution to volunteering and healthcare

- **Pippa Nightingale**—Member of the Order of the British Empire (MBE) for her services to midwifery

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 July 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 2020, 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 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 2019/20 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 2020, the Board had six executive directors (including the chief executive) and nine non-executive directors (including the chairman). The Board comprises 33% female and 67% male directors. The skills, expertise and experience of each Trust Board director as at the end of Mar 2020 are detailed below and is appropriate to meet the requirements of an NHS foundation trust.

Executive directors

Lesley Watts, Chief Executive Officer

Lesley became chief executive of Chelsea and Westminster Hospital NHS Foundation Trust on 14 Sep 2015. A nurse and midwife by training, Lesley has executive experience at the highest level, having been a chair of a health authority, and director of nursing and operations at a major hospital. Prior to her appointment as chief executive, Lesley was accountable officer (chief executive) for East and North Hertfordshire Clinical Commissioning Group. In 2018 Lesley was awarded the prestigious NHS CEO of the Year at the *HSJ* Awards.

Sandra Easton, Chief Financial Officer

Sandra joined the Trust in Aug 2015 as director of finance before becoming chief financial officer in Apr 2016. Previously she was deputy director of finance at Imperial College Healthcare NHS Trust. Sandra started her NHS career in 2001 after finishing her degree in financial services and has a wealth of experience across acute, tertiary, community and mental health providers. Sandra left employment with the Trust in Sep 2020.

Zoë Penn, Chief Medical Officer

Zoë was appointed as medical director in Mar 2013. She was previously divisional medical director for women, neonatal, children and young people, HIV, GUM and dermatology services and is a consultant obstetrician by background. Zoë has been a consultant with

the Trust since 1996, during which time she has held a number of positions including clinical lead for gynaecology and clinical director for women's and children's services. She is also a member of the independent reconfiguration panel of the Department of Health since May 2018. Zoë left employment with the Trust in Apr 2020.

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, and 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.

Virginia Massaro, Acting 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 working in finance teams across other NHS organisations in North West London. She has been acting chief financial officer since Oct 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, and director of midwifery and clinical director at Chelsea and Westminster.

Pippa has experience at leading large-scale, complex health system reorganisations and led the transition of maternity services in North West London which ensured that safe care was delivered to 33,000 women by standardising maternity services across six acute providers. She is committed to ensuring healthcare services provide high-quality, safe and personalised care to users and their families, and supports staff to develop and progress their careers. Pippa also has responsibility for quality, including our assurance systems and processes.

Thomas Simons, Director of Human Resources and Organisational Development

Tom joined the Trust as director of human resources and organisational development in Mar 2019. Previously he held the chief people officer role at East and North Hertfordshire NHS Trust and took a leading role in the merger of Barts Health NHS Trust. Prior to joining the NHS, Tom had a range of HR roles within retail and consulting. Tom has a wealth of experience in delivering large-scale change, service transformation and improvement in transactional HR services. He is a Fellow of the Chartered Institute of Personnel and Development (FCIPD).

Non-Executive Directors

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 a number of 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 Thomas is married to Juliet, the founder and chair of the charity Smart Works, and his great passions are choral music and family life.

Aman Dalvi

Aman, a voting Trust Board member since 1 Dec 2019, was appointed as a non-executive director on 25 Jul 2019. He 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 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 a number of organisations which include the Anchor Trust and PA Housing. In addition, Aman has been a statutory appointment on a number of large and diverse organisations. Aman is currently working as a consultant for two major developers and is chair of a development company. He is a member of 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 & 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 a member of the Audit and Risk Committee and 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 director 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 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+.

Stephen Gill

Steve was appointed as a non-executive director on 1 Nov 2017 for a three-year term. On 1 Feb 2018 he was appointed as chair of the People and Organisational Development Committee. 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 non-executive director roles 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 is chair of trustees of Age Concern, Windsor. Steve is currently chair of the People and Organisational Development Committee and a member of the Finance and Investment Committee.

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 15 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.

Jeremy Jensen

Jeremy was reappointed as a non-executive director on 1 Jul 2017 for a further period of three years. Jeremy is an experienced financial and managerial troubleshooter with a strong track record of success in rescuing and turning around large complex organisations with multiple stakeholder groups. He has comprehensive experience in both operational

roles and as a non-executive director in a wide range of sectors. He is a chartered accountant and holds a degree in economics and economic history from the London School of Economics. In addition to chairing the Finance and Investment Committee, Jeremy is vice chairman of the Trust and its senior independent director.

Dr Andrew Jones

Dr Jones was appointed as a non-executive director on 1 Jul 2014. He is currently chief executive officer at Ramsay Health Care UK and a member of the Ramsay Global executive board. A GP by background, he was formerly chief operating officer and, prior to this, managing director of the wellbeing division and medical director at Nuffield Health. Dr Jones has also been an independent advisor to the Department of Health and has a wide range of clinical and strategic executive experience. He studied medicine at Leeds and an MBA at Cambridge. Dr Jones is currently a member of the Audit and Risk Committee and the Quality Committee.

Ajay Mehta

Ajay, a voting Trust Board member since 1 Dec 2019, was appointed as a non-executive director on 25 Jul 2019. 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.

Ajay 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 a member of the Quality Committee and the People and Organisational Development Committee.

Liz Shanahan

Liz was appointed as a non-voting Board member on 1 Jul 2014 and appointed as a non-executive director on 27 Nov 2015. A medical education and communications professional by background, Liz has extensive experience in healthcare strategy and change consulting. Liz is chief executive of Sante Healthcare Consulting, a healthcare communications consultancy. Previously Liz was global head of healthcare and life sciences for FTI Consulting, where she was a member of the executive leadership forum. She joined FTI in 2007 when they acquired her company. She is also involved with a portfolio of businesses on investment, advisory and non-executive levels. She is a member of the Global Irish Network, ex-chair of the Irish International Business Network, a member of the British Council's Provocation Group and the Kerry Person of the Year 2017/18. Liz is also is a trustee of hospital charity CW+. Liz's term of office came to an end in Nov 2019.

Directors and others in regular attendance at Board meetings 2019/20

- Chis Chaney, Chief Executive, CW+
- Roger Chinn, Acting Medical Director
- Iain Eaves, Director of Improvement[16]
- Kevin Jarrold, Chief Information Officer
- Martin Lupton, Associate Dean and Head of Undergraduate Medicine, Imperial College London
- Sheila Murphy, Interim Company Secretary[17]
- Serena Stirling, Director of Corporate Governance and Compliance[18]

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

- 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 of its non-executive directors to be independent in character and judgement. Key changes on the Trust Board in 2019/20 were as follows:

- Liz Shanahan, Non-Executive Director—term expired 30 Nov 2019
- Aman Dalvi, Non-Executive Director—joined the Board on 1 Dec 2019
- Ajay Mehta, Non-Executive Director—joined the Board on 1 Dec 2019

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 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 2019/20 and provided assurance reports to the Audit and Risk Committee which, in turn, reported the effectiveness of the Committees to the Trust Board.

[16] Left the Trust in Dec 2019
[17] Left the Trust in Mar 2020
[18] Joined the Trust in Jan 2020

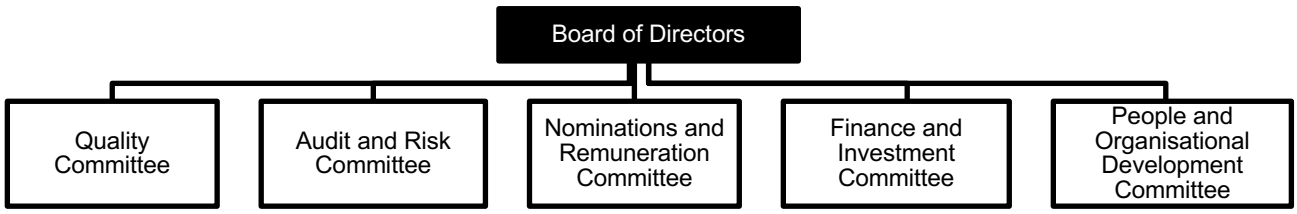
Board meetings

The Trust Board meets on average no less than six times per year. Special meetings are organised as and when required. There were six public meetings and one extraordinary private meeting in 2019/20. Director attendance is detailed below.

	Ordinary Board meeting attendance	Extraordinary Board meeting attendance
Non-executive directors		
Sir Tom Hughes-Hallett	5/6	1/1
Aman Dalvi	2/2	n/a
Nilkunj Dodhia	5/6	1/1
Nick Gash	6/6	1/1
Stephen Gill	6/6	1/1
Eliza Hermann	6/6	1/1
Jeremy Jensen	6/6	1/1
Dr Andrew Jones	5/6	1/1
Ajay Mehta	2/2	n/a
Liz Shanahan[19]	5/6	1/1
Executive directors		
Lesley Watts	6/6	1/1
Sandra Easton[20]	3/3	1/1
Rob Hodgkiss	6/6	1/1
Virginia Massaro	3/3	n/a
Pippa Nightingale	6/6	1/1
Zoe Penn[21]	2/6	1/1
Thomas Simons	6/6	n/a

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 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.

[19] Left the Trust Board in Nov 2019
[20] Left the Trust Board in Sep 2019
[21] Left the Trust Board in Apr 2020

The committee met on 5 Mar 2020 to review and agree the committee's terms of reference, executive director pay and very senior manager pay including formal approval of the appointment of the director of corporate governance and compliance and the deputy chief executive.

Nominations and remuneration committee attendees	Attendance
Hughes-Hallett, Sir Tom (Chairman)	1/1
Jensen, Jeremy (Deputy Chairman)	1/1
Dalvi, Aman	1/1
Dodhia, Nilkunj	1/1
Gash, Nick	1/1
Gill, Stephen	1/1
Hermann, Eliza	1/1
Jones, Dr Andrew	1/1
Mehta, Ajay	1/1
Shanahan, Liz[22]	n/a
In attendance	
Watts, Lesley	1/1
Simons, Thomas	1/1
Stirling, Serena	1/1

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 2019/20, on recommendation by the committee and agreement of the Council of Governors it was agreed that Trust Chairman Sir Thomas Hughes-Hallett would remain in office for up to a further three years to 31 Jan 2023.

