NHS
Central and
North West London
NHS Foundation Trust

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Annual Report and Accounts 2018-19

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of the National Health Service Act 2006

Staff at Roxbourne rehabilitation services

Contents

Performance report

Overview of performance

Chair and Chief Executive's statement

CNWL provides NHS services for the entire lifespan, in physical and mental health and in the space between GPs and hospitals (though we also have 900 beds!). In this sense we are a very modern part of the NHS, something the new Long Term Plan wants to see more of, with better integration and coordination of care, delivered as close to home as possible.

Partnerships are central to what we do here – with patients and their families, with staff and with other organisations, especially commissioners and providers but also with local authorities, GPs, universities and the voluntary sector. We envisage more of them as we go into the next year and into the 2020s.

The last year has been very challenging but we achieved a huge amount with hard working staff, delivering treatment and care in the most varied of settings.

This report contains so much about everything we do: our performance and targets, our initiatives, our governance processes, patient feedback, quality, involvement, customer care, ratings, our people, our charity and accounting for every penny we receive and spend.

It's quite right that there is this degree of accountability and scrutiny – the NHS belongs to the people.

It's a massive undertaking and something worth looking through and we hope you do.

All that said we know that we are judged most on the quality of our care and this remains central to everything we have done and will do.

Thanks to all our staff who are a real credit to the NHS and their professions.

A good example from this year, was the opening of Lavender Walk, a new inpatient unit for adolescents with mental health difficulties in North West London at the Centre for Mental Health in South Kensington, next to Chelsea and Westminster Hospital.

This was funded through the national New Models of Care programme and delivered from the North West London CAMHS New Models of Care programme, which is made up of West London NHS Trust and CNWL – working together jointly for better services and improved care.

There are others: we are working in partnership to provide integrated models of care with other providers, local authorities and commissioners all over our patch so we reduce the inefficiency of patients moving between different partners. This directly impacts on the quality of the care that is offered and is central to national policy as set out in the Five Year Forward View (2014) and reconfirmed in the Long Term Plan this year.

This includes the integrated model in Hillingdon, support to developing programmes in North West London (NWL), the Community Independence Service also in NWL and a Home 1st Service in Milton Keynes, as well as our successful bid to provide community services across Ealing – in partnership with West London NHS Trust. This is a 10-year contract during which we can build services with assurance that we have time to develop a truly integrated service. This is an exciting new venture.

We are proud of the progress being made by CNWL in this respect with examples such as Hillingdon Health and Care Partners; the Milton Keynes development of integration at 'Place'; and the varied models across NWL.

As an illustration of the power of integration, our Community Independence Service (CIS) provided with West London NHS Trust, GP Federations and local authorities has this year seen 5,300 people, prevented 2,000 avoidable admissions to hospital and supported 2,400 to leave hospital as soon as possible. This is a huge saving for the system – and a quality gain as over 98% of those who received CIS care have said they would recommend the service.

We are committed to strengthening our partnership in the three Sustainability Transformation Plans/Integrated Care systems in North West and North Central London and Bedford Luton and Milton Keynes.

Over recent years we have invested in our information systems so that we are able to respond to the new opportunities in our digital world. We have called this programme 'More Time to Care' to remind us that at the centre of this lies our determination that clinical time should not be consumed in bureaucracy. A major part of this programme was bringing mental health and community services together onto the same system

– 'SystmOne'. We're grateful for the patience and dedication of teams in making sure this went smoothly.

Last year we referred to our work through the focussed programme of 'Quality Improvement', QI. This is a proven methodology for working with staff and patients to deliver improvements in care. I've been pleased to see the enthusiasm of staff in their own projects with 1,100 staff now trained and running almost 400 improvement projects!

Another key area of work for us is to improve access to physical health services for people with mental health difficulties. The inequality of life expectancy between this group and the rest of the population is not acceptable and is a priority at national level as well as for us in CNWL – and we are making real progress in providing health checks to all our patients.

We have made great strides with our workforce, including reducing our use of temporary staff to the level set for us.

This is not to say that we are always getting it right; things do go wrong; outcomes are not always achieved and sometimes we fail to meet the high standards we set ourselves. We like to make sure we learn from what has not gone well, reflecting on what we could have done better so other people can benefit.

The skills of our staff and services continue to be recognised through awards, accreditations and scholarships from prestigious organisations. We thank them for their continued hard work, dedication and achievements.

This is the second year since the terrible Grenfell Tower fire of the night of 14 June 2017.

People who live and work in the vicinity continue to be deeply affected by it, and this year have faced the additional challenge of the inquiry. We have sought to provide the best care and support in partnership with local people since that night. We thank all our staff and our partners as we continue to respond and work with the Grenfell community.

We also thank all our Governors who whilst formally appointed are all volunteers; they provide invaluable skilled insight to our work.

Finally, we thank those who are the reason we are here and whose needs must form the very centre of all we do; our patients and their families.

Claire Murdoch CBE
Chief Executive
28 May 2019

Professor Dorothy Griffiths OBE, FCGI
Chair
28 May 2019

Lead Governor's statement

I am honoured to be Lead Governor of CNWL.

As Governors, our mission is to understand and communicate the views of our members, and I have always found the Trust to be an organisation that welcomes these views – listens and responds – whether these are views from our new Governors or longer-standing ones.

Our voice is important in ensuring that members' views influence the direction of CNWL. There are a range of events and learning opportunities, including visits to services. We use these opportunities to voice our members' views on how the Trust can improve the quality of healthcare services for those who need them. With the strong input of our Governors, I believe the Trust is able to develop services that meet the needs of the population as well as they do.

Grenfell continues to exert its shadow over a lot of the work that CNWL carries out within West London, so as Governors we were pleased to visit and support the Grenfell Health and Wellbeing Team over the course of the year. This is a team that has achieved so much in such a short space of time.

It has been pleasing to see the progress that our Chief Executive, Claire Murdoch, has been making through her position as National Mental Health Director and how this is being replicated within CNWL.

An example of this has been the A&E mental health training project between CNWL and London North West University Healthcare NHS Trust to improve the quality of care at Northwick Park Hospital in January 2019.

I am also pleased to have seen the way in which our physical health services, especially in the community, have achieved so much and have helped the whole health economy; this type of work is where the future of the NHS lies and the Governors are fully involved and support it.

We have been experiencing a variety of financial challenges and as Governors we can be under no illusions that the coming year is likely to be even tougher. However, we have made progress this year and we will continue to work with the Trust to make sure this progress continues.

I would like to thank all the Governors for their continued commitment and our Chair, Professor Dorothy Griffiths, who has led the Council of Governors so effectively this year.

We're listening; if you have any comments, ideas and feedback the Governors can, as always, be contacted at: governors.cnwl@nhs.net

Councillor Ketan Sheth
Lead Governor

Strategic report

A brief history of CNWL and its statutory background

2002

Central and North West London NHS Mental Health Trust was formed, following a merger of three mental health trusts covering the London boroughs of Brent, Kensington and Chelsea, Westminster and Harrow, and addiction services in West London.

2007

CNWL became a Foundation Trust in 2007 – Central and North West London NHS Foundation Trust. In the same year, Hillingdon Child, Family and Adolescent Consultation Service joined the Trust.

2009

Enfield Learning Disability Services joined CNWL.

2010

CNWL took on primary care, mental health and substance misuse services within a range of prison services.

2011

CNWL integrated with community health services in Hillingdon and Camden including sexual health services in Camden.

2013

CNWL integrated with Milton Keynes community and mental health services (April).

2016

Community Independence Service joined CNWL.

2017

CNWL rated as 'Good' by the CQC.

2018

CNWL returns to Hounslow to provide addictions services, after a four-year absence

2019

Ealing CCG confirms that West London Trust, in partnership with CNWL, has been awarded the contract to deliver its single contract for community -based services within the borough. Services to start from June 2019.

Who we are

CNWL is a large community facing Trust, caring for people with a wide range of physical and mental health needs in a variety of settings (hospitals, clinics, schools, homes, prisons) for every age. We are the eighth largest provider of mental health and community care in England, rated by income.

We also provide specialised services to communities outside those areas.

We are rated as overall 'Good' by the CQC with outstanding services in Learning Disability and Sexual Health.

We have nearly 7,000 staff providing a range of mental health, community, learning disability, substance misuse, sexual health, dentistry and specialised services to a population of around three million in the South East of England, including in North West London, Surrey, Kent, Milton Keynes and Buckinghamshire, treating around 300,000 people either in the community or as inpatients.

This means there are very different levels of wealth and deprivation in CNWL's patch, which we must consider in designing services with local people.

CNWL's services are mainly within three of the 44 regional Sustainability and Transformation Programmes (STPs) for England. STPs are catchments or 'footprints' within which all the health and social care community needs to work together with shared objectives and shared financial goals.

A snapshot of our services

Your Life Line

2:00 Your Life Line – receives a call from a daughter anxious at her mother's distress. The mother has advanced cancer and over the last few days has deteriorated. The daughter thinks her mother is suffering and in pain and wants to call an ambulance to take her to hospital.

She is known to both the Hillingdon Palliative Care Service and to Your Life Line. Looking at her notes through Coordinate My Care the team are aware of the mother's preference to die at home. The team reassure the daughter and suggest that they come and see her and her mother.

2.30 The team arrive at the house. The support worker sits with the daughter and lets her express her fears; the clinical nurse specialist sits with the mother and reassesses her symptoms.

After a discussion with them both an extra injection is given to support the pain control and the syringe driver re-adjusted. The team stay with the family while the symptoms subside. The daughter reassured supports her mother staying at home and decides not to call an ambulance.

5.30 The mother dies at home, her symptoms controlled with her daughter present.

Single Point of Access

8:00 A service user contacts the Single Point of Access in suicidal crisis. The shift coordinator is a registered mental health nurse and their day began five minutes ago. They have not received a handover before an administrator, who answered the phone, hands them a Post-It note with a name and NHS number. The call is transferred to the shift coordinator as others begin to queue.

The moments that follow reveal several pieces of information. The caller is not currently receiving mental health support. They were recently discharged. They have been drinking heavily. They have taken an overdose. They will not go to hospital. The emergency services have exhausted all available options.

The next hour is spent negotiating, de-escalating and, even, pleading with the caller to access treatment. Eventually they do. There is quiet for a moment before a telephone ringing breaks the silence once more.

Surrey Integrated Sexual Health and HIV Services

9:00 A 31 year old female attended for a contraception appointment. During the consultation the mandatory domestic abuse question was asked, "Are you afraid of anyone at home or of any partner?"

Tentatively she responded "yes, possibly". She disclosed that her partner was controlling.

More questions were asked and following this the safeguarding lead called 24 hours later and a "Safe Life" assessment was undertaken.

As there were individuals aged under 18 living in the house a referral to Social Services was made. The patient was advised to call 999 should the violence escalate and was given information and advice on how to access local domestic abuse services and was encouraged to contact them as soon as possible.

Ealing Recovery Intervention Services

9:30 Titration Clinic: Newly assessed and prepped patients attend the service in a state of 'physical withdrawal' from their usual choice of illicit opioid addiction.

While a bit unpleasant, this allows the clinical staff to assess and prescribe a safe substitute such as Buprenorphine or Methadone which will alleviate the withdrawal symptoms within minutes.

This process also ensures that patients are not accidentally given excess opioids on top of what is already in their system.

The patient will go on to be reviewed twice before they are stabilised on a therapeutic dose. This has been the life-line that has helped hundreds of people fight their addiction to opioids in Ealing. This process has ensured that no-one in our care has suffered ill-health or fatality in the process of being introduced to prescribed substitute to heroin and the like.

Central London Action on Sexual Health Health Promotion Outreach Service

9:30 Two health promotion specialists have a booked session at a Drug and Alcohol Service in Islington from 9.30am to 12.30pm where homeless clients and those affected by drug and alcohol issues attend.

They set up in two places a private and confidential room for consultation and screening and also set up a health promotion table in the main space of the service to engage with clients.

Following the session, staff return to the Mortimer Market Centre to process samples and admin from the session.

Central Criminal Court

10:00 Our clinical nurse specialist receives a telephone call to attend the court room. The judge requests a fitness assessment on a defendant who has been charged with murder. He attends the court room at 2pm with his written report following the assessment undertaken in the cells.

The judge requests the clinical nurse specialist contacts the consultant psychiatrist for the team for a further report. He joins the consultant for the assessment and contacts another consultant psychiatrist for a second opinion as requested by the Crown Prosecution Service.

This second opinion takes place and the two consultants produce a joint statement for the court about their findings and the trial continues to a conclusion.

Harrow 0 to 19 Service

10:00 The admin contact centre receives a late new birth notification and notifies the health visitor team leader.

All new birth visits need to be undertaken between days 10 and 14 post-delivery, so late notifications need to be allocated as a matter of urgency.

The allocated health visitor contacts the family by telephone and a home visit is arranged for the afternoon.

During the visit, the health visitor reviews the health and wellbeing of baby and mother, covering their physical and mental health needs.

The health visitor also provides the parent with an information pack including how to access the 0-19 service, clinic and weighing schedule and information on health issues such as feeding and safety.

Mother is also encouraged to attend a local children centre for assistance from breast feeding peer supporters. Mother agrees to a referral to the infant feeding lead for additional support.

The health visitor arranges a return call to assess that progress has been made regarding the breast feeding issue and whether any further support is needed.

Community Independent Service Rehabilitation Team

10:00 Two CIS rehab occupational therapists (OT) meet a patient and her two carers at her home to try out her new hoist and chair.

The OTs train the carers on how to use the hoist safely; it's a new piece of equipment to them and they are nervous but keen to learn.

Since she came out of hospital four weeks ago the patient has been cared for in bed. She has been working on exercises with the CIS rehab physiotherapist and rehab assistant, which have included her rolling from side to side in her bed to build up her core strength. She is now able to participate more actively in her care, as the carers put the sling of the hoist around her.

The OTs show the patient how to use the hand controls of her new hoist and with their close supervision she hoists herself out of bed and into her new riser-recliner arm chair. This is the first time she has sat out of bed in months and as her feet touch the floor she says "this feels strange actually!".

The OTs assess her positioning to reduce pressure care risks and advise her on how long to sit safely for and how to adjust her position.

The OTs update the care plan and share it with the carers, if she continues to be able to hoist herself there's a good chance that Adult Social Care Reablement services can reduce the amount of carers supporting her every day.

The patient chooses her first meal sitting out in her chair to be scrambled eggs on toast. Meanwhile the OTs work out how best she can watch her favourite TV programmes in her new furniture set up.

Offender Care pharmacy team at HMP and YOI Winchester

10:30 A patient arrives at the service from another establishment. Our on-site pharmacist is told he is currently receiving treatment for Hepatitis C using a specialist medication initiated by hepatology. The medication is high cost (about £36,000 for a 12 week course) and on the 'red list' of drugs only available through the relevant clinic or specific home delivery services. However he has not come with his medication so there is an urgent need to source this medication so the patient can continue their course with as little interruption as possible.

Eventually our pharmacist is able to locate medication and also discovered that the patient had only been with the previous establishment for 24 hours as he was an onward transfer from another establishment.

This establishment is contacted to get details of the prescribing clinic and the specialist nurse is emailed to find out what they need done for care continuation.

Our pharmacist then liaises with local clinicians to request liver function tests and ultrasound as requested by the hepatology team.

Referral to local hepatology service processed for patient follow-up and blood tests booked on system for end of treatment and 12 week post completion of course to confirm eradication of Hepatitis C virus.

HMP Woodhill Primary Care Team

10:45 The prison calls a 'Code Red' on House Unit Two to attend an incident on the wing where a prisoner has caused self-inflicted injuries to his neck with a razor. A 'Code Red' means the Control Room automatically call an ambulance and they are requesting more information.

There is a nurse on the wing already and Hotel One – an emergency care technician – responds from his current location in the prison. A prison officer brings the wing based medical emergency bags.

Senior healthcare staff arrive to offer support and clinical leadership.

Staff on scene finds the prisoner is fully alert. There is blood on the bed and floor of the cell. He has a large incision on the right side of his neck. It's gaping and bleeding freely. He is holding a t-shirt to the wound. On examination of the wound, vessels and underlying structures are visible but intact. The prisoner's observations are stable with no signs of shock. Decision is taken for the Doctor on site to suture the wound with assistance from the practice nurse in Healthcare.

Hotel One informs Control "stand the ambulance down, we can manage this".

Vincent Square Eating Disorders Inpatient Unit

12:00 Staff set up the dining room for lunch, but a patient is unable to eat the meal. Staff and peers gather around the table offer support reminding her of her goals.

She walks out of the dining room and goes back to her bedroom, refusing to come back. Staff check to see how she is as completing meals is non-negotiable.

She is given the option of returning to the dining room to complete the meal or offered a nutrition drink as a supplement or through Naso Gastric Feeding. The patient opts for Naso Gastric Feeding, which is then administered by nursing staff.

Milton Keynes Home 1st

14:00 The Home 1st Therapy Team return from a home visit. They are concerned for a patient's safety. An emergency team meeting is therefore called to discuss options.

It is quickly concluded that the risks of remaining at home remain too high, but there are only two community rehab beds available; one is already earmarked for another patient, the other is in a unit whose staffing levels are such that they may not be able to cope with another patient with high management needs.

It is decided this is the best option for the patient but this means extra staffing needs to be arranged for the unit as well as a specialist mattress sourced, which requires a special out of hours request to be made to the equipment store.

Three hours later, Home 1st is told that the patient is safely on the unit.

Harrow Older Adult Community Mental Health Team

15:30 A GP rings with concerns of a risk of serious harm to an individual where the individual wishes to harm himself.

We explore any support networks from the GP/ social services/ other providers like care providing agencies.

After establishing the actual extent of concerns and urgency, we visit the individual and establish the risks and decide if we can support the individual in their own living environment or we need additional support ranging from social care to hospital admission. Based on information we gather, we visit that same day and put in place a support programme.

School nurses

15:00 One of our school nurseshas called into a school in Camden to follow up the wellbeing of one of the pupils who attended A&E at the Royal Free after injuring his arm on some broken glass. She provided emotional support to this pupil a few months after he was involved in an incident between his mother and her partner, which resulted in the police being called.

She is concerned that this injury is connected to this previous incident.

She meets up with the pupil in a private space in the school and undertakes a universal screening of his emotional health. While the conversation is happening, the pupil reveals that the fighting has continued between his mother and her partner and the injury was caused while trying to protect her as he was concerned that her partner was likely to hit her.

She contacts the Camden child protection adviser for her support. She also seeks the pupil's consent to talk to his mother and his head of year to make sure that the pupil is helped to feel safe at home and that the school know how to support his emotional needs.

Hillingdon Child and Adolescent Mental Health Urgent Care

16:00 A 15-year-old boy attends A&E after taking an overdose of his dad's medication with the intent to end his life. He was referred to the Urgent Care team at 5.15pm and was assessed an hour later by a CAMHS practitioner.

The teenager was seen alone initially and his parents joined for the latter part of the assessment. He reported struggling for the past six months since moving to London. He was hearing a negative voice telling him to do things.

He felt life was not worth living, felt unmotivated, and had had poor concentration, poor appetite and poor sleep for the past six months. He denied any issues at school and at home, other than his parents both worked long hours.

While speaking with the CAMHS practitioner he regretted his actions and denied wanting to end his life. His parents agreed they worked long hours and this added to his isolation since they moved to London. Coping strategies and a safety plan was agreed together.

The CAMHS practitioner discussed this plan with the CAMHS medic on duty at 8.25pm and provided a handover to the nurse in charge in A&E so that he could be reviewed by their team prior to discharge home.

An urgent follow up appointment made with the CAMHS Urgent Care Team. A referral was also made to Children's Services.

The boy and his parents were called the next day and an appointment made to be seen the same week for a seven day follow up CAMHS review.

Camden Rapid Response Team

17:00 New referral received from the London Ambulance Service to the team based at St Pancras Hospital, Camden.

This is of an elderly patient who is usually independent but who has had a fall sustaining bruising, no fractures or head injury. She has lost confidence and is in pain – the paramedics feel she needs extra support in the community to avoid an admission to hospital.

The service agrees to see the patient at her house within two hours of receiving the call.

On arrival of a physiotherapist a full assessment is completed to identify what support she needs to continue living safely at home to try to avoid an admission.

With the patient, it is agreed she would benefit from a walking frame, a care package morning and evening to help with personal care and meals, and a commode for toileting downstairs to avoid using the stairs all day, which is now too painful.

The GP is contacted and painkillers are prescribed, collected and delivered to the patient. This is all organised the same day – first carer visit and all equipment delivered that evening.

The patient is complaining of dizziness on standing so the rapid response nurse visits and diagnoses postural hypotension – they advise an increase in fluid intake which is passed to the carers – and a temporary hold of water tablets in communication with the GP.