Appointments

During 2019/20, the committee commenced work to appoint two new non-executive directors. Odgers Berndtson were successful at tender and appointed to undertake the process of recruitment of suitable candidates for consideration by the committee for the non-executive director vacancies.

The Nominations and Remuneration Committee met on 3 Apr 2019 to discuss the process for appointment of non-executive director. The committee met to undertake longlisting and shortlisting for the post of two non-executive directors on 27 Jun and 15 Jul 2019 respectively. These meetings were chaired by Sir Thomas Hughes-Hallett.

On recommendation by the committee and agreement of the Council of Governors, it was agreed that Aman Dalvi and Ajay Mehta be appointed as non-executive directors for a term of three years 1 Dec 2019–30 Nov 2022.

[22] Left the Trust Board in Nov 2019

The appointment and terms and conditions of appointment of non-executive directors Aman Dalvi and Ajay Mehta were approved by the Council of Governors at its meeting on 25 Jul 2019.

Nominations and Remuneration Committee attendees	Attendance
Sir Tom Hughes-Hallett, Chairman	4/4
Richard Ballerand (Public Governor)	4/4
Simon Dyer (Lead and Patient Governor)	4/4
Angela Henderson (Public Governor)	4/4
Minna Korjonen (Patient Governor)	4/4
David Phillips (Patient Governor)	4/4
Laura Wareing (Public Governor)	4/4
In attendance	
Lesley Watts, Chief Executive Officer	3/4
Thomas Simons, Director of HR & OD	4/4
Jeremy Jensen, Deputy Chairman/Senior Independent Director	2/4
Sheila Murphy, Interim Company Secretary[23]	4/4

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.

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 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 2019/20), external audit (provided by Deloitte in 2019/20) 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 2019/20).

[23] Left the Trust in Mar 2020

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 2019/20, which includes two other non-executive directors. The Committee met five times in 2019/20.

Attendance at Audit and Risk Committee

Non-Executive Directors	Attendance
Nick Gash	5/5
Nilkunj Dodhia	3/3
Dr Andrew Jones	2/2
Eliza Hermann	1/2
Liz Shanahan[24]	3/3

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

During the course of the year, the Audit and Risk Committee received a number of reports from the internal auditors KPMG. These covered a number of areas including IT disaster recovery, estates project governance, patient experience, business continuity, divisional governance, risk assurance framework, financial controls, patient safety data (mortality), discharge planning, patient transport procurement and data security and protection (DSP) toolkit.

For the period 1 Apr 2019–31 Mar 2020 no high-risk recommendations were identified by our internal auditors.

Following the year end, the committee considered the draft annual report and accounts 2019/20 and received the ISA 260 report from the Trust's external auditors.

During 2019/20, 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 auditor over the course of 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 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.

[24] Left the Trust in Nov 2019

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 2019/20. 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 2020 are provided within the table below:

Last name	First name	Constituency	Organisation	Date elected or appointed	Term	Attendance at council meetings 2019/20
Anderson	Nowell	Public	Hounslow	Nov 2018	2	2/4
Ballerand	Richard	Public	Kensington and Chelsea	Nov 2017	1	3/4
Bauer	Juliet	Patient	–	Nov 2018	2	3/4
Bhatti	Majid	Staff	Management	Nov 2019	n/a	1/1
Bouillat	Caroline	Public	Wandsworth	Nov 2019	1	1/1
Cass-Horne	Cass J.	Public	City of Westminster	Nov 2019	1	1/1
Church	Tom	Patient	–	Nov 2018	3	3/4
Davies	Nigel	Public	Ealing	Nov 2018	2	3/4
Digby-Bell	Christopher	Patient	–	Nov 2017	2	4/4
Dyer	Simon	Patient/Lead Governor	–	Nov 2018	2	4/4
Grinham	Jodeine	Staff	Contracted	Nov 2017	1	1/4
Henderson	Angela	Public	Hammersmith and Fulham	Nov 2018	n/a	4/4
Hodson-Pressinger	Anna	Patient	–	Nov 2018	4	4/4
Hutton	Elaine	Public	Wandsworth	Nov 2018	2	2/3
Jackson	Richard	Staff	Support, Admin and Clerical	Nov 2019	1	1/1
Kanodia	Kush	Patient	–	Nov 2018	2	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	1/1
Levi	Anthony	Public	City of Westminster	Nov 2019	1	1/1
Mayerhofer	Johanna	Public	Richmond upon Thames	Jan 2018	1	3/4
McDonald	Chisha	Staff	Allied Health Professionals, Scientific and Technical	Nov 2016	n/a	3/3
Nelson	Mark	Staff	Medical and Dental	Nov 2017	1	2/4
O'Farrell	Fiona	Public	Richmond upon Thames	Jan 2018	1	3/4

Last name	First name	Constituency	Organisation	Date elected or appointed	Term	Attendance at council meetings 2019/20
Parr	Jennifer	Staff	Management	Nov 2018	n/a	2/3
Phillips	David	Patient	–	Nov 2018	2	4/4
Pollak	Tom	Public	Wandsworth	Nov 2018	n/a	3/3
Quigley	Cllr Patricia	Local Authority	Hammersmith and Fulham	July 2018	1	2/4
Samuels	Sonia	Public	Westminster	Nov 2016	n/a	0/2
Scott	Jacquei	Staff	Nursing and Midwifery	Nov 2018	1	2/4
Walsh	Dr Desmond	University	Imperial College	Oct 2018	1	2/3
Wareing	Laura	Public	Hounslow	Nov 2018	2	3/4

Council of Governors elections held during 2019/20

An election was held in Nov 2019 to fill vacant seats in the public and staff constituencies. The results were as follows:

- **Public—City of Westminster:** Cass J Cass-Horne (elected) and Anthony Levy (elected)
- **Public—London Borough of Hammersmith and Fulham:** Trusha Yardley (elected)
- **Public—London Borough of Wandsworth:** Caroline Boulliat Moulle (elected)
- **Public—Royal Borough of Kensington and Chelsea:** Paul Kitchener (re-elected)
- **Staff—Allied Health Professionals, Scientific and Technical Class:** Thewodros Leka (elected unopposed)
- **Staff—Management Class:** Majid Bhatti (elected unopposed)
- **Staff—Support Administrative and Clerical Class**: Richard Jackson (elected unopposed)

Council of Governors' register of interests

Governors are required to sign a code of conduct, declare any interests that are relevant annually and to 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 ft.secretary@chelwest.nhs.uk, 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 ft.secretary@chelwest.nhs.uk 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 are able to 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 2019/20, the focus has been on developing the communication and engagement with members and the general public. This has included open days and Christmas events at both the Chelsea and Westminster and West Middlesex sites, the annual members' meeting, *Your Health* seminars, and regular 'meet a governor' sessions in the hospitals and the community. Governors participated in all public and member engagement events organised by the Trust and ran member recruitment sessions within the hospital and across the community throughout the year.

We engage and keep our members updated by distributing a monthly e-newsletter and electronic link to our hospital magazine *Going Beyond*. 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 2019/20 is 18,611. Demographic information provided by member's shows our membership is broadly representative of the population we serve. As at 31 Mar 2020 the membership profile was as follows:

	Public	Patient	Staff	Total
Age	**7,136**	**5,644**	**5,831**	**18,611**
0–16	0	0	0	0
17–21	128	9	10	147
22+	6,326	3,830	5,820	15,976
Not stated	682	1,805	1	2,488
Age 22+	**6,326**	**3,830**	**5,820**	**15,976**
22–29	377	75	1,008	1,460
30–39	699	425	1,742	2,866
40–49	1,102	847	1,454	3,403
50–59	1,269	932	1,108	3,309
60–74	1,509	938	498	2,945
75+	1,370	613	10	1,993
Gender	**7,136**	**5,644**	**5,831**	**18,611**
Unspecified	114	51	0	165
Male	2,561	2,106	1,405	6,072
Female	4,461	3,487	4,426	12,374
Transgender	0	0	0	0
Ethnicity	**7,136**	**5,644**	**5,831**	**18,611**
White—English, Welsh, Scottish, Northern Irish, British	3,491	2,187	1,989	7,667
White—Irish	190	120	198	508
White—Gypsy or Irish Traveller	0	0	0	0
White—Other	906	533	667	2,106
Mixed—White and Black Caribbean	101	57	44	202
Mixed—White and Black African	22	11	39	72
Mixed—White and Asian	56	23	45	124
Mixed—other mixed	92	70	86	248
Asian or Asian British—Indian	322	133	472	927
Asian or Asian British—Pakistani	124	53	90	267
Asian or Asian British—Bangladeshi	50	39	38	127
Asian or Asian British—Chinese	42	34	70	146
Asian or Asian British—other Asian	218	138	548	904
Black or Black British—African	310	227	513	1,050
Black or Black British—Caribbean	122	83	235	440
Black or Black British—other Black	67	37	72	176
Other ethnic group—Arab	10	0	0	10
Other ethnic group—any other ethnic group	78	53	256	387
Not stated	935	1,846	469	3,250
Total membership	**7,136**	**5,644**	**5,831**	**18,611**

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 officers responsibilities section from page 90.

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 United Kingdom 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 11 Mar 2020.

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

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1–4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes informing the NHS oversight framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score.

		2019/20 scores				2018/19 scores			
Area	**Metric**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**
Financial sustainability	Capital service capacity	2	2	3	3	1	1	2	3
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin	1	1	2	4	1	1	2	3
Financial controls	Distance from financial plan	2	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	2	1
Overall scoring		**1**	**1**	**2**	**3**	**1**	**1**	**2**	**2**

STATEMENTS OF ACCOUNTING OFFICERS' 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).