After five days of regular monitoring of pain and mobility, her pain is better controlled, she is more independent with stairs and meals, water tablets are restarted and the care is reduced to once daily and handed over to social services to take over. An onward referral is made to the community rehab team to progress the patient back to mobilising without her frame and make an onward referral to the Camden Falls group once she is ready.

Key issues and risks

These are identified in our corporate risk register – the highest level register of the Trust and it encompasses risk in delivering our objectives. For each of these, we have plans to manage the risk.

Area	Risk	Managing the risk
Maintaining and improving quality of services	• Potential distraction from quality improvement due to ongoing change in the wider NHS system • Maintaining the quality of our services while managing the financial and workforce challenges	• CNWL's QI programme uses frontline and patient expertise to improve care – it has been rolled out across CNWL with 300 programmes and significant gain and positive experience • Savings plans are checked for impact on quality (Quality Impact Assessment) • We analyse and respond to staff and patient surveys
Workforce	• Brexit – 7% of CNWL staff are EU citizens. Impact on retention and recruitment • Finding and retaining the right kind of staff	• Our European staff are welcome and this has been made clear in a range of communication including from our CEO. Support has been provided for time and cost for application to remain • A strong workforce strategy has improved recruitment and reduced agency cost
Partnership and governance	• Legal and regulatory obstacles to partnership • New contracting processes • Changes for staff	• Growing experience of successful partnership development including contracting – Hillingdon, Ealing, CIS, MK, Camden • OD programme to support staff through change
Financial health and viability	• Ongoing CIP programmes with non-recurrent items maintain an underlying deficit • Control totals must be maintained to gain essential funding • Complexity of partnership risk share • ICT costs have been a pressure for CNWL	• Robust financial scrutiny including monthly review by Finance and Savings Group; monthly review by the Business and Finance Committee and Quarterly review by full Executive • Monthly report to NHSI • Ability to plan and manage shared risk in partnerships • New ICT partner and good grip on budget – together with benefit of new system

Performance analysis

How the Trust measures performance

CNWL has developed a suite of Key Performance Indicators (KPIs) in consultation with staff at all levels in the organisation that cover quality and safety measures as well as those KPIs outlined in the Single Oversight Framework.

We have made advances in making information and performance available to staff, teams, committee and board through the use of our online Business Intelligence Tool, Tableau.

This has given staff throughout the Trust access to dashboards, scorecards, reports and raw data extracts as well as bespoke reporting, trending and benchmarking both internally and externally, all of which are refreshed on a daily basis.

Tableau looks at trends over time and can identify areas of ongoing under-performance or areas that may need some improvement and support to maintain performance. This aids strategic decision making and empowers staff to manage day-to-day services at an operational level.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy.

A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

The Trust has been placed by NHS Improvement under segmentation one. NHSI in its capacity as Monitor have not taken any regulatory action. They have advised that the rating reflects the CQC rating of 'good'. The Trust has a programme of work to address all remaining CQC concerns.

This segmentation information is CNWL's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '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 feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018-19 scores				2017-18 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	2	2	4	4	1	3
	Liquidity	2	2	2	2	1	2
Financial efficiency	I&E margin	2	3	4	4	1	3
Financial controls	Distance from financial plan	1	2	1	1	1	1
	Agency spend	1	1	1	1	1	1
Overall scoring		**2**	**2**	**2**	**2**	**1**	**2**

Financial performance

The Annual Accounts have been prepared under an accounts direction issued by NHS Improvement under the National Health Service Act 2006. After making enquiries, the Directors have reasonable expectation that CNWL has adequate resource to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in the accounts.

The underlying deficit for the year was £4.8m, which after adjusting for impairement of non-current assets, gain on sale of asset and PTF funding, resulted in an overall deficit of £17.8m.

The Trust closed on a deficit of £17.8m against a planned deficit of £2.3m. The variance was largely as a result of an impairment of Intangible Assets (£11.9m) following the revaluation of the Clinical Assets which came into use this year and an impairment of £10.9m, relating to the revaluation of the Trust Estate. The impact of this impairment was partly offset by the Provider Sustainability Fund (PSF) received by the Trust which was £3.5m greater than plan.

Financial Performance	2018/19	
	Actual	Plan
	£m	£m
Deficit for year	**(17.8)**	**(2.3)**
Gain on sale of Assets	2.1	2.1
PSF Funding Core	4.1	4.1
PSF Bonus and Incentive	3.5	–
Impairment	(22.8)	(5.0)
Underlying Deficit for year	**(4.8)**	**(3.5)**

Financial Performance	2017/18	
	Actual	Plan
	£m	£m
Surplus/(Deficit)	**(7.4)**	**3.3**
Gain on sale of Assets	0.7	–
PSF Funding Core	3.3	3.3
PSF Bonus and Incentive	3.0	–
Impairment	(14.1)	–
Underlying Surplus/Deficit for year	**(0.3)**	**–**

The Trust submitted a plan for 2019-20, meeting its controlled total of an operational deficit of £1.9m. After PSF of £4.1m the position is a surplus of £2.2m. For 2019-20 the Trust is required to make £21.9m in efficiency savings in addition to a £3.7m QIPP target.

Quality reporting targets

As agreed through consultation, the Quality Account for 2018-19 set out two quality priorities focussing on 'patient and carer involvement' and 'staff engagement', using five quality indicators to show these had been achieved.

The quality priorities were:

1. Patients and carers feeling involved, supported and taking ownership of the decisions about their care
2. A workforce which is committed, well-trained, well-supported, and above all, engaged.

This year, the overall performance against patient reportable indicators remained above target.

Patient and carer involvement			
Measure	**Method**	**Target**	**Outcome**
Patients report feeling involved as much as they wanted to be in decisions about their care or treatment	Patient survey	Minimum 85%	96%
Patient report that their care or treatment helped them to achieve what matters to them	Patient survey	Minimum 85%	96%

Staff engagement			
Measure	**Method**	**Target**	**Outcome**
Staff recommend the Trust as a place to work	Staff FFT survey	70%	57.6%
Staff recommend the Trust as a place to receive care or treatment to a friend or relative	Staff FFT survey	70%	68.9%
Staff turnover	Internal database	15%	16.6%

We have made progress on staff turnover, and note that this improvement has been sustained. However, our scores on staff recommending CNWL as a place to receive treatment and work remain lower than we would like; albeit that this year we had our highest quarterly scores of the last two years. Staff engagement, while not one of the Quality Priorities next year, remains of the highest importance for the Trust. We are finalising our new People Strategy and associated actions that will primarily be aimed at improving staff engagement.

2019-2020 Quality Priorities

Our priorities for 2019-2020 were guided by four principles; we wanted to focus on what matters most, we wanted to deliver improvement as part of business as usual, we wanted to align our Quality Priorities across all our services and we want to ensure that improvement is sustained.

With these principles in mind, we consulted widely with our stake holders (both internally and externally) and held a consultation event on the 1 March 2019. Together, we agreed to focus on the following Quality Priorities for the year ahead:

1. Reducing Falls
2. Improving the management of the deteriorating patient
3. Reducing violence and aggression for staff and patients
4. Improving the quality of supervision

We also agreed to plan how we aim to meet these priorities over three years to ensure we sustain improvements in the above four areas, while continuing the conversation with our stakeholders so they remain sighted on our progress.

Please see page 63 to view the full Quality Account for 2018-19.

Risk management and quality governance

The Trust's Risk Management Policy defines structures for the management and ownership of risk, and explains the Trust's risk management processes.

The development of local risk registers has served to promote awareness and understanding of the identification of risks and their management across the organisation.

Key to the effectiveness of risk management in the organisation is the Executive Board, comprising of all the Executive Directors.

This membership recognises the importance and high profile of risk management in the organisation and facilitates senior ownership of the identification and management of risks on a continuing basis.

This is important in ensuring that the Trust takes an integrated approach to governance and risk management issues.

Issues that are identified as constituting a significant risk are monitored by the Executive Board, with progress being reported to the Board of Directors at each meeting. Lower graded risks are managed by the relevant service line or directorate.

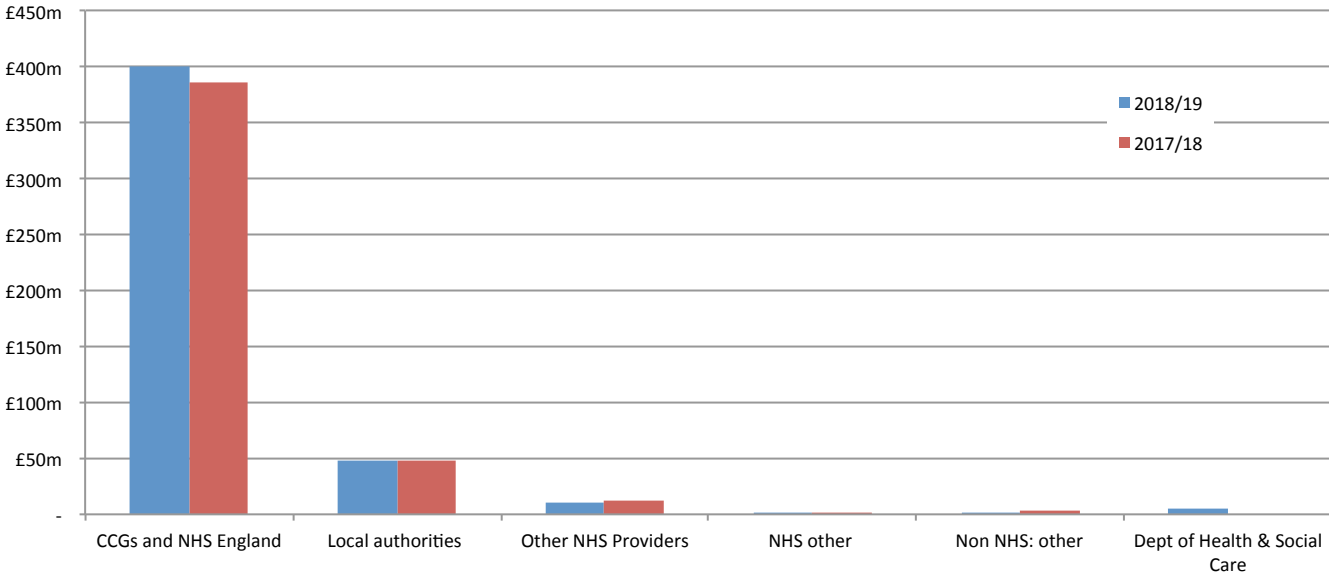
The Board has a Quality and Performance Committee chaired by a Non Executive Director, with Board [Executive and Non Executive Director] membership. A range of groups, with responsibility for monitoring areas of work relating to clinical quality and governance, report to this committee.