NHS Improvement, 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

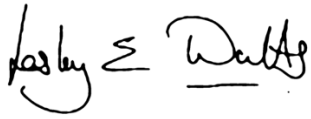
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy

- 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

18 June 2020

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 in Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 Mar 2020 and up to the date of approval of the annual report and accounts.

COVID-19 and internal control

The COVID-19 incident has significantly impacted the NHS operating environment. To ensure a responsive approach to the incident, the Trust established an executive-led incident response team in Mar 2020. This managed the Trust's response to the incident in a command and control structure, which was in line with the level 4 national incident response. The remit of this approach encompassed the implementation of the national guidance and directions and provided assurance on the safety of our staff and patients during the incident response. The Trust was fully integrated into the North West London, London and national response structures. Several of the Trust's executive directors are leading North West London response workstreams.

The team monitored incident response measures and reported assurance to the Board committees on the changing risks and controls required to support the organisation's response. This included the development of a COVID-19 risk framework which was reported to the Quality Committee and public Board in May 2020. This detailed risks and mitigation plans for estates, workforce, governance, infection control, procurement and medical equipment.

The impact of COVID-19 was felt by Trust at the end of the 2019/20 financial year, with significant impact expected to continue into 2020/21. At the time of writing the Trust is working with the North West London sector to understand the impact of COVID-19 on quality, performance and, consequently, finance. In particular this will include elective care pathways which will be considered as part of the sector recovery plan. Where metrics or measures reported within the annual report have been impacted due to the response to COVID-19 these will be highlighted within the relevant sections.

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 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. The Trust maintains an organisation risk register—the register is a management tool which promotes visibility and escalation, providing a repository from which assurance can be offered that risks are being identified and appropriately managed.

All items recorded within the organisation's risk register system are categorised according to risk 'subject'—each categorisation is aligned to a committee of the Board so that an assessment of the level of assurance provided by the organisation's risk management approach can be considered. The risk assurance framework is scrutinised by the following committees of the Board:

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

All staff (including Trust Board members) receive risk management training on various aspects of risk (such as information governance, fire, health and safety) 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 Trust risk management policy is accessible to all staff via the Trust intranet and aims to provide guidance on the conduct of risk assessments and the escalation of risk, as appropriate, in accordance with each staff member's level of authority and duties.

An essential aspect of the Trust's risk management approach is the need to learn and share the lessons arising from realised risks, incidents and near misses. This helps to ensure ongoing systems of improvement and safeguards patient care and business safety. This is achieved through the regular aggregation of claims, complaints, incidents and inquests for the purpose of identifying key themes, trends and best practice. The Trust also ensures learning from nationally recognised good practice, seeking to comply with the national standards set by the Care Quality Commission, National Institute for Health and Care Excellence, the Health and Safety Executive and NHS Improvement, among others. Where best practice is identified, either through internal analysis or as a result of the publication of national guidance, it is incorporated into Trust policy on the particular subject matter and shared with all staff via the Trust intranet system.

Risk and control framework

It is inherent within good risk management practice that identified risk is analysed, actioned and evaluated at regular intervals for the purposes of regular monitoring in order to further improve.

Identification of risk

There are four principal methods of risk identification which the Trust uses:

- Known ongoing inherent risks of which the Trust is aware, which are controlled and managed
- Foreseeable risks which are inherent and identified proactively by competent persons
- Strategic risks identified by the Board (including the risks associated with complying with 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 a number of sources, including but not restricted to:

- Recommendations from incident investigations and themes/trends arising from cumulative analysis of incident data
- Clinical risk assessments
- Non-clinical risk assessments (security, health and safety, health and wellbeing etc)
- 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
- 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 which affect or involve external organisations, such as stakeholders within the local healthcare community. Where this is the case, the Trust adopts a collaborative approach to 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 foreseeable, as required by health and safety legislation. Risks are evaluated in order 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)

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 <3 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 which the Trust employs, there are also patient- and staff-specific risk assessment forms used at ward/department level in relation to particular risks, for example:

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

The risk register is structured in a way which 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 the risk post-mitigating actions.

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 which could substantially impact on the achievement of the Trust's strategic objectives. It provides a framework for reporting information to the Board by identifying key controls in place to manage those objectives, assurance about effectiveness of controls and any gaps in the controls or assurances.

As of Mar 2020, the key principal risks were:

1. Failure to deliver the NWL health and care partnership system recovery plan and build a sustainable portfolio of outstanding acute and specialised services consolidated across North West London leading to improved care and patient experience

This risk is monitored by the Finance and Investment Committee and the Trust Board. The Trust is responsible for providing care to ageing local patient populations, with non-elective activity levels increasing in excess of commissioning projections. In addition, there continues to be an increase in the presentation of complex patients with multiple comorbidities brought about by demographic changes. The Trust is working with local commissioners on admission avoidance and early supported discharge strategies to ensure the appropriate use of acute inpatient beds. The Trust has invested in ambulatory emergency care services to redirect appropriate non-elective patients. Moving forward to 2020/21, the impact of COVID-19 incident has yet to be fully understood in terms of what recovery for the organisation will look like. During the incident, we have seen a significant reduction in non-elective demand alongside elective capacity and only now at the time the writing are we assessing the longer impact on these patient groups.

2. Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high-quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards

This risk is monitored by the Quality Committee and Audit and Risk Committee. The Trust has established processes and associated governance structures to monitor progress and compliance with relevant local and national quality, performance and regulatory standards. This includes a standardised integrated performance report, annual clinical audit plan, CQC self-assessment and inspection reports, ward accreditation programme and service deep dives, to name a few. The Trust annual business planning process ensures alignments across strategic objectives and quality, workforce, operational and financial plans. The Trust will continue to monitor adverse risks to quality and safety as a result of proposed changes to services and financial plans through the quality impact assessment process.

3. Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'employer of choice' in a competitive labour market

This risk is monitored by the People and Organisational Development Committee. The organisation is committed to providing 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 2019/20 we have continued to develop our culture and values to support the ambition to become the 'employer of choice' within the local NHS economy. During 2020/21 the Trust will continue to deliver the equality, diversity and inclusion action plan, and further develop retention and recruitment work streams to ensure that any barriers to the achievement of this strategic objective are addressed.

4. Failure to maintain the financial sustainability of the Trust and the services it provides

This risk is monitored by the Finance and Investment Committee. The Trust has a robust financial strategy. Risk and barriers to the delivery of this strategy are reported to the Finance and Investment Committee. A failure to maintain the organisation's financial sustainability would reduce the Trust's capacity to respond to growth in activity, continue to invest in the workforce and infrastructure, make investment and other decisions within the relevant regulatory frameworks, policies and guidance. Detailed planning and budget control mechanisms have been established within the 2020/21 financial plan to ensure controls to this risk are in place and effective.

5. Failure to embed innovation and improvement in our culture and deliver innovative, patient-centred services at scale

This risk is monitored by the Quality Committee, the Finance and Investment Committee and the Trust Board. The Trust has developed an improvement and innovation framework detailing the approach to developing the organisation's improvement and innovation culture while building the capability and capacity to deliver this objective. We have a strong partnership with our CW+ charity to drive a bespoke innovation programme, which includes attracting new partners and funding. In addition, the Trust has invested in an improvement team and innovation hub to engage staff with this objective. We have established an improvement board to monitor and drive the Trust progress with this objective, which includes quality and financial improvement.

6. Failure to develop our estate to support the delivery of high-quality, effective and efficient care

This risk is monitored by the Finance and Investment Committee. During 2019/20 the Trust continued to deliver the estates strategy designed to ensure high-quality, effective and efficient care can be delivered across all sites. During this financial year the Trust has overseen the successful delivery of developments at the Chelsea site, which includes the development of the new state-of-the-art critical care facilities (adult and neonatal). Within 2020/21, development work is planned for the West Middlesex site to ensure that our patients receive an improved patient experience and high-quality care.

7. Failure to deliver the electronic patient record (EPR) programme on time and within budget, including failure to effectively manage and mitigate any associated risks. Failure to develop and implement digital strategy to support modern workforce, innovation and improvement, the needs of our patient and population and wider requirements of London and North West London Strategies

This risk is monitored by the Finance and Investment Committee. The Trust has invested in a director of digital operations post. The EPR programme is supported by an EPR programme board chaired by the deputy chief executive and the programme assured by external auditors Ernst Young. Additional investment to address known cyber security weaknesses support this programme of work.

The implementation of the new EPR system on the Chelsea site was conducted in Nov 2019 on time and with full organisational engagement. The programme structure supported a safe and efficient cutover from the previous system to mitigate any impact on patient safety, clinical systems and data quality. In 2020/21 the Trust will undertake the next phase of the programme which will see complete deployment of the CernerEPR system to the West Middlesex site using the same governance processes.

EU exit

Throughout 2019/20 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 weekly 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.

Data security and protection toolkit (DSPT) attainment levels

Information governance is the way that 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 Dame Fiona Caldicott, the National Data Guardian for health and adult social care.

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 2018/19 the Trust achieved 'standards met'. Due to the COVID-19 incident, the deadline for submission to the DSPT has been moved to 30 Sep 2020, before which time, standards will have been met.

At the time of writing, the Trust is 95% compliant with the information governance training for substantive staff under the new guidelines from NHS Digital.

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 DSPT. There were seven incidents reported on the DSPT, four of which were reported to the ICO. The ICO decided that no further action was needed for any of the four incidents.

Freedom of information (FOI)

Compliance with FOI has maintained good performance levels. We achieved 90.5% compliance against the 20-day response rate for the financial year 2019/20, with 761 FOI requests received. This figure includes 39 FOI requests which were withdrawn in Feb/Mar 2020 due to the COVID-19 pandemic. Without the withdrawals, compliance was at 90.03%.

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 has purchased data protection compliance software which centralises most of the tasks required for compliance, making upkeep and reporting available to all.

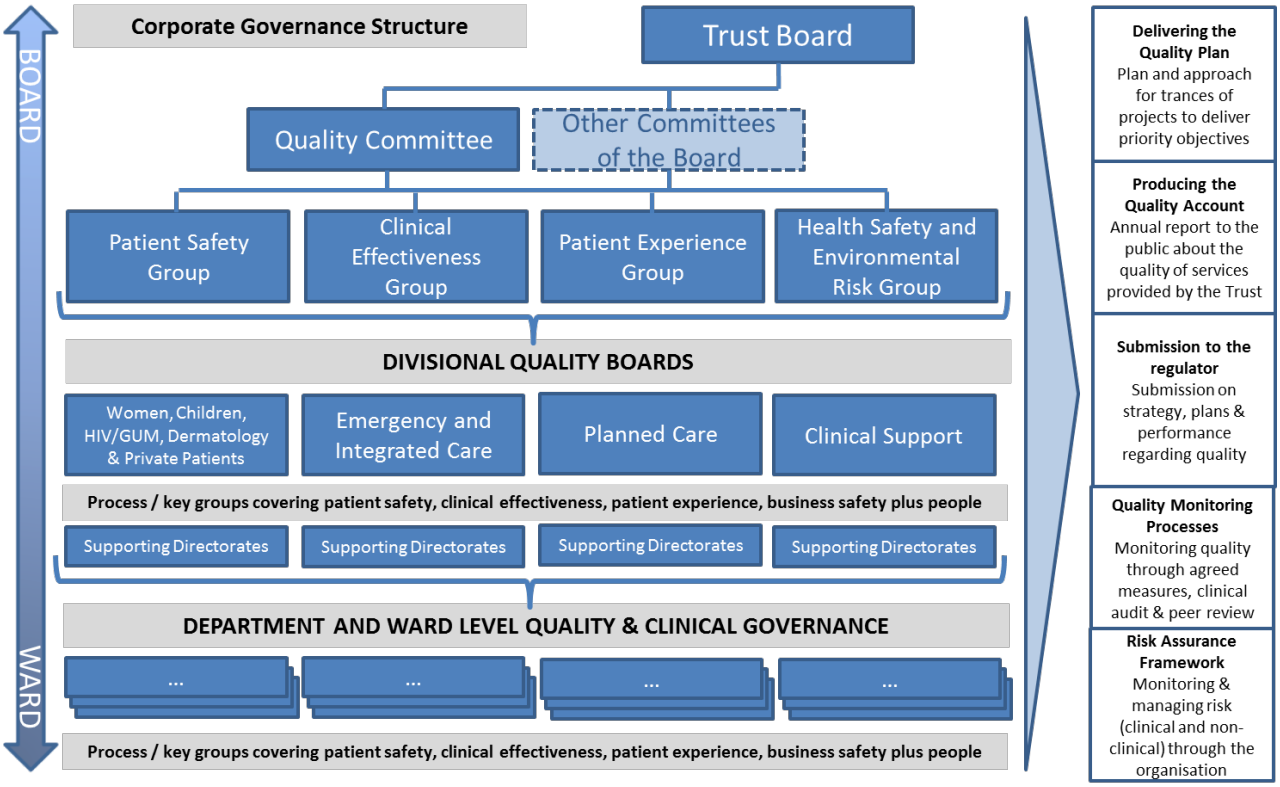
Quality governance and performance

The Trust's quality governance structure, detailed below, enables the organisation to maintain and continually improve quality of care from 'ward to board'. This assurance framework supports the Care Quality Commission framework and provides clear assurance from wards and departments to the board.

The framework has been audited and reviewed by external partners and viewed as effective. It is governed by the Quality Committee, chaired by a non-executive director, with executive leadership being provided by the chief nursing officer and chief medical officer.

Within the divisional structure, divisional medical directors and divisional nurses chair divisional quality boards, which are supported by the clinical governance team. These groups monitor quality performance and risk within their services, which includes mortality, serious incidents, complaints and other key metrics. These groups are responsible for overseeing of our quality priorities for 2020/21.

Our quality governance and decision-making



The improvement journey

As part of the Trust Quality Strategy 2019–24, the Trust continues to embed a culture of continuous improvement and innovation. Continually improving healthcare requires engagement with staff, patients, carers, families and the local communities served by the Trust. The organisation's ambition is for improvement to be an everyday narrative used in all activities. In addition to formalised education and training, our staff are able to access support and advice through our improvement community, improvement hubs and face-to-face and virtual improvement clinics.

As part of our continuous improvement programme, we continue with our well-embedded ward accreditation programme which is aligned to the Care Quality Commission standards and supports clinical areas with quality improvement. The Trust also has an embedded Quality Friday where weekly education sessions, audits and information cascades with clinical teams occur.

This comprehensive assurance framework and approach to systematic improvement prepared the organisation for the Care Quality Commission inspection in Nov 2019 and was instrumental in delivering the outcome of the Trust being rated ‘good’ overall, with outstanding for ‘well-led’ and ‘use of resources’.

In 2020/21 we will continue to use the model for improvement to help teams accelerate and embed improvement in their day-to-day work and deliver on our specific quality priorities. Our ambitions in 2020/21 include improving how we co-produce and engage on quality improvements with our staff, patients and communities.

Ensuring safe staffing

The Trust is fully compliant with NHS Improvement safe staffing guidance. The Trust undertakes twice-yearly acuity and dependency safe staffing audits and undertakes and submits monthly ‘care hour per patient day’ data and planned versus actual data which the Trust uses to monitor compliance with its workforce plan. This data is submitted to public Board monthly in the integrated board report.

The Trust also has a realtime safe staffing tool in place which is reviewed four times a day in each bed meeting to record red flags of safe staffing and allows for immediate management of staffing shortages. The Trust uses the acuity and dependency audits to inform the long-term workforce plan. Any changes to clinical staffing establishments are reviewed at quality impact assessment panels which are chaired by the chief nursing officer and chief medical officer to identify any potential for adverse effects on the safety and quality of care.

The Trust has an embedded guardian of safe working process and named lead. The Board receives regular guardian of safe working reports. This role is effective in managing immediate changes to medical staffing and also in informing the long-term workforce plan.

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, executive management board, Quality Committee and Trust Board.

We have an advanced feed from the patient administration system 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.

A manual data validation process is undertaken by the information team to review the information entered into the patient administration system and to investigate the data which underlies reported performance. Identified data issues are logged by the performance team, investigated and corrected. Recurring issues are subject to root cause analysis, 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 our electronic patient record system CernerEPR. The Trust has had a number of 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 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 incident management process. These incidents are summarised and reported to the information governance steering group. The information governance team assists 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 39. 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 Board committees. This includes the key areas of quality, workforce, performance and finance, giving further assurance that the Trust is fully compliant with the Care Quality Commission 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 a number of 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.

Climate change

The Trust will continue to develop sustainable management plans in line with the UK Climate Projections 2018 and comply with the Climate Change Act. Improvements in reducing the carbon footprint of the Trust include actions to increase energy efficiency with further implementation of LED lighting and utilising smart energy management using the building management system.

The Trust has signed up to the plastics pledge to remove single use plastics, targeting non-clinical areas for removal of all plastic cutlery and replace with sustainable alternatives.

Aims to improve the air quality with reductions in emissions will focus on the use of transport, with trials implemented of electric and hybrid vehicles for non-emergency patient transport.

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 and cost-effectiveness.

During 2019/20 the Trust has increasingly used various benchmarking sources and the improvement board to identify efficiency opportunities including Model Hospital, Getting it Right First time (GIRFT), Carter and local benchmarking across the system. Where the Trust Board identifies key risks and issues in relation to the Trust's use of resources, it 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 board meetings for teams to be challenged on their use of resources 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 2019/20.

The detail of the key actions of the internal audit programme can be found in the *Review of Effectiveness* section on page 105.

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 the update from NHS England and NHS Improvement in May 2020, NHS providers were advised of a revised deadline of 15 Dec 2020 for submission of the quality accounts 2019/20 in light of pressures caused by COVID-19. The Trust Board recognises the importance of the quality report for the organisation and our local communities and intends to publish an unaudited version later in the year.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee 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 and actions taken to address any identified risks and improve the quality of healthcare that is provided.

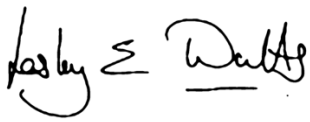
The role of the Board, Audit and Risk Committee, Quality Committee, Finance and Investment Committee and People and Organisational Development Committee in maintaining and reviewing the Trust's systems of internal control is described above. The internal audit programme provides a further mechanism for 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 2019/20 there were no high-risk recommendations identified by our internal auditors.

The overall head of internal audit opinion for the period 1 Apr 2019–31 Mar 2020 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 2019/20.