For information on principal risks and uncertainties see the Annual Governance Statement on page 56.

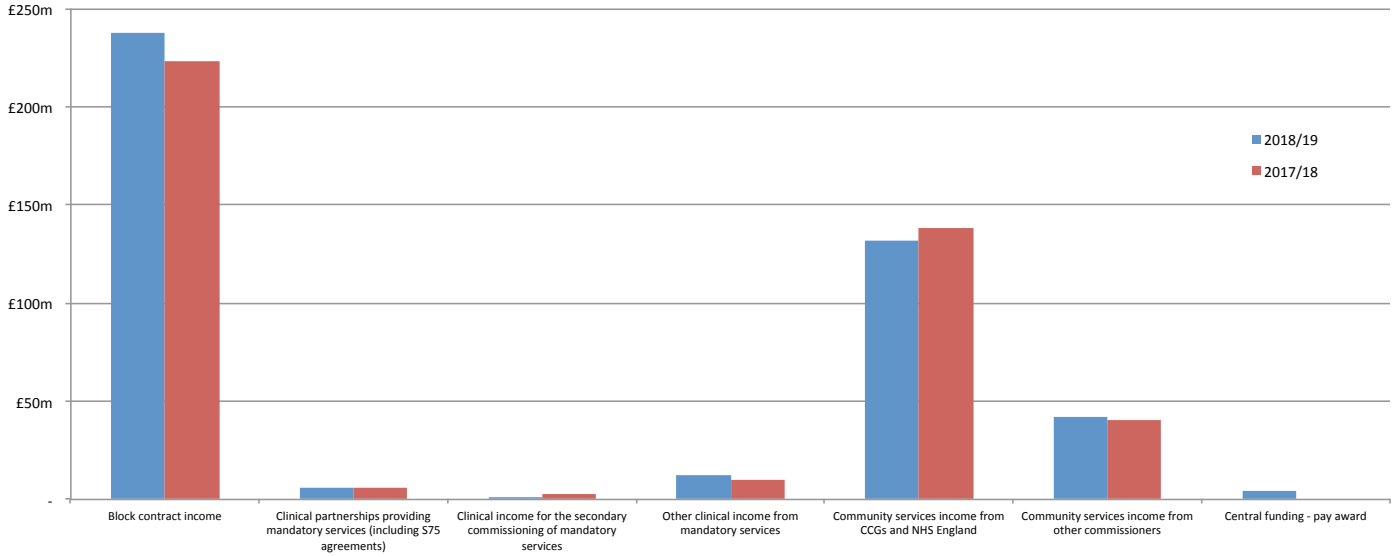
Performance analysis

Surplus/(deficit) for the year from continuing operations			
	2018-19	2017-18	2016-17
	£000	£000	£000
Total operating income from continuing operations	508.1	490.0	473.9
Operating expenses	(519.9)	(490.0)	(459.8)
Operating surplus/(deficit) from continuing operations	(11.8)	–	14.1
Net finance costs (incl PDC Dividends)	(8.2)	(8.1)	(8.2)
Gains/(losses) of disposal of non-current assets	2.1	0.7	5.5
Surplus/(deficit) for the year from continuing operations	(17.8)	(7.4)	11.4

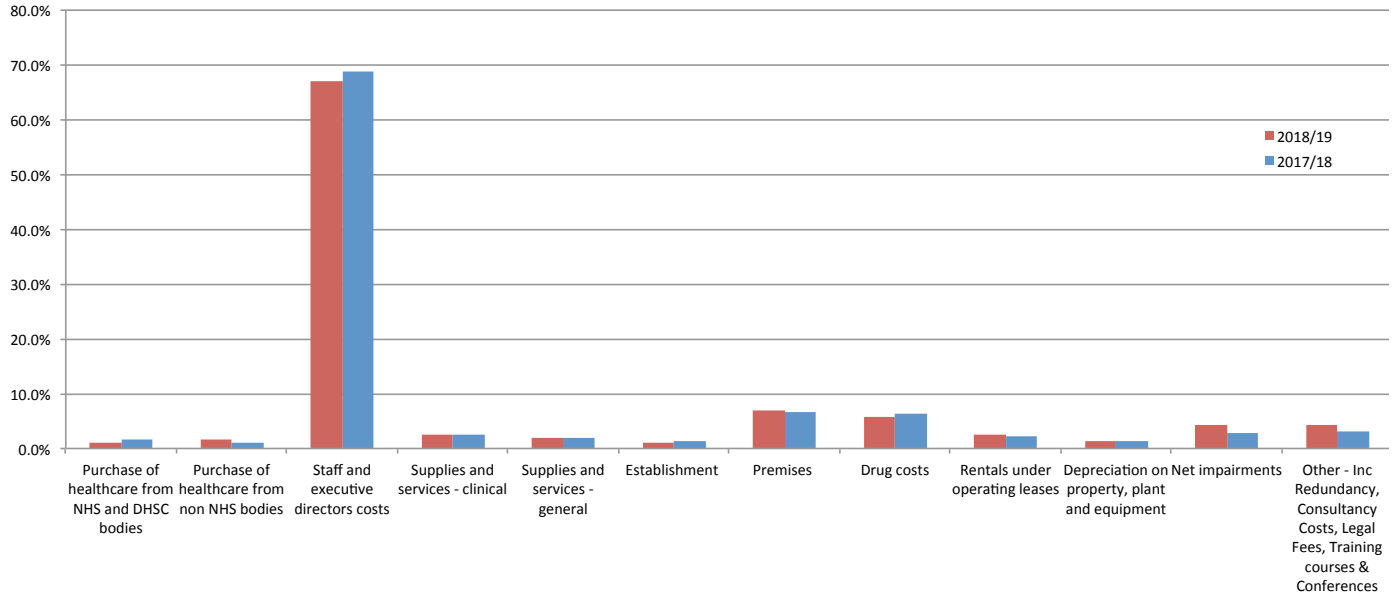
Income from patient care activities (by source)



Income from patient care activities (by nature)



Operating expenses



Sustainability and environmental

The Sustainable Development Management Plan (SDMP) adopted in 2014 sets out key objectives to minimise the impact of our business on the environment. The section below looks at the Trust's overall carbon emissions from utilities (electricity, gas and water) along with expenditure.

Finite resources

Electricity	kWh	tCO_2e	Gross (£k)
13/14 (baseline)	6,797,310	3,028	867,185
18/19	4,819,003	1,364	737,701
% Reduction	-29.10%	-54.95%	-14.93%

Gas	kWh	tCO_2e	Gross (£k)
13/14 (baseline)	15,856,106	2,918	670,311
18/19	11,965,148	2,201	423,469
% Reduction	-24.54%	-24.57%	-36.82

Water (clean and waste)	m3	tCO_2e	Gross (£k)
13/14 (baseline)	70,580	74	159,283
18/19	70,244	74	159,359
% Reduction	-0.48%	0%	0.04%

Combined Electricity, Gas and Water	tCO_2e
13/14 (baseline)	6,020
18/19	3,639
% Reduction	-39.55%

To maintain a consistent carbon reporting boundary for utilities, the figures above excludes occupancy within buildings that are on Service Level Agreements. This decision was taken because at present consumption data is not provided and, in many cases, is not separately metered. Therefore, a significant amount of estimation would occur and there is also the risk of duplication in carbon reporting with those organisations that have ownership of the utility meters.

At present, we can report that from electricity, gas and water to date the Trust has exceeded the 28% target on a 2013-14 baseline year and made a 39.55% reduction in tCO_2e. This has been achieved through the greening of the national grid, implementation of LEDs and solar panels at some sites, uptake of the British Gas AMR implementation, improved data quality from invoicing, and an estate rationalisation programme; the latter of which improved occupational density and utilisation figures as well as introduce new ways of working and ultimately rationalise the property portfolio.

The Trust's retained energy and sustainability advisors, LCE, have also continued to ensure that the Trust has maintained compliance with regards to Display Energy Certificates and Advisory Reports (DEC and AR). While completing these LCE have been able to review their performance and make energy saving recommendations where appropriate.

To continue embedding sustainability holistically LCE and the Trust organised sustainable engagement events to mark National Recycle Week and NHS Sustainability

Day at the new headquarters in 350 Euston Road and Argo House. These events were well received and provided opportunities to join the growing sustainable champion's network.

Over the forthcoming year, the Trust will continue to seek further opportunities for reducing their carbon emissions and update the 2014 SDMP to align current UK Climate Change Projections (2018) and National Adaptation planning.

Soft Facilities Management (FM) Services

The vast majority of Soft FM services within the Trust are provided by Outsourced Client Solutions (OCS) Group UK Ltd as part of a Total Soft Facilities Management (TSFM) contract.

This includes areas such as cleaning, catering, reception/ security, waste, pest control, linen and laundry and window cleaning.

In May 2018 the previously in-house Milton Keynes Domestic Services (cleaning) team was transferred to OCS.

In January 2019 all Soft FM services at South Wing at St Pancras Hospital were transferred from the previous contract provided through Camden and Islington NHS Foundation Trust to CNWL's OCS contract.

All centrally managed Soft FM contracts and services continue to meet KPI and national standards targets across the board.

The centrally managed waste contracts delivered to CNWL have achieved 'zero to landfill' for the second consecutive year. Quality Trusted Solutions (QTS) is actively represented on the NHSI led review of the National Cleaning Standards which are due to be launched in mid-2019

Patient Led Assessments of the Care Environment (PLACE)

The 2018 PLACE (Patient Led Assessment of the Care Environment) scores were officially released in August and CNWL continues to perform above the national average score across all six of the PLACE domains.

Under PLACE, all NHS funded healthcare providers in the UK are required to undertake an in-depth assessment of the non-clinical aspects for all qualifying in-patient settings as part of a national programme.

The assessments focus on how the environment supports service provision and patient care, looking at core aspects such as cleanliness, food, maintenance, as well as the extent to which the environment supports privacy and dignity, dementia and disability compliance. The assessments are undertaken by teams consisting of peer reviewing staff groups and patient assessors provided through independent patient organisations and CNWL user groups.

Included below is a table showing the 2018 Trust average scores in comparison to the National average scores for each of the six PLACE domains.

	Trust Average	National Average
Cleanliness	99.76%	98.47%
Food	93.91%	90.17%
Privacy, dignity and wellbeing	93.44%	84.16%
Condition, appearance and maintenance	96.41%	94.33%
Dementia	92.79%	78.89%
Disability	86.73%	84.19%

QTS has led representation on the NHSI led national review of PLACE, which is due for completion in April/ May 2019. The 2019 PLACE programme will take place later in the year that it normally does, likely to commence in September/October.