Lesley Watts
Chief Executive Officer

18 June 2020

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 2020 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
- 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
- the related notes 1 to 36

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)) 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.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Revenue recognition • Management override of controls • Valuation of land and buildings Within this report, any new key audit matters are identified as follows: Ⓘ Newly identified Ⓐ Increased level of risk Ⓢ Similar level of risk Ⓓ Decreased level of risk
Materiality	The materiality that we used for the financial statements was £10.4m which was determined on the basis of 1.5% revenue.
Scoping	The foundation trust is a single entity with no subsidiaries. Audit work was performed at the foundation trust's operational sites at the Chelsea and Westminster Hospital and West Middlesex University Hospital, as well as at the foundation trust's finance function's offices, directly by the audit engagement team. Post year end audit testing was completed remotely given the COVID-19 lockdown restrictions.
Significant changes in our approach	Our approach is largely consistent with previous years, however, additional procedures have been considered where COVID-19 has impacted the balances within the financial statements.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where: • the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate, or • the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue	**We have nothing to report in respect of these matters**

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit, and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

NHS revenue and provisions ◈	
Key audit matter description	As described in note 1, Accounting Policies and note 1.25 Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners. Details of the foundation trust's income, including £548m (2019: £513m) of Commissioner Requested Services are shown in note 4.2 to the financial statements. £11.4m (2019: £41.5m) of Provider Sustainability Funding (PSF) is disclosed in note 3 to the financial statements. NHS receivables are shown in note 20.1 and provisions against these are shown in note 20.2 and 26.1 to the financial statements. The foundation trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. We presumed a fraud risk to exist in revenue recognition in accordance with International Standards on Auditing.
How the scope of our audit responded to the key audit matter	We obtained an understanding of the relevant controls over recognition of NHS income. We have assessed management's position regarding the principal disputes with commissioners. We have challenged management's assumptions and corroborated management explanations to documentary evidence, such as correspondence with commissioners. We have reviewed the outcome of the Agreement of Balances process and tested a sample of differences to support. We have also tested a sample of unsettled balances through to cash received or to alternative evidence of validity of debtors and accrued amounts. We have evaluated the adequacy of and rationale for the bad debt and contractual dispute provisions against NHS debtors.
Key observations	We did not identify any material misstatements through our procedures in respect of this key audit matter, and we consider the estimates made by the foundation trust to be within an acceptable range.
Property valuation ◈	
Key audit matter description	The foundation trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £404.9m (2019: £373.4m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. The net valuation movement on the foundation trust's estate shown in note 14 is an increase of £22.0m (2019: £16.9m). As detailed in note 1.24, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report "*for changes in the relevant property markets and tender price indices in the period between 31 December 2019 and 31 March 2020. This is on the basis of uncertainties in markets caused by COVID-19. The Trust has recognised this material uncertainty in the accounts as a key source of estimation uncertainly, and also reduced the land value by 5% (£5.0m) and dwellings by 5% (£0.6m) due to impact on nurses accommodation income. The valuation was the best information available to the Trust.*"

How the scope of our audit responded to the key audit matter	We obtained an understanding of relevant controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's properties. We challenged the foundation trust's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by reviewing the foundation trust's Clinical Strategy, and critically evaluating whether the alternatives considered would be viable given the nature of the foundation trust's activities. We have reviewed the disclosures in notes 1.8 and 1.24 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU and the COVID-19 pandemic upon property valuations in evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty. We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	While we note the increased estimation uncertainty in relation to the property valuation as a result of COVID-19, and as disclosed in note 1.24, we consider that the key judgements are within the acceptable range. The Trust's valuation is based on a number of judgmental assumptions. We are satisfied that the Trust assumptions and valuation methodology are appropriate.
Management override of controls ⟲	
Key audit matter description	We consider that there remains a risk across the NHS that management may override controls to manipulate fraudulently the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The foundation trust has been allocated £11.4m (2019: £41.5m) of the Provider Sustainability Fund, contingent on achieving financial and operational targets each year, equivalent to a "control total" for the year of a surplus (adjusted for certain items). This creates an incentive for reporting financial results that exceed the control total of £11.8m. The foundation trust's reported results show a surplus of £29.5m (2019: £9.9m), equivalent to £0.03m above the control total after adjusting items. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.24 and 1.25.

How the scope of our audit responded to the key audit matter	**Manipulation of accounting estimates** Our work on accounting estimates included considering areas of judgement, including those identified by NHS Improvement. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the foundation trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.
Key observations	We have not identified any significant bias in the key judgements and estimates made by management.

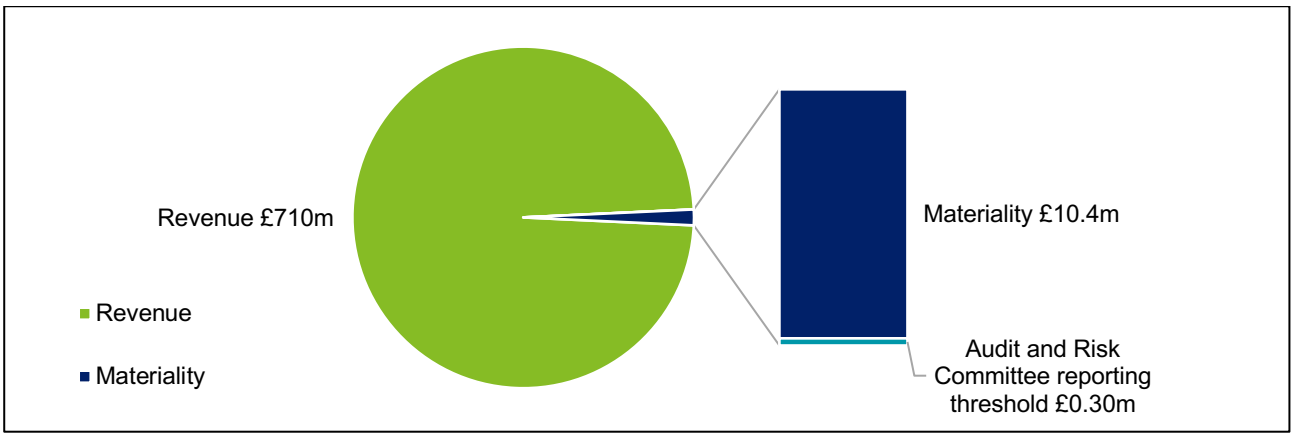
Our application of materiality

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£10.4m (2019: £10.0m)
Basis for determining materiality	1.5% of revenue (2019: 1.4% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



Performance materiality
We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Performance materiality was set at 75% of materiality for the 2020 audit (2019: 75%). In determining performance materiality, we considered the following factors:

- the quality of the control environment
- corrected and uncorrected misstatements identified in the previous audit; their nature, volume and size

Error reporting threshold
We agreed with the Audit and Risk Committee that we would report to the committee all audit differences in excess of £300k (2019: £300k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit & Risk Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Identification and scoping of components
The foundation trust is located at two main sites in Chelsea and Twickenham, London. Both sites operate under a single control environment with a shared general ledger audited directly by our audit engagement team, led by the audit partner.

Our areas of our audit scope
Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's operational sites at the Chelsea and Westminster Hospital and West Middlesex University Hospital, as well as at the Trust's finance function's offices. Post year end audit work was completed remotely given the COVID-19 lockdown restrictions.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

Data analytic techniques were used as part of audit testing, to support identification of items of audit interest and in particular journal testing.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. 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. In connection with our audit of the financial statements, 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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. 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 respect of these matters**

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, 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 the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

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.

Report on other legal and regulatory requirements

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

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006
- 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

Annual Governance Statement, use of resources, 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 • the foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources • 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 • 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**

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report
This report is made solely to the Council 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 foundation trust and 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

18 Jun 2020

SECTION 4

FINANCE

ANNUAL ACCOUNTS 2019/20

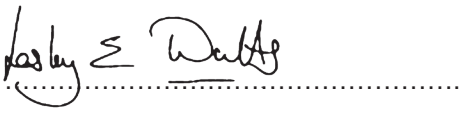
Chelsea and Westminster Hospital NHS Foundation Trust

Annual accounts for the year ended 31 Mar 2020

Foreword to the accounts

Chelsea and Westminster Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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 **19-Jun-20**

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	2	603,795	577,332
Other operating income	3	106,115	136,602
Operating expenses	5, 7	(665,596)	(688,859)
Operating surplus from continuing operations		**44,314**	**25,075**
Finance income	10	927	605
Finance expenses	11	(5,712)	(5,466)
PDC dividends payable		(10,456)	(10,772)
Net finance costs		**(15,241)**	**(15,633)**
Other (losses) / gains	12	(444)	13
Share of profit of associates / joint arrangements	17	909	404
Surplus for the year		**29,538**	**9,859**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	13,309	19,342
Fair value (losses) / gains on equity instruments designated at fair value through OCI	18	(3,242)	77
Other reserve movements		-	(472)
Total comprehensive income for the period		**39,605**	**28,806**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	42,663	37,043
Property, plant and equipment	14	451,257	416,511
Investments in associates and joint ventures	17	2,185	1,276
Other investments / financial assets	18	1,357	4,599
Receivables	20	1,673	-
Total non-current assets		**499,135**	**459,429**
Current assets			
Inventories	19	7,784	6,663
Receivables	20	60,496	95,866
Cash and cash equivalents	21	117,161	100,260
Total current assets		**185,441**	**202,789**
Current liabilities			
Trade and other payables	22	(87,740)	(99,717)
Borrowings	24	(6,744)	(6,764)
Provisions	26	(7,265)	(10,335)
Other liabilities	23	(14,229)	(14,285)
Total current liabilities		**(115,978)**	**(131,101)**
Total assets less current liabilities		**568,598**	**531,117**
Non-current liabilities			
Borrowings	24	(86,696)	(92,927)
Provisions	26	(4,919)	(3,108)
Total non-current liabilities		**(91,615)**	**(96,035)**
Total assets employed		**476,983**	**435,082**
Financed by			
Public dividend capital		262,141	259,845
Revaluation reserve		119,637	106,342
Financial assets reserve		(3,165)	77
Income and expenditure reserve		98,370	68,818
Total taxpayers' equity		**476,983**	**435,082**

The notes on pages 8 to 54 form part of these accounts.