Estate Maintenance

The commencement of the financial year in April 2019 saw the Third year of the Contract with CBRE delivering the Hard FM Services across the CNWL portfolio under the contractual management of Quality Trusted Solutions (QTS) the wholly owned subsidiary of Central North West London which was incorporated into Companies House from 1 April 2018.

As part of this transition the existing CNWL Estates and Facilities team were TUPE'd over to the new company. Realignment of the team in both QTS and CBRE produced a leaner more productive structure.

This resulted in improved management processes and an upward trend of services.

The new structure incorporated the existing processes and brought improvements, resulting in even tighter contractual controls. To ensure CBRE worked within the specification of the service delivery of the contract.

However challenges did occur inclusive of overdue re-active works. This resulted in contractual financial abatements being applied.

A strategically viable plan was developed and initiated by the QTS Hard Services management to reduce the volume of tasks and this has resulted in a continued downward trend in overdue tasks.

In support of this, an improved communication plan to the CNWL Site Service Managers and staff as a whole, form part of this strategy.

The maintenance provision contract is a long term joint venture requiring input from CBRE, our frontline clinical staff through to the Trust board to ensure a successful outcome.

Capital Spend

The Trust's capital programme for 2018-19 for investing in its estate was £10.3million.

The capital is prioritised and reviewed on a bi-monthly basis at the Estates Strategy Group.

Quality Trusted Solutions Limited Liability Partnership (QTS)

In April 2018, seeking to extract best value from our existing assets and allow certain freedoms, for instance investments that might provide income generation opportunities, such as providing a service to our partner organisations. The Trust established Quality Trusted Solutions a wholly owned subsidiary, to facilitate the longer term growth and efficient operation of its estate.

The objectives of QTS as set out in the initial business case are identified below:

1. QTS is a limited liability partnership (a wholly owned subsidiary of Central and North West London NHS Foundation Trust) that provides a range of property services including consultancy and estates and facilities management services to other organisations on a commercial basis.
2. The organisation will also be working with developers and contractors on the construction of major new developments. QTS plans to develop, sell, rent and invest in new developments, including NHS, residential, commercial and possibly retail, to fund redevelopment and, in so doing, generate new income streams.
3. Engaging in commercial activities provides a degree of autonomy to QTS to engage in commercial activities to gain more value from the assets than if they remain in the Trust and remains in keeping with the Trust's strategic values and objectives.
4. Financial benefits of developing properties to their full potential – there are likely to be significant profits from developing properties to their full potential at an upfront cost, based on the current trajectory of the London property markets.

Any innovation to reduce costs, maximise use of the estate or income generate must also be aligned to the on-going strategic planning process. Expansion of CNWL will be predominantly based on increasing the range and depth of services offered within current Boroughs. There is an appetite within the organisation for growth, including geographic expansion, but this has yet to be quantified.

Common aspirations across the sector and core to QTS delivery of the estates and facilities function for CNWL are:

- The necessity to reduce estates and facilities costs, along with improving the efficiency of the estate
- Improved quality of clinical space as well as reducing the administration areas
- Align the quality of space across the Estate, to make certain all space are to a consistent standard
- Right sizing the portfolio of buildings and space to meet requirements

The objectives of QTS have not changed and the above is still relevant. It is demonstrable that QTS has achieved some of the above and is actively working to achieve the others.

Since QTS was established in 2018, it has become apparent that other opportunities will present themselves occasionally which the QTS Management Team will apprise on a case by case basis. Examples of this are as follows:

1. ERIC software. Whilst developing software was not identified as a QTS core objective in itself, it does fall under a new business category in that it has the potential to generate income for QTS and CNWL. As this software is related to our core business, provision of estates and facilities, it is deemed relevant and the Senior Management Team (SMT), when appraising this opportunity, thought it was something QTS should develop.
2. Acting as Landlord. Again, this was not something identified as a core objective in itself but upon appraising the Beaufort House opportunity. It became apparent that this opportunity generates income for QTS and CNWL. Again, the SMT appraised the opportunity and thought it was a sound proposition which they would put to the CNWL Executive Board.

In summary, the direction of travel in terms of the objectives and the identity of QTS appear to be in line with the original vision. However, as opportunities present themselves, it is important to appraise them appropriately and not to chase each and every opportunity.

Social, community, human rights and equal opportunities update

During the last year, good progress was made against our work priorities. Achievements include:

- The development of the Equality Diversity and Inclusion (EDI) Steering Group which has divisional and corporate representation to oversee the development and implementation of the Trust's Equality, Diversity and Inclusion strategy and Quality Objectives and oversight of the Trust Working Groups; Workforce Race Equality Standard, Workforce Disability Equality Standard and Stonewall.
- Developed a multi-faith resource guide for staff and improved awareness of resources to meet spiritual needs, strengthening this in relation to End of Life Care with the revised Compassionate Care After Death Policy
- Supported the five Staff Networks to develop, improved capacity to support the work, developing Co-Chair skills and confidence and increasing awareness of intersectionality and how the networks collaborate with each other
- We have completed our second gender pay gap assessment in accordance with the amended Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which requires us to publish six statutory calculations every year showing how large the pay gap is between our male and female employees. Analysis of our data shows that women make up 77% of the workforce, but the hourly pay gap between men and women is still 11.4% showing marginal improvement compared to last year. The bonus gender pay gap which is largely due to the Clinical Excellence Awards (CEA) is also 44% in favour of men, and has improved compared to last year which was 48%. CNWL will be addressing the pay gap by:
  - Promoting shared parental leave, and flexible working opportunities, as well as increasing support for staff returning from adoption or maternity leave to ensure there is equal opportunity
  - Supporting the development of staff from all protected characteristic groups through revised leadership and talent management programmes
  - Providing training for CEA panels to ensure that criteria are proportionate to applicants' job planned hours
  - Supporting a Women's Group to engage with the Trust on gender pay issues
- We have renewed our Disability Confident Committed status and worked on improving reasonable adjustments for disabled staff, streamlining performance systems to make adjustments more accessible to staff and managers
- Improved Trans inclusion through the launch of the revised co-produced policy, revised LGBT+ training which includes a film of the journey of a trans staff member
- We improved our performance in Stonewall's Top 100 LGBT+ Friendly Employers from 95th in 2018 to 28th in 2019 and again were the only London based NHS organisation to feature in the Top 100 for 2019

In the coming year, the Trust will place more emphasis on:

- Strengthening an understanding of EDI, the strategy and workstreams for staff and service users in Divisions and Services
- Analysing the data and implementing the new Workplace Disability Equality Standard which will help us improve the experience of our disabled staff and progress to stage 2 as a Disability Confident Employer
- Reduce mental health stigma in the workplace through enhancing the Disability Employment Policy and access to mental health first aid training
- Sustaining improvement against our WRES metrics, notably metric 2 improving recruitment through diverse panels, metric 5 to address bullying and harassment, metric 7 with delivering a range of development programmes to enhance career progressions and metric 3 improving cultural awareness to reduce disciplinaries, and Quality Improvement work in collaboration with other London NHS organisations
- Use our gender pay gap analysis to inform the development of a Trust-wide Action Plan to support reducing the gender pay gap and in particular, female doctors in applying for our clinical excellence awards scheme for medical staff
- Review our eligibility for the Carers Benchmarking Scheme run by Employers for Carers
- Maintaining our place in the Stonewall's Top 100 LGBT+ Friendly Employers and strengthening trans awareness

Important events since close of financial year

There were no important events to report since close of financial year.

Details of overseas operations

The Trust has no overseas operations.

Claire Murdoch CBE
Chief Executive
28 May 2019

Accountability report

This section of the Annual Report provides details on the Trust's activities during 2018 to 2019.

Directors' report

The Directors present their report and audited financial statement for the year to 31 March 2019. The Directors are responsible for preparing the Annual Report and Accounts, and consider the report, taken as a whole, to be a fair, balanced and understandable account of the performance of the organisation during the year 2018-19. The information within this report provides details for our stakeholders on the Trust's performance business model and strategy.

Principal activities

The Trust's principal activity is the provision of mental health, community, substance misuse, and learning disability services to patients.

Business review

The NHS Foundation Trust's activities are reviewed in:

1. The Chair and Chief Executive's Statement on page 6
2. The Annual Governance Statement on page 56
3. The Financial performance on page 18. In addition to this, other information relevant to the Trust's activities is set out in the other sections of this document.

Political donations

The Trust has not made any political donations this year.

Better Payment Practice Code

The Non NHS Trade Creditor Payment Policy of the NHS is to comply with both the CBI Prompt Payment Code and the Government Accounting Rules. The Government Accounting Rules state: The timing of payment should normally be stated in the contract. When there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later.

"During the financial year 2018-19, the Trust achieved an average of 48% (prior year 52%) by number of invoices and 64% (prior year 80%) by value of all NHS invoices. For non-NHS, the Trust achieved an average of 58% (prior year 61%) by number of invoices and 71% (prior year 47%) by value."

Costing information returns

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

Enhanced quality governance reporting

The Trust has had regard to Monitor's quality governance framework in reviewing its own systems and processes and is clear that quality of service delivery underpins all discussions and decisions taken within the Trust. The Assurance Framework sets out internal and external sources of assurance and identifies the responsibilities of the Board and its committees for reviewing that assurance.

'The CQC previously rated the Trust as 'good' in July 2017. They are undertaking a well led inspection in spring 2019 with the outcome expected in May 2019. For more information on our Quality Account go to page 63.

Disclosure of information to auditors

As far as each of the Directors is aware, there is no relevant audit information of which the auditors are unaware. Each Director has taken all the steps a Director ought to have taken to make themselves aware of any relevant audit information and to establish that the auditors are aware of such information. For more on our auditors turn to page 30.

Income disclosures

The Trust receives most of its income from clinical commissioning groups and NHS England for patient care activities. It also receives monies for the education and training of clinical staff, research and development and from the sale of manufactured pharmacy products.

The Trust has met section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

The income the Trust receives from the provision of goods and services for any other purposes is generated from capacity within the organisation; such work is not given priority over NHS work. Income from such activities are undertaken only where they can demonstrate a positive impact for the Trust, such as a financial contribution to the Trust, which can be invested for the purposes of healthcare, or as part of a wider clinical benefit analysis.

How we are organised

Board of Directors

The Board of Directors is chaired by Professor Dorothy Griffiths OBE who also chairs the Council of Governors.

Meetings are held every two months and are open to the public. A quorum of two thirds is needed for the meeting to take place.

Decisions taken by the Board

The Board is responsible for all key strategic decisions. It has established a number of committees with clear terms of reference and levels of delegation to undertake detailed review of areas of Trust business. Currently these are:

- Audit Committee
- Business and Finance Committee
- Executive Board
- Informatics Committee
- Investment Committee
- Nominations Committee
- Quality and Performance Committee

Decisions delegated to management

The Executive Directors are responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board.

Board of Directors' balance

The Board has carefully considered its composition and currently has seven Executive Directors including the Chief Executive (one vacancy), and nine Non Executive Directors including the Chair. The Board will review its composition regularly and believes that this current composition reflects the skills and competencies required for the Trust to fulfil its obligations.

Performance evaluation of the Board of Directors

The Board of Directors has a systematic approach to assessing its collective performance including annual away days to consider its own performance and to set strategic objectives for the Board throughout the coming year. The Board also carries out self-evaluations at the conclusion of each Board meeting, when it decides how to structure its future agenda and ensure the most important items are given the time they deserve. The Committees follow a similar process.

The Chair is appraised annually through a process approved by the Council of Governors. The process requires independent input from each director, which is then considered by the Governors. The process does not require Non Executive Directors to meet separately without the Chair.

Process for appointment of Chair and Non Executive Directors

The Nominations Committee of the Board meets to discuss potential vacancies and to determine the skills and experience most valuable to the Board. The Appointments Committee of the Council of Governors receives these considerations and decides on the job description, recruitment and appointment process.

Process for termination of Chair and Non Executive Directors

The Council of Governors at a general meeting of the Council of Governors can remove the Chair of the Trust and the other Non Executive Directors. Removal of the Chair or another Non Executive Director shall require the approval of three-quarters of the Members of the Council of Governors.

Criteria of Independent Directors

All Non Executive Directors are considered by the Council of Governors to fulfil the criteria of Independent Director.

Conditions of service for Non Executive Directors

The length of appointments of the Non Executive Directors is three years. Appointments beyond two terms can be agreed by the Council of Governors where it is in the best interests of the efficient and effective management of the Trust. Terms of office may be ended by resolution of the Council of Governors following a procedure laid down in the Foundation Trust's constitution.

Conditions of service for Executive Directors

No Executive Director serves as a Non Executive Director in any other organisation.

Executive Directors

The Executive Directors are full-time employees of the Trust and are the most senior managers responsible for its day-to-day running. They decide the future strategy and direction of the Trust, are accountable to independent regulators, and are responsible for ensuring clinical and corporate effectiveness.

Every NHS [Trust Board] must include a medical doctor and a nurse at executive level. Each Executive Director has their own area of responsibility.

Claire Murdoch CBE
Chief Executive

Appointed: 2007

Qualifications: Registered Mental Health Nurse, honours degree in Social Policy.

As Chief Executive, Claire is the head of the organisation with overall responsibility for the performance of the Trust. This includes the Trust's financial performance and the quality and standards of the clinical services. Claire is a registered Mental Health Nurse and has over 20 years NHS experience.

Robyn Doran
Chief Operating Officer

Appointed: 2008

Qualifications: Registered Psychiatric Nurse, MSc in Change Agent Skills.

Robyn joined the Trust in 1988 and is now responsible for the day-to-day running of all the Trust's services to ensure the highest standards are achieved. She works closely with clinical commissioning groups (CCGs) (the organisations who pay for our services) to ensure the right services are delivered in each area.

Andy Mattin
Director of Nursing and Quality

Appointed: 2010

Andy joined the NHS in 1983 and the Trust in 2010. He works alongside Robyn to manage the day-to-day running of the Trust's services. He is the Lead Nurse, which means he provides leadership for nursing staff, as well as being responsible for the supervision and training of nurses. He also represents the views of service users at the Board of Directors.

Dr Cornelius Kelly
Medical Director

Appointed: 2015

Dr Kelly qualified in Ireland 30 years ago before moving to train in psychiatry in London. Since joining CNWL in 2001 he has been Clinical Director for Older Adults and Acute Services, Divisional Medical Director and is now the Medical Director for the Trust.

Hardev Virdee
Chief Finance Officer

Appointed: 2016

Hardev was appointed in 2016 after previously being Chief Financial Officer at Wandsworth Clinical Commissioning Group. He is responsible for the financial performance of the Trust. He plans the Trust's finances over a long period to ensure the Trust has enough money to deliver high quality services.

John Vaughan
Director of Strategy and Performance

Appointed: 2006

John was appointed in 2006 and oversaw the Trust's application for Foundation Trust status. John is responsible for monitoring and evaluating the Trust's performance and uses this information to plan for the Trust's activities in the future. John also manages the Trust's communications.

Non Executive Directors

The Non Executive Directors are not employees of the Trust and are not involved in the day-to-day running of CNWL. They provide valuable external insight to scrutinise and challenge the Trust's processes. Non Executive Directors hold other senior positions outside of the Trust and bring knowledge, experience and expertise from other fields, such as accounting, management and organisations outside of the NHS.

Their responsibilities also include measuring performance against goals, evaluating risk, appointing the senior management, and contributing to the development of the Trust's strategic plans.

Professor Dorothy Griffiths OBE
Chair

Professor Griffiths has been a Non Executive Director of CNWL since 2000. She has degrees in sociology from London and Bath Universities. Prior to joining CNWL, she was Dean of the Imperial College Business School and Professor of Human Resource Management. In 2010 she was awarded an OBE for services to higher education.

David Walker
Non Executive Director and Deputy Chair

David Walker is a communications professional with experience in journalism, research, public affairs and marketing. He is currently chair of Understanding Society (the UK household longitudinal study) and contributing editor of the Guardian's Public Leaders Network. Until 2010 he was Managing Director, Communications and Public Reporting at the Audit Commission.

Tom Kibasi
Non Executive Director

Tom is the Director of the Institute for Public Policy Research (IPPR), a leading progressive thinktank with a strong programme of policy development in health. Prior to joining IPPR, Tom spent more than a decade at McKinsey and Company where he held leadership roles in the healthcare practice in both London and New York. He is an honorary lecturer at Imperial College London, where he has collaborated with Lord Darzi for many years, including on the landmark report High Quality Care for All and Better Health for London, the report of the London Health Commission.

Helen Edwards
Non Executive Director

Helen served as Deputy Permanent Secretary and Director General for Local Government and Public Services at the Department for Communities and Local Government from 2013 to 2016.

She was Director General of Criminal Justice in the Ministry of Justice (2008 to 2013), following a number of senior roles at the Home Office. Before that Helen was Chief Executive of Nacro, the national crime reduction charity and began her career as a social worker. Helen was appointed Chair of Recovery Focus (a coalition of mental health charities), Peabody, and Lloyds Bank Foundation in 2016.

Michael Nutt
Non Executive Director

Michael has experience in Finance with his previous roles including working for European Investment Bank and as a Non Executive Director for a tourism business in Canada. Michael is an osteopath with a personal interest in mental health and community issues. He has strong accountancy and communication skills and is intellectually able to manage complexity and contribute across a wide spectrum of interests.

David Roberts
Non Executive Director

David has over 35 years experience in strategic and financial roles in the private and public sectors.

Prior to joining CNWL, David was head of the Remedies, Business and Financial Analysis division in the Competition Commission and its successor body the Competition and Markets Authority. David also worked for Sainsbury's for 19 years where his roles included Group Treasurer and Director of Corporate Finance. David originally trained as a chartered accountant with Deloitte, Haskins and Sells.

Amanda Harrison
Non Executive Director

Amanda has experience as HR Director for British Gas and Centrica and has led major change across large organisations. Amanda is passionate and committed and has obtained awards for carers and eldercare and working families.

Dr Reva Gudi
Non Executive Director

Dr Reva works as a GP in Hillingdon, where she has practiced for the last 17 years. Up until November 2016, she was also a senior health care commissioner for the borough.

She has been involved in providing health care services to the local population, working with other health and social care organisations, where her focus in particular, has always been delivery of high quality, safe and seamless joined up patient care.

Dr Reva has an interest in social sciences, and is currently studying for an Executive MBA degree at Warwick University.

Ian Mansfield
Non Executive Director

Ian has over 35 years of commercial, strategic, operational, supply chain and governance experience across the private and third sectors.

Prior to joining CNWL, Ian held many roles with Baker Hughes, an oil services company, including Operations Director, Materials Director and Commercial Director, during which he was responsible for business transformation projects and technology governance.

He is currently Chair of Richmond CVS, who provide infrastructure support for all charity, community and voluntary activity in Richmond upon Thames, improving local health and wellbeing, and providing leadership on health related initiatives such as Community Independent Living Services and Social Prescribing.

Non Executives Term of Office

Prof Dorothy Griffiths – 1 January 2020

Helen Edwards – 31 March 2019

Amanda Harrison – 1 May 2018

Tom Kibasi – 1 June 2019

David Roberts – 30 September 2021

David Walker – 31 March 2019

Ian Mansfield – 1 October 2021

Michael Nutt – 1 May 2020

Dr Reva Gudi – 1 January 2021

The Council of Governors at a general meeting of the Council of Governors can remove the Chair of the Trust and the other Non Executive Directors. Removal of the Chair or another Non Executive Director shall require the approval of three-quarters of the Members of the Council of Governors.

Code of Governance

Central and North West London NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors uses the NHS Foundation Trust Code of Governance as best practice advice to improve governance practices across the Trust. The Trust complies with the code in all aspects but two; the exceptions are that the Executive Directors of the Trust are all on standard employment contracts and they are not entitled to performance-related pay. There is provision for non-pensionable bonus for exceptional performance.

Members of the public can gain access to the Register of Directors' Interests by contacting the Trust Secretary, Christine Baldwinson on 020 3214 5776 or email christine.baldwinson@nhs.net

The Audit Committee

The Audit Committee provides the Board of Directors with an independent review of financial and corporate risk management and governance. With a membership of independent Non Executive Directors, the committee uses independent external and internal audit to provide assurance to the Board. The committee ensures we have the right policies and procedures in place to ensure good governance and effectiveness.

The members of the Audit Committee are all independent Non Executive Directors:

- David Roberts – Non Executive Director (Chair from March 2017)
- David Walker – Non Executive Director
- Dr Reva Gudi – Non Executive Director (from December 2018)

There have been 4 meetings between 1 April 2018 and 31 March 2019.

Member Attendance

Audit Committee	Total Meetings = 4
David Roberts (Chair)	4 out of 4
David Walker	4 out of 4
Dr Reva Gudi	2 out of 2

Effectiveness of the Committee

The Committee reviews and self-assesses its effectiveness regularly and ensures that any matters arising from this review are addressed.