Name	Lesley Watts
Position	Chief Executive
Date	19-Jun-20

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

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**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**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**244,608**	**87,028**	**-**	**59,403**	**391,039**
Surplus/(deficit) for the year	-	-	-	9,859	**9,859**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(28)	-	28	**-**
Impairments	-	19,342	-	-	**19,342**
Fair value gains on equity instruments designated at fair value through OCI	-	-	77	-	**77**
Public dividend capital received	15,237	-	-	-	**15,237**
Other reserve movements	-	-	-	(472)	**(472)**
Taxpayers' and others' equity at 31 March 2019	**259,845**	**106,342**	**77**	**68,818**	**435,082**

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

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus		44,314	25,075
Non-cash income and expense:			
Depreciation and amortisation	5.1	18,059	17,884
(Impairment reversals) / impairments	6	(11,352)	36,252
Income recognised in respect of capital donations	3	(7,250)	(6,067)
Decrease / (increase) in receivables and other assets		34,156	(8,312)
(Increase) / decrease in inventories		(1,121)	470
(Decrease) / increase in payables and other liabilities		(5,799)	28,020
(Decrease) in provisions		(1,262)	(3,507)
Other movements in operating cash flows		223	(4,522)
Net cash flows from operating activities		**69,968**	**85,293**
Cash flows from investing activities			
Interest received		952	979
Purchase of intangible assets		(11,781)	(17,422)
Purchase of PPE and investment property		(28,368)	(34,133)
Sales of PPE and investment property		22	13
Receipt of cash donations to purchase assets		7,250	5,855
Net cash flows used in investing activities		**(31,925)**	**(44,708)**
Cash flows from financing activities			
Public dividend capital received		2,296	15,237
Movement on loans from DHSC		(3,673)	(2,401)
Movement on other loans		(1,247)	10,884
Capital element of finance lease rental payments		(180)	(171)
Capital element of PFI, LIFT and other service concession payments		(1,132)	(1,063)
Interest on loans		(1,240)	(1,022)
Other interest		(1)	(4)
Interest paid on finance lease liabilities		(27)	(38)
Interest paid on PFI, LIFT and other service concession obligations		(4,460)	(4,390)
PDC dividend (paid)		(11,478)	(9,950)
Net cash flows (used in) / from financing activities		**(21,142)**	**7,082**
Increase in cash and cash equivalents		**16,901**	**47,667**
Cash and cash equivalents at 1 April - brought forward		**100,260**	**52,593**
Cash and cash equivalents at 31 March	21.1	**117,161**	**100,260**

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 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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

Note 1.2 Going concern

The Trust submitted a draft plan for 2020/21 to generate an overall deficit of £12.1m, with an adjusted financial deficit of £12.6m (excluding Marginal Rate Emergency Rule (MRET) or Financial Recovery Fund) against a financial improvement trajectory of £1.3m deficit, before the planning round was paused due to COVID19. As at the 31 March 2020 the Trust holds £117m of cash reserves and has a forecast cash balance of £67m at 31 March 2021.

The directors are confident that despite the draft deficit plan, 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 2021/22. The impact of COVID19 and associated changes to the cash regime for the first 4 months of 2020/21 (with block and top up arrangements) and the arrangements of NHSE-I to fund specific COVID19 spend have been taken into account for the Trust's plans and projections, including cash flows, liquidity and income base. As well as considering regulatory commitments, the Directors have a reasonable expectation that the Trust has adequate plans and resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

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.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. The value of these debts are not material (£0.9m).

The Trust does not receive income where a patient is readmitted for an avoidable reason within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of unavoidable readmissions is made at the year end and revenue is reduced by this value.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

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

Note 1.5 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

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

Measurement

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

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

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

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

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.
All land and buildings are restated to fair value in accordance with IAS 16 and NHSI guidance, using professional valuations at least every five years to ensure that fair values are not materially different from the carrying amounts. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation – Global Standards and the national standards and guidance as set out in the RICS Valuation – Professional Standards UK based on fair value, with specialised assets measured using the DRC method applying the alternative site approach where appropriate. The last valuation was carried out by Gerald Eve (Independent Chartered Surveyors, Registration number 5020866) as at 31 December 2019, this was a desk-top valuation following last year's full on-site evaluation.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5 by management.

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 for Chelsea and Westminster Hospital site and existing site for West Middlesex University Hospital.
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.

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 all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

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

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

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. Anortisation 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.

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 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.13 Financial assets and financial liabilities

Financial Instruments are defined as contracts that give rise to a financial asset of one entity and a financialliability orequity instrument of another entity. The Trust will commonly have the following financial assets and liabilities: trade receivables (but not prepayments), cash and cash equivalents, trade payables (but not deferred Income), finance lease obligations, borrowings.

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure with the exception of Sensyne 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 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 21.79% for 2019-20. 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 1.14 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

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 1.15 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 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

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

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.2 but is not recognised in the Trust's accounts.

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

Note 1.16 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 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, 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

Note 1.17 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, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.18 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 1.19 Third party assets

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

Note 1.20 Losses and special payments

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

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

Note 1.21 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 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. 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 1.24 Critical judgements in applying accounting policies

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

Property Valuations

The valuation exercise was carried out in December 2019 with a valuation date of 31 December 2019. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report for changes in the relevant property markets and tender price indices in the period between 31 December 2019 and 31 March 2020. This is on the basis of uncertainties in markets caused by COVID-19.

The Trust's valuer Gerald Eve outlined to the Trust there reasoning for the valuation uncertainty; *The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries. Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported as being subject to 'material valuation uncertainty' as set out in VPS 3 and VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation under frequent review.*
For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the declaration has been included to ensure transparency of the fact that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case. The material uncertainty clause is to serve as a precaution and does not invalidate the valuation.

The values in the 31 December 2019 report had been used to inform the measurement of property assets at valuation in these financial statements. However as the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and in accordance with further advice received from Gerald Eves, the Trust made further adjustments to the valuation of the property portfolio; reducing the land value by 5% (£5.0m) and dwellings by 5% (£0.6m) due to impact on nurses accomodation income; and so this was the best information available to the Trust.

Of the £405m net book value of land and buildings subject to valuation, £377m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service.

Note 1.25 Sources of estimation uncertainty

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

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 £0.9m at 31st March 2020 (31st March 2019 £2.9m). Disputes relate to challenges on pricing of activity and drugs, activity recording or 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 £17.0m of debt with NHS bodies at 31 March 2020 (2019 £33.6m) and £5.4m of debt with Local Authorities (2019 £9.5m). Management has considered the recoverability of this debt as at 31 March 2020 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.

Valuation
The valuer has declared a ‘material valuation uncertainty’ in the valuation report for changes in the relevant property markets and tender price indices in the period between 31 December 2019 and 31 March 2020. This is on the basis of uncertainties in markets caused by COVID-19. The Trust has recognised this material uncertainty in the accounts as a key source of estimation uncertainly, and also reduced the land value by 5% (£5.0m) and dwellings by 5% (£0.6m) due to impact on nurses accommodation income. The valuation was the best information available to the Trust.

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)	2019/20 £000	2018/19 £000
Acute services		
Elective income	66,286	71,786
Non elective income	186,061	171,114
First outpatient income	33,940	32,798
Follow up outpatient income	76,466	71,229
A & E income	35,611	29,794
High cost drugs income from commissioners (excluding pass-through costs)	59,110	71,999
Other NHS clinical income	76,216	69,142
Community services		
Community services income from CCGs and NHS England	2,495	2,616
All services		
Private patient income	18,883	18,442
Agenda for Change pay award central funding*	862	4,047
Additional pension contribution central funding**	14,616	-
Other clinical income	33,249	34,365
Total income from activities	**603,795**	**577,332**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

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

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	154,233	137,627
Clinical commissioning groups	394,196	375,827
Department of Health and Social Care	-	4,047
Other NHS providers	2,062	3,832
NHS other	159	498
Local authorities	28,068	31,340
Non-NHS: private patients	18,883	18,442
Non-NHS: overseas patients (chargeable to patient)	3,588	3,278
Injury cost recovery scheme	1,361	1,129
Non NHS: other	1,245	1,312
Total income from activities	**603,795**	**577,332**
Of which:		
Related to continuing operations	603,795	577,332

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

	2019/20 £000	2018/19 £000
Income recognised this year	3,588	3,276
Cash payments received in-year	2,236	1,771
Amounts added to provision for impairment of receivables	1,534	1,729
Amounts written off in-year	943	141

Note 3 Other operating income

	2019/20			2018/19		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	3,343	3,373	**6,716**	3,145	2,862	**6,007**
Education and training	24,440	-	**24,440**	26,708	-	**26,708**
Non-patient care services to other bodies	12,093	-	**12,093**	11,381	-	**11,381**
Provider sustainability fund (PSF)	11,374	-	**11,374**	41,462	-	**41,462**
Marginal rate emergency tariff funding (MRET)	6,385	-	**6,385**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	9,080	-	**9,080**	7,738	-	**7,738**
Receipt of capital grants and donations	-	7,250	**7,250**	-	6,067	**6,067**
Charitable and other contributions to expenditure	-	282	**282**	-	202	**202**
Support from the Department of Health and Social Care for mergers	-	11,040	**11,040**	-	16,544	**16,544**
Rental revenue from finance leases	-	-	**-**	-	-	**-**
Rental revenue from operating leases	-	736	**736**	-	694	**694**
Amortisation of PFI deferred income / credits	-	-	**-**	-	-	**-**
Other income	16,719	-	**16,719**	19,741	58	**19,799**
Total other operating income	**83,434**	**22,681**	**106,115**	**110,175**	**26,427**	**136,602**
Of which:						
Related to continuing operations			**106,115**			**136,602**
Related to discontinued operations			**-**			**-**

Other income of £16.7m (2018/19 £19.7m) includes ED funding £2.5m (2018/19 £3.2m), maternity funding for modular building £1.5m (2018/19 £2.9m, as maternity lease), staff accommodation rental £2.4m (2018/19 £3.6m), car parking income £2.6m (2018/19 £2.3m), Clinical Excellence Award £0.9m (2018/19 £0.9m), Sexual Health E-Services £0.9m (2018/19 £0.8m) and other various departmental schemes.

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	6,696	9,919
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	347	2,647

Note 4.2 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:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	548,429	513,454
Income from services not designated as commissioner requested services	55,366	63,878
Total	**603,795**	**577,332**

Note 5.1 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	3,903	3,432
Purchase of healthcare from non-NHS and non-DHSC bodies	8,492	8,037
Staff and executive directors costs	398,117	362,516
Remuneration of non-executive directors	140	142
Supplies and services - clinical (excluding drugs costs)	71,895	72,788
Supplies and services - general	43,635	39,316
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	70,187	83,672
Inventories written down	383	194
Consultancy costs	721	994
Establishment	2,572	3,050
Premises	14,191	13,545
Transport (including patient travel)	3,325	3,040
Depreciation on property, plant and equipment	13,862	14,306
Amortisation on intangible assets	4,197	3,578
(Impairment reversal)/ impairments	(11,352)	36,252
Movement in credit loss allowance: contract receivables / contract assets	(2,345)	(1,146)
Movement in credit loss allowance: all other receivables and investments	(141)	196
(Decrease)/increase in other provisions	(1,346)	262
Audit fees payable to the external auditor		
audit services- statutory audit	142	135
other auditor remuneration (external auditor only)	-	15
Internal audit costs	146	164
Clinical negligence	22,436	21,130
Legal fees	253	440
Insurance	221	218
Research and development	3,327	2,509
Education and training	1,546	1,439
Rentals under operating leases	3,066	5,368
Redundancy	109	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	11,808	11,551
Car parking & security	930	889
Hospitality	20	54
Losses, ex gratia & special payments	446	83
Other services, eg external payroll	473	452
Other	237	238
Total	**665,596**	**688,859**
Of which:		
Related to continuing operations	665,596	688,859

Note 5.2 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	-	15
Total	**-**	**15**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2019/20 or 2018/19.