The Committee is supported by the Trust Secretary who ensured that the Committee received adequate information in a timely manner to facilitate the consideration of all relevant issues. Meetings are scheduled annually to accommodate Trust business. Each meeting is minuted and reported to the Trust Board.

Internal audit and counter fraud services

RSM Risk Assurance Services LLP provide internal audit and counter fraud services to CNWL and attend each meeting of the committee. At these meetings, progress on internal audits and actions taken as a result of the internal audit were reviewed.

Our audit activity ensures effective oversight of our financial reporting and governance processes. The areas focused on arise from the review of our own risks as an organisation. Our internal audit and counter fraud plan included amongst others, a review of Divisional Financial management arrangement, Financial Systems –procurement cards and SBS contract monitoring, ICT Governance, Use of Medical Locums, Payments to Staff, Cost Improvement Plans and Cash Management.

We incurred audit fees of £83,000 (excluding VAT) for the accounting period.

External audit

KPMG LLP was appointed in 2014 by the Council of Governors as our external auditors. At our Audit Committees, KPMG present updates regarding accounting and business matters that are relevant to our organisation; including their audit plans and reports, for discussion by the committee. As part of this, the committee considers the implications of new accounting guidance, and whether our financial statements are compliant with the relevant financial reporting standards. KPMG are required to make the case to the committee that they are objective and comply with the technical and ethical standards that apply to them as auditors.

We incurred audit fees of £92,000 for the accounting period. This was a fee for an audit in accordance with the Audit Code issued by the National Audit Office in 2012. KPMG also perform an independent examination of the charitable fund for a fee of £8,000 (excluding VAT).

For details of our audit fees please see page 139.
The Committee engages regularly with the external auditor over the course of the financial year. The subjects covered include consideration of the external audit plan, matters arising from the audit of the Trust financial statements, the review of the Trust quality accounts and any recommendations on control and accounting matters proposed by the auditor.

The Committee considered the independence principles set out by the Auditing Practice Board in relation to the work of the external auditor undertaking non audit work. It did not identify any risks in this respect particularly in relation to self-review and familiarity.

Financial reporting

The Committee reviewed the Trust's accounts and Annual Governance Statement. To assist this review it considered reports from management and from the internal and external auditors to assist consideration of: the quality and acceptability of accounting policies, including their compliance with accounting standards;

- Key judgements made in preparation of the financial statements
- Compliance with legal and regulatory requirements
- The clarity of disclosures and their compliance with relevant reporting requirements
- Whether the Annual Report as a whole is fair, balanced and understandable and provides the information necessary to assess the Trust's performance and strategy.

The Committee has reviewed the content of the annual report and accounts and on behalf of the Board is of the view that, taken as a whole:

- It is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy
- It is consistent with the draft Annual Governance Statement, Head of Internal Audit Opinion and feedback received from the external auditors.

The Nominations Committee

There was one meeting of the Nominations committee during 2018-19. The Committee considered the skills required of the forthcoming Non Executive Director vacancies

The members of the Nominations Committee are:

- Professor Dorothy Griffiths OBE – Chair, Non Executive Director
- Claire Murdoch CBE – Chief Executive
- Helen Edwards – Non Executive Director
- Tom Kibasi – Non Executive Director
- David Roberts – Non Executive Director
- David Walker – Non Executive Director
- Amanda Harrison – Non Executive Director
- Ian Mansfield – Non Executive Director
- Michael Nutt – Non Executive Director
- Dr Reva Gudi – Non Executive Director

The purpose of the Nominations Committee is to:

- Review the structure of the Board of Directors and make recommendations for change where appropriate
- Prepare a description of the role and capabilities required for a particular appointment in the event of a vacancy
- Agree with the Appointments Committee of the Council of Governors a clear process for the nomination of a Chair or Non Executive Director
- Make recommendations to the Board on the appointment of Executive Directors.

Ian Mansfield was appointed as Non Executive Director in 2018-19 following national advertising for the position, an interview process involving Executives and Governors and approval of these appointments by the Council of Governors. An external search consultancy was not used in 2018-19.

Number of meetings and attendance at the Nominations Committee:

	Total Meetings = 1
Claire Murdoch	1
Professor Dorothy Griffiths	1
Helen Edwards	1
Tom Kibasi	0
David Roberts	0
David Walker	1
Michael Nutt	1
Dr Reva Gudi	1
Ian Mansfield**	1
Amanda Harrison***	0

Number of meetings and attendance at the Board of Directors

Board of Directors	Total Meetings 6
Prof Dorothy Griffiths (Chair)	6
Claire Murdoch	6
Robyn Doran	6
Dr Cornelius Kelly	6
Andy Mattin	6
John Vaughan	6
Hardev Virdee	6
Ian Mansfield	(3 out of 3)
David Walker	6
Helen Edwards	5
David Roberts	5
Tom Kibasi	5
Michael Nutt	6
Amanda Harrison	0
Dr Reva Gudi	6

*** Amanda Harrison was Non Executive Director until May 2018
** Ian Mansfield started as Non Executive Director from October 2018

Wider committees

There are three more formal sub-committees, which Non Executive Directors are involved in to ensure the Trust achieves its objectives and adhere to all regulatory frameworks. These are the Business and Finance Committee, a Quality and Performance Committee and an Informatics Committee. In addition an Investment Committee, chaired by a Non Executive Director, oversees any major investments or acquisitions.

The Council of Governors

The Council of Governors plays an essential role in the governance of the Trust, with its main duties being to:

- Appoint or remove the Chair and other Non Executive Directors
- Hold the Non Executive Directors to account for the performance of the Trust
- Approve the appointment of the Chief Executive
- Decide the remuneration and allowances of the Chair and Non Executive Directors
- Appoint or remove the external auditor
- Be consulted in setting the forward business plans of the Trust
- Review annually the Trust's objective of delivering high quality services
- Approve any amendments to the Constitution
- Receive the annual accounts and annual report
- Represent the interests of members and the public

There has not been any change to the significant commitments of the Chair in 2018-19.

The make-up of the Council of Governors

CNWL's Council of Governors is made up of elected Governors across four constituencies, plus appointed Governors from our partner organisations. The four elected governor constituencies are listed below:

- Service user – this is open to people over 16 years of age.

There are two sub-categories based on a geographical split of the geographical areas served by the Trust.

- Carer – this is open to people over 16 years of age who care for a patient of this Trust
- Public – this is open to residents in England and Wales
- Staff – all staff are automatically members unless they choose to opt-out. Membership is also open to employees of our partner organisations where they are managed within our services and have been in post for more than 12 months.

Meetings of the Council of Governors

The Council of Governors meets quarterly and meetings are open to the public. Individual attendance by Governors is shown in the table on page 34.

Governors were satisfied with the attendance of Directors and Non Executive Directors at their meetings.

The Register of Interests of the Council of Governors is available any time through the Trust Secretary, Christine Baldwinson Tel. 020 3214 5776 or email christine.baldwinson@nhs.net.

Communication

The Council of Governors has a good working relationship with the Board of Directors and Directors regularly attend Council of Governor meetings to be available to answer questions and participate in discussions. There is regular communication with individual Governors and questions regarding the performance of any individual. Directors would be channelled through the Chief Executive or Chair, as appropriate.

The Governors Annual and Strategic Planning working group looks in detail at annual planning.

Performance evaluation of the Council of Governors

The Council of Governors regularly reviews its operation to ensure its effectiveness.

We have focused in the year on developing a greater understanding of our Community Services. The Chair meets with Governors informally prior to each Council meeting and discusses training needs with them and there is an opportunity at the conclusion of each meeting to reflect on the effectiveness of the meeting.

There will be a new intake of Governors in May 2019 and a full induction programme will be provided. A full performance evaluation will be undertaken once these new Governors are in post.

Lead Governor

Councillor Ketan Sheth was re-appointed lead Governor in November 2015.

Conditions of service for Governors

The length of appointments of Governors is three years. Terms of office may be ended by resolution of the Council of Governors following a procedure laid down in the Foundation Trust's constitution.

Terms of office and summary attendance by individual Governors at meetings of Council of Governors 2018-19

There were five Council of Governors meetings in 2018-19.

Constituency	Name	Meetings attended	End of appointment
Service user Governors			
Hillingdon, Harrow, Brent, Ealing Hounslow	Jasmine Hodge Lake	3	May 2021
Hillingdon, Harrow, Brent, Ealing Hounslow	John Clark	4	May 2021
Hillingdon, Harrow, Brent, Ealing Hounslow	Angela Hook	4	May 2019
Hillingdon, Harrow, Brent, Ealing Hounslow	Colin Hurst	1	May 2019
Hillingdon, Harrow, Brent, Ealing Hounslow	Ushma Soneji	1	May 2019
Westminster K&C,H&F,Camden, Enfield and the rest of the GLA	Simon Emin	2	May 2021
Westminster K&C,H&F,Camden, Enfield and the rest of the GLA	Elvira De Souza	4	May 2021
Westminster K&C,H&F,Camden, Enfield and the rest of the GLA	Lina Christopoulou	4	May 2019
Westminster K&C,H&F,Camden, Enfield and the rest of the GLA	Pascale Gourlay	0	May 2021
Westminster K&C,H&F,Camden, Enfield and the rest of the GLA	Gloria Goldring	1	May 2019
Carer Governors			
Carer	Margarita Reygan	4	May 2021
Carer	Chandu Shah	5	May 2019
Carer	**Ponniah Rasanesan	1	May 2019
Public Governors			
Brent	Silvia Gerea	3	May 2021
Harrow	Irene Leeman	3	May 2019
Hillingdon	Lameck Ngulube	2	May 2021
Kensington & Chelsea	Ivan Moore	5	May 2021
Westminster	Cheryl Prax	5	May 2021
Milton Keynes	***Kenneth Bejon	4	May 2021
Ealing Hounslow Hammersmith & Fulham	Howard McFarlane	5	May 2019
Boroughs within England & Wales excluding those named above	Ejaz Elhak	0	May 2021
Camden	Vacant		

Constituency	Name	Meetings attended	End of appointment
Staff Governors			
Nursing	Carina Sheridan	1	May 2019
Nursing	Lisa Oluyinka	1	May 2021
Medical	Karim Dar	4	May 2021
Allied Health Professionals	Debbie Peter	5	May 2021
Social care	Karen Cook	4	May 2021
Other staff	Philip Ayers	2	May 2021
Appointed Governors			
Brent Local Authority	Cllr Ketan Sheth	2	Appointed
Harrow Local Authority	Vacant		Appointed
Hillingdon Local Authority	Cllr Nick Denys	Nil	Appointed
Kensington and Chelsea Local Authority	Cllr Charles Williams	3	Appointed
Westminster Local Authority	Lorraine Dean	1	Appointed
Camden Local Authority	Vacant		Appointed
Milton Keynes Local Authority	Cllr Nigel Long	0	Appointed
Imperial College	Mike Crawford	3	Appointed
NHS Commissioning Collaborative	Currently vacant	N/A	N/A
Mencap	Currently vacant	N/A	N/A
Terrence Higgins	Currently vacant	N/A	N/A
Age UK	Currently vacant	N/A	N/A

** Ponniah Rasanesan was a Trust Governor until August 2018
*** Kenneth Bejon was a Trust Governor until February 2019

Expenses

Directors and Governors Expenses Disclosure – Annual Report 2018-19				
	Directors		Governors	
	18-19	17-18	18-19	17-18
Total number in office	7	7	33	34
Number receiving expenses in reported period	6	6	8	1
Aggregate sum of expenses paid in period	£5,600	£5,600	£1,510.31	£100

Membership

Foundation Trusts are not for profit organisations mutually "owned" by members. They have greater freedom to develop services that meet the specific needs of local communities. Local people are invited to become members of CNWL, where they can help ensure the Trust is providing the most suitable services when and where they are needed.