Note 6 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(11,352)	36,252
Total (impairment reversals) / impairments charged to operating surplus / deficit	**(11,352)**	**36,252**
Impairments charged to the revaluation reserve	(13,309)	(19,342)
Total (Impairment revelsals) / impairments	**(24,661)**	**16,910**

The Trust instructed Gerald Eve to carry out a revaluation of its property portfolio as at 31st December 2019. The revaluation was predominantly based on modern equivalent asset values using the alternative site approach where appropriate. This exercise resulted in a increase in the value of the relative assets by £30.3m which has been accounted for, initially against the Income and Expenditure Account as reversal of prior year net impairments of £11.4m and thereafter as a net increase in revaluation reserve of £18.9m in accordance with the Trust's accounting policies and NHS Improvement guidance.

Following the outbreak of the Novel Coronavirus (COVID-19) declared by the World Health Organisation as a 'Global Pandemic' on the 11th March 2020, has impacted global financial markets. In accordance with the advice received from Gerald Eves, the Trust made further adjustments to the valuation of the property portfolio; reducing the land value by 5% (£5.0m) and dwellings by 5% (£0.6m) due to impact on nurses accomodation income. This exercise resulted in a revised increase in the value of the relative assets by £24.7m which has been accounted for, initially against the Income and Expenditure Account as reversal of prior year net impairments of £11.4m and thereafter as a net increase in revaluation reserve of £13.3m in accordance with the Trust's accounting policies and NHS Improvement guidance.

Note 7 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	311,983	287,815
Social security costs	33,056	30,946
Apprenticeship levy	1,503	1,389
Employer's contributions to NHS pensions	47,836	31,252
Pension cost - other	37	24
Temporary staff (including agency)	15,248	20,593
Total staff costs	**409,663**	**372,019**
Of which		
Costs capitalised as part of assets	8,219	6,994

Note 7.1 Retirements due to ill-health

During 2019/20 there were no early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is 0k (£126k in 2018/19).

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

In 2019/20 Directors' remuneration (including Non-Executive Directors) was £1,481k (2018/19 £1,437k) of which £0k (2018/19 £0k) is included for redundancy. Remuneration includes employer contributions to the pension scheme of £80k (2018/19 £68k).

Further details of directors' remuneration can be found in the remuneration report.

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 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 Financial Reporting Manual (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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 a defined contribution workplace pension scheme backed by the UK Government.
In 2019/20 the Trust paid £39,376 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.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	736	694
Total	**736**	**694**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	736	694
Total	**736**	**694**

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).

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.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	3,463	5,751
Less sublease payments received	(397)	(383)
Total	**3,066**	**5,368**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	2,879	3,346
- later than one year and not later than five years	6,403	3,015
- later than five years.	5,273	2,744
Total	**14,555**	**9,105**

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.

Note 10 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	832	463
Other finance income	95	142
Total finance income	**927**	**605**

Note 11.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	980	1,024
Other loans	254	7
Finance leases	27	38
Interest on late payment of commercial debt	1	4
Main finance costs on PFI and LIFT schemes obligations	2,463	2,545
Contingent finance costs on PFI and LIFT scheme obligations	1,984	1,845
Total interest expense	**5,709**	**5,463**
Unwinding of discount on provisions	3	3
Total finance costs	**5,712**	**5,466**

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

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	417
Amounts included within interest payable arising from claims made under this legislation	1	4

Note 12 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	22	13
Losses on disposal of assets	(466)	-
Total (losses) / gains on disposal of assets	**(444)**	**13**

The disposal losses relates to the disposal of an IT clinical portal for Patient Records in the year. As the Trust has been in development of a new electronic patient record (EPR) system for the past three years which went live in 2019/20, the portal was no longer required.

Note 13.1 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 - brought forward	**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 - brought forward	**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 13.2 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	**4,591**	**19,256**	**18,873**	**42,720**
Additions	-	-	13,995	**13,995**
Reclassifications	595	15,318	(15,913)	**-**
Disposals / derecognition	-	(91)	-	**(91)**
Valuation / gross cost at 31 March 2019	**5,186**	**34,483**	**16,955**	**56,624**
Amortisation at 1 April 2018 - as previously stated	**2,531**	**13,563**	**-**	**16,094**
Provided during the year	473	3,105	-	**3,578**
Disposals / derecognition	-	(91)	-	**(91)**
Amortisation at 31 March 2019	**3,004**	**16,577**	**-**	**19,581**
Net book value at 31 March 2019	**2,182**	**17,906**	**16,955**	**37,043**
Net book value at 1 April 2018	**2,060**	**5,693**	**18,873**	**26,626**

Note 14.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**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 - brought forward	**-**	**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 14.2 Property, plant and equipment - 2018/19

	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 2018 - as previously stated	**82,498**	**288,034**	**13,472**	**11,883**	**71,434**	**121**	**14,559**	**3,672**	**485,673**
Additions	-	10,884	-	25,986	-	-	-	-	**36,870**
Impairments	(1,214)	(42,975)	-	-	-	-	-	-	**(44,189)**
Reversals of impairments	11,018	16,203	58	-	-	-	-	-	**27,279**
Revaluations	-	(8,442)	(386)	-	-	-	-	-	**(8,828)**
Reclassifications	-	9,800	175	(14,415)	4,370	-	84	(14)	**-**
Disposals / derecognition	-	-	-	-	(3,423)	-	(237)	(79)	**(3,739)**
Valuation/gross cost at 31 March 2019	**92,302**	**273,504**	**13,319**	**23,454**	**72,381**	**121**	**14,406**	**3,579**	**493,066**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**5,061**	**409**	**-**	**53,497**	**121**	**12,947**	**2,781**	**74,816**
Provided during the year	-	8,736	363	-	4,417	-	583	207	**14,306**
Revaluations	-	(8,442)	(386)	-	-	-	-	-	**(8,828)**
Disposals / derecognition	-	-	-	-	(3,423)	-	(237)	(79)	**(3,739)**
Accumulated depreciation at 31 March 2019	**-**	**5,355**	**386**	**-**	**54,491**	**121**	**13,293**	**2,909**	**76,555**
Net book value at 31 March 2019	**92,302**	**268,149**	**12,933**	**23,454**	**17,890**	**-**	**1,113**	**670**	**416,511**
Net book value at 1 April 2018	**82,498**	**282,973**	**13,063**	**11,883**	**17,937**	**-**	**1,612**	**891**	**410,857**

Note 14.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £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 - government granted	-	1,061	-	-	16	-	-	**1,077**
Owned - donated	-	7,171	-	10,104	665	-	-	**17,940**
NBV total at 31 March 2020	**95,749**	**296,805**	**12,333**	**25,761**	**19,347**	**732**	**530**	**451,257**

Note 14.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	92,302	208,118	12,933	17,416	17,218	1,113	670	**349,770**
Finance leased	-	2,354	-	-	-	-	-	**2,354**
On-SoFP PFI contracts and other service concession arrangements	-	52,054	-	-	-	-	-	**52,054**
Owned - government granted	-	997	-	-	21	-	-	**1,018**
Owned - donated	-	4,626	-	6,038	651	-	-	**11,315**
NBV total at 31 March 2019	**92,302**	**268,149**	**12,933**	**23,454**	**17,890**	**1,113**	**670**	**416,511**

Note 15 Donations of property, plant and equipment

The Trust has received donations of £6,369k in the year. Within it £6,273k for the construction and purchase of property, plant and equipment and £96k for Covid 19 equipment purchase.

Note 16 Revaluations of property, plant and equipment

The Trust instructed Gerald Eve to carry out a revaluation of its property portfolio as at 31st December 2019. The revaluation was predominantly based on modern equivalent asset values using the alternative site approach where appropriate. This exercise resulted in an increase in the value of the relative assets of £30.3m, this represents £11.4m increase in value charged to the I&E for reversal of prior year impairment and £18.9m increase in revaluation reserves in accordance with the Trust's accounting policies and NHS Improvement guidance. Following the outbreak of the Novel Coronarius (COVID-19) declared by the World Health Organisation as a 'Global Pandemic' on the 11th March 2020 and in accordance with the advice received from Gerald Eves declaring a 'material valuation uncertainty' in the valuation report, changes in the relevant property markets and tender price indices in the period between 31 December 2019 and 31 March 2020 have been made; reducing the land value by 5% (£5,039k) and dwellings by 5% (£649k) due to impact on nurses accomodation income, this £5,688k movement was all against the revaluation reserves.

Note 17 Investments in associates and joint ventures

	2019/20	2018/19
	£000	£000
Carrying value at 1 April - brought forward	**1,276**	**872**
Share of profit / (loss)	909	404
Carrying value at 31 March	**2,185**	**1,276**

The Trust holds a 50% share in Systems Powering Healthcare Limited ("Sphere"), an IT shared services company set up as a joint venture with the Royal Marsden Hospital Foundation Trust and receives a 58% share of profit or loss. Sphere is a United Kingdom company which commenced operations in April 2015. The Trust accounts for its share of Sphere's gains and losses using the equity method. The Trust has served notice to Sphere in its participation in the joint venture, for the end of 2020/21.

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

	2019/20	2018/19
	£000	£000
Carrying value at 1 April - brought forward	**4,599**	**-**
Acquisitions in year	-	4,522
Movement in fair value through OCI	(3,242)	77
Carrying value at 31 March	**1,357**	**4,599**

The Trust recognises Sensyne Plc shares as Fair Value through OCI. As at 31 March 2020 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 2020	31 March 2019
	£000	£000
Drugs	3,880	3,057
Consumables	3,635	3,365
Energy	216	188
Other	53	53
Total inventories	**7,784**	**6,663**

Inventories recognised in expenses for the year were £67,220k (2018/19: £78,079k). Write-down of inventories recognised as expenses for the year were £383k (2018/19: £194k).

Note 20.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	56,116	91,319
Allowance for impaired contract receivables / assets	(9,691)	(13,618)
Allowance for other impaired receivables	(446)	(589)
Prepayments (non-PFI)	10,042	12,483
Interest receivable	35	60
PDC dividend receivable	484	-
VAT receivable	812	1,739
Other receivables	3,144	4,472
Total current receivables	**60,496**	**95,866**
Non-current		
Other receivables	1,673	-
Total non-current receivables	**1,673**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	27,298	64,883
Non-current	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 £1.7m 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

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**13,618**	**589**	**15,666**	**393**
New allowances arising	3,054	40	4,552	290
Reversals of allowances	(5,399)	(181)	(5,698)	(94)
Utilisation of allowances (write offs)	(1,582)	(2)	(902)	-
Allowances as at 31 Mar 2020	**9,691**	**446**	**13,618**	**589**

The total balance for allowances contract credit losses includes £4,587k for Overseas patients credit losses, £1,138k for NHS, £1,021k for Local Authorities, £556k for Private Patient, £1,135k for Others and £1,254k Road Traffic Accident (RTA). Each year the Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the RTA income, for 2019/20 this figure is 21.79%. The total balance for allowances for non contract credit losses is for salary overpayment of £446k.

Note 21.1 Cash and cash equivalents movements

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

	2019/20 £000	2018/19 £000
At 1 April	**100,260**	**52,593**
Net change in year	16,901	47,667
At 31 March	**117,161**	**100,260**
Broken down into:		
Cash at commercial banks and in hand	191	307
Cash with the Government Banking Service	116,970	99,953
Total cash and cash equivalents as in SoFP	**117,161**	**100,260**

Note 22.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	17,224	15,758
Capital payables	6,013	11,709
Accruals	48,741	58,125
Social security costs	4,773	4,445
Other taxes payable	4,139	4,054
PDC dividend payable	-	538
Other payables	6,608	5,088
Total current trade and other payables	**87,498**	**99,717**
Of which payables from NHS and DHSC group bodies:		
Current	16,492	23,586

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	14,229	14,285
Total other current liabilities	**14,229**	**14,285**

Note 24.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	3,781	3,787
Other loans	1,285	1,254
Obligations under finance leases	28	180
Obligations under PFI, LIFT or other service concession contracts	1,650	1,543
Total current borrowings	**6,744**	**6,764**
Non-current		
Loans from DHSC	48,177	51,850
Other loans	8,359	9,637
Obligations under finance leases	248	276
Obligations under PFI, LIFT or other service concession contracts	29,912	31,164
Total non-current borrowings	**86,696**	**92,927**

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 £34.5m with an interest rate of 1.8%. The capital investment loans have balances of £8.7m, with an interest rate of 1.46%, and £8.8m, 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 £9.6m

Note 24.2 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**
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 24.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**57,925**	**-**	**627**	**32,887**	**91,439**
Cash movements:					
Financing cash flows - payments and receipts of principal	(2,401)	10,884	(171)	(1,063)	**7,249**
Financing cash flows - payments of interest	(1,022)	-	(38)	(2,559)	**(3,619)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	111	-	-	425	**536**
Application of effective interest rate	1,024	7	38	2,545	**3,614**
Other changes	-	-	-	472	**472**
Carrying value at 31 March 2019	**55,637**	**10,891**	**456**	**32,707**	**99,691**

Note 25 Finance leases

Note 25.1 Chelsea and Westminster Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**355**	**562**
of which liabilities are due:		
- not later than one year;	45	207
- later than one year and not later than five years;	179	180
- later than five years.	131	175
Finance charges allocated to future periods	(79)	(106)
Net lease liabilities	**276**	**456**
of which payable:		
- not later than one year;	28	180
- later than one year and not later than five years;	131	124
- later than five years.	117	152

The Trust had two finance lease arrangements during 2019/20:
1. MRI building. The outstanding period for this lease is 8 years.
2. MRI scanner. This lease completes in May 2020.

Note 26.1 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 2019	**1,630**	**918**	**287**	**2,911**	**636**	**7,061**	**13,443**
Arising during the year	**190**	**168**	**623**	**755**	**137**	**1,895**	**3,768**
Utilised during the year	(185)	(63)	(49)	(748)	(28)	(555)	**(1,628)**
Reversed unused	**(46)**	**-**	**(73)**	**(2,029)**	**(222)**	**(1,032)**	**(3,402)**
Unwinding of discount	**1**	**2**	**-**	**-**	**-**	**-**	**3**
At 31 March 2020	**1,590**	**1,025**	**788**	**889**	**523**	**7,369**	**12,184**
Expected timing of cash flows:							
- not later than one year;	184	64	788	889	523	**4,817**	**7,265**
- later than one year and not later than five years;	730	257	-	-	-	**527**	**1,514**
- later than five years.	676	704	-	-	-	**2,025**	**3,405**
Total	**1,590**	**1,025**	**788**	**889**	**523**	**7,369**	**12,184**

Contractual disputes relate to challenges from Commissioners on pricing, charging and penalties. Other provisions include NHS Resolution LTPS Claim of £99k (2018/19 £89k), dilapidations £879k (2018/19 £805k), contractual pay claims £2,311k (2018/19 £3,088k), clinician pension tax £1,673k (2018/19 £0) and other contractual claims £2,407k (2018/19 £3,078k).

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £375,367k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Chelsea and Westminster Hospital NHS Foundation Trust (31 March 2019: £344,168k).

Note 27 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(36)	(33)
Net value of contingent liabilities	**(36)**	**(33)**

Note 28 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	6,792	13,685
Intangible assets	504	4,429
Total	**7,296**	**18,114**

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

Note 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**54,930**	**58,538**
Of which liabilities are due		
- not later than one year;	3,626	4,006
- later than one year and not later than five years;	13,341	13,781
- later than five years.	37,963	40,751
Finance charges allocated to future periods	(23,368)	(25,831)
Net PFI, LIFT or other service concession arrangement obligation	**31,562**	**32,707**
- not later than one year;	1,650	1,543
- later than one year and not later than five years;	4,803	4,869
- later than five years.	25,109	26,295

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**275,335**	**288,036**
Of which payments are due:		
- not later than one year;	14,741	14,298
- later than one year and not later than five years;	61,632	60,112
- later than five years.	198,962	213,626

Note 29.3 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 £4.3m 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.

	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**18,626**	**18,200**
Consisting of:		
- Interest charge	2,463	2,545
- Repayment of balance sheet obligation	1,132	1,063
- Service element and other charges to operating expenditure	11,808	11,551
- Capital lifecycle maintenance	1,239	1,196
- Contingent rent	1,984	1,845
Total amount paid to service concession operator	**18,626**	**18,200**

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 30 Financial instruments

Note 30.1 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 2020 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 30.2 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 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**

Carrying values of financial assets as at 31 March 2019	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	81,644	-	-	**81,644**
Other investments / financial assets	-	-	4,599	**4,599**
Cash and cash equivalents	100,260	-	-	**100,260**
Total at 31 March 2019	**181,904**	**-**	**4,599**	**186,503**

The Trust recognises Sensyne Plc shares as Fair Value through OCI. As at 31 March 2020 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 30.3 Carrying values of financial liabilities

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**

Carrying values of financial liabilities as at 31 March 2019	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	55,637	-	**55,637**
Obligations under finance leases	456	-	**456**
Obligations under PFI, LIFT and other service concession contracts	32,707	-	**32,707**
Other borrowings	10,891	-	**10,891**
Trade and other payables excluding non financial liabilities	86,182	-	**86,182**
Provisions under contract	5,116	-	**5,116**
Total at 31 March 2019	**190,989**	**-**	**190,989**

Note 30.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	89,950	97,257
In more than one year but not more than two years	6,305	6,339
In more than two years but not more than five years	18,756	19,353
In more than five years	61,634	68,040
Total	**176,645**	**190,989**

Note 31 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	31	2	1	11
Bad debts and claims abandoned	912	1,137	407	240
Stores losses and damage to property	26	383	22	194
Total losses	**969**	**1,522**	**430**	**445**
Special payments				
Ex-gratia payments	30	62	37	75
Total special payments	**30**	**62**	**37**	**75**
Total losses and special payments	**999**	**1,584**	**467**	**520**
Compensation payments received		56		19

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 were no individual cases over £300,000 in the year (2018/19 none).

Note 32 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 33 Academic Health Partnership

The Trust has continued to be a partner in Imperial College Healthcare Partners Limited, a company limited by guarantee, in the year, 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 (2018/19 £34k).

Note 34 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 35 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 none of the Board members or members of the senior management team or parties related to them has undertaken any material transactions with the Trust.

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 of the Trust.

Sphere	**2019/20 £000s**	**2018/19 £000s**
Receivables	520	1,414
Payables	15	-
Income	397	383
Expenditure	7,484	6,860

CW+	**2019/20 £000s**	**2018/19 £000s**
Receivables	374	19
Payables	7	-
Income	7,249	5,855
Expenditure	48	-

Note 36 Events after the reporting date
Following the impact of COVID19, the Trust's financial regime for 2020/21 has changed for the first four months of the financial year, where the Trust has been instructed to report a breakeven position and been placed on a block contracting arrangement with commissioners. Any shortfall in income or costs above the agreed breakeven baseline are to be accrued and will be reimbursed by NHSE/I.

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