Members' views are represented at the Council of Governors by the 33 Governors listed previously. The Governors' constituencies cover patients, carers, staff, partner organisations and public members.

Since becoming a Foundation Trust in 2007, the membership has grown to 15,505 members.

Building our membership

This year we have continued to not seek to increase our membership, but to ensure that it remains stable and engaged. We have held learning events on "The Impact of heart failure and what we do in CNWL". The learning event are held for members of the public to showcase some of our services and engage with members. The positive feedback from this event have led us to introduce further learning events for members for the public in 2018-19.

Keeping members informed

The Trust's Body and Mind magazine,continues to be published to ensure all our interested members and stakeholders are kept in informed of CNWL's activities. Body and Mind magazine provides updates on key issues for the Trust, news and dates of upcoming meetings. This year it has included features on Governors and their work in and around their community.

Members can contact Governors and directors through the CNWL website: www.cnwl.nhs.uk/have-your-say/members/ become-a-member/

Membership figures 2019

Constituency	Members at March 2019
Patient / Carer	2,301
Public	6,668
Staff	6,536
Total	**15,505**

Claire Murdoch CBE
Chief Executive
28 May 2019

Annual report on remuneration

Remuneration Committee

The Remuneration Committee determines the salaries of the Chief Executive and Executive Directors by considering market rates. All Executive Directors are appointed on permanent contracts with the Chief Executive having a six month notice period and Executive Directors three months. There is no performance-related pay and no compensation for early termination is provided.

The members of the Remuneration Committee are all Non Executive Directors:

Professor Dorothy Griffiths OBE – Chair, Non Executive Director

Helen Edwards – Non Executive Director

Tom Kibasi – Non Executive Director

David Roberts – Non Executive Director

David Walker – Non Executive Director

Amanda Harrison – Non Executive Director

Michael Nutt – Non Executive Director

Dr Reva Gudi – Non Executive Director

Amanda Harrison – Non Executive Director

Ian Mansfield – Non Executive Director

There were two meetings of the Remuneration Committee in 2018-19.

The remuneration for Non Executive Directors is set by the Council of Governors.

This was considered by the Council of Governors in 2010-11 and it was decided that the remuneration remain unchanged. No 'golden hellos', compensation for loss of office or other remuneration from the Trust was received by any of the above during 2018-19. All benefits in kind payments relate solely to the provision of cars. As Non Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non Executive members.

Number of meetings and attendance at the Remuneration Committee:

	Total Meetings = 2
Professor Dorothy Griffiths	2
Helen Edwards	2
David Walker	2
David Roberts	1
Tom Kibasi	1
Ian Mansfield	2
Michael Nutt	2
Amanda Harrison	0
Dr Reva Gudi	2

Annual statement on remuneration

The Remuneration Committee determines the salaries of the Chief Executive and the other Executive Directors by considering market rates. All Directors are on permanent contracts with the Chief Executive having a six month notice period and other Directors having a three month notice period. There is no performance related pay and no compensation for early termination.

The Council of Governors determines the pay for the Chairman and Non Executive Directors and in so doing take into account comparative remuneration of other Foundation Trusts. They are on fixed term, renewable contracts. There is no performance related pay and no compensation for early termination.

Major decisions on senior managers' remuneration

There were no substantial changes relating to senior managers' remuneration made during the year. The Council of Governors have not been asked to review the salaries for the Chair and Non Executive Directors as these are still in line with those offered across the sector.

Professor Dorothy Griffiths OBE, FCGI
Chair
28 May 2019

Senior Managers Remuneration Policy

Set out below are the main components of the remuneration package for senior managers:

Component	How that component supports the Trust short and long term strategy	How it operates	Maximum payable	Performance framework
Senior managers are entitled to a basic salary which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the remuneration committee who take into account • Qualifications required for the role • Spans of responsibility and accountability • Performance • Market forces	The Trust believes that its senior managers should be well remunerated for their work. Trust salaries should be competitive and enable the Trust to attract high calibre staff. However salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisation. The remunerations committee will therefore reference its salaries to the NHS Providers survey of executive salaries.	Salaries are reviewed against external NHS benchmarking and set at the lower end of the upper quartile for similar organisations, taking into a other factors including performance and qualifications. A report is presented to the Remuneration Committee		Subject to annual appraisal as for all staff
There is provision for providing a bonus in exceptional circumstances	Provides an opportunity to provide appropriate reward when an Executive Director delivers against a significant additional responsibility.	At the discretion of the Chief Executive in consultation with the Chair. No individual could receive more than one such increase in any year and the Chief Executive would not award such increases to more than two individuals in any given year. Any awards made will be reported to the Remuneration Committee These payments will be non-consolidated. However where it is felt that the individual performance is being sustained the Remuneration Committee may consider consolidating them	£5000	
Allowance for Lease car	This is to support certain directors who require their own transport to fulfil their role	This is taken into consideration when looking at the whole package		

Note: Annual Appraisal follows the same process as for all staff in the organisation and includes

- Achievement of agreed objectives (set annually in consultation with the Chief Executive and the Chair)
- Completion of statutory and mandatory training
- Behaviour compatible with the Trust's vision and values
- Strong financial management

No bonus payments are attached to satisfactory appraisal.

Each contract for directors gives the Trust the right to deduct from a director's salary, or any other sums owed, any money owed to the Trust. If on termination of the appointment the director has taken in excess of their accrued holiday entitlement the Trust shall be entitled to recover by way of deduction from any payments due.

The Trust's policy on senior managers' remuneration and its general policy on employees' remuneration differs only, in so far as other staff are on the Agenda for Change or Medical and Dental terms and conditions, while Directors pay is determined outside of these frameworks.

Non Executive Directors Policy on remuneration

The Non Executive Directors remuneration is set by the Appointments Committee of the Council of Governors.

The remuneration is reviewed in light of benchmarking undertaken of NHS organisations.

The payments have been reviewed on an annual basis

There are three levels of remuneration based on the level of commitment expected of the post holder: Chair; Chair of Audit Committee; and other Non Executive Directors.

Service contracts obligations

There is one standard contract for all Directors. This puts the following obligations on the Trust:

- To review performance annually
- To give reasonable notice of any variation to salary
- To determine redundancy pay by reference to Part XI of the Employment Rights Act 1996. Any redundancy payment will be calculated in accordance with paragraphs 16.8 and 16.9 of the NHS terms and conditions of service handbook
- To pay appropriate expenses incurred in the course of duties in accordance with the Trust's Travel and Expenses policy
- Annual Leave follows standard NHS terms, likewise sickness
- Notice period for all Executive Directors except Chief Executive – three months; Chief Executive – six months

No executive director is on a fixed term contract.

Policy on Loss of Office

- Notice periods as above for resignation all directors bar Chief executive – 3 months; Chief Executive – 6 months
- Payments in lieu of notice are at the discretion of the Trust
- Senior manager's performance is relevant for loss of office when a material element of the Business Plan has not been delivered and then it can be dismissal without notice

Setting senior managers remuneration policy

- This has been a matter solely for the remuneration committee

High paid off-payroll arrangements

The Trust has a policy on off-payroll arrangements whereby there a range of checks that are incumbent on the managers to perform and a declaration that the individual has to sign-off.

- There were no existing arrangements at 31 March 2019
- No new arrangements in 2018-19
- No engagements that reached six months in duration in 2018-19
- There are eight individuals that have been deemed "board members, and/or senior officers with significant financial responsibility", during the financial year.

Exit packages 2018-19

Exit package cost band (including any special payment element)			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	31	–	31
£10,000 – £25,000	16	–	16
£25,001 – 50,000	7	–	7
£50,001 – £100,000	4	–	4
Total number of exit packages by type	58	–	58
Total cost (£)	£900,552	£0	£900,552

Exit packages 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	-	-
£10,001 – £25,000	1	-	1
£25,001 – 50,000	1	-	1
£50,001 – £100,000	1	-	1
£100,001 – £150,000	-	-	-
£150,001 – £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	3	-	3
Total resource cost (£)	£149,513		£149,513

Statement of consideration of employment conditions elsewhere in the foundation Trust

The pay and conditions of employees (including any other group entities) were not taken into account when setting the remuneration policy for senior managers except in so far as senior managers were subject to the same financial restrictions as other staff and were awarded a cost of living increase in line with that received by other staff.

The Trust did not consult with employees when preparing the senior managers' remuneration policy.

The Remunerations Committee of the Trust utilised the NHS Providers annual survey of salaries as a remuneration comparison for setting Senior managers' pay.

Table of Senior Managers' remuneration

Name and Title	2018-19				
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind (Rounded to the nearest £100)	Pension Benefit (bands of £2500)	Total (bands of £5000)
Chairman					
Prof Dorothy Griffiths	50 – 55	0	0	0	50 – 55
Chief Executive					
Claire Murdoch	190 – 195	0	0	0	190 – 195
Executive Directors					
John Vaughan – Director of Strategy and Performance	115 – 120	0	0	0 – 2.5	115 – 120
Robyn Doran – Chief Operating Officer	120 – 125	0	1,300	0 – 2.5	125 – 130
Andrew Mattin – Director of Nursing and Quality	115 – 120	0	900	0 – 2.5	115 – 120
Hardev Virdee – Chief Finance Officer	150 – 155	0	0	0 – 2.5	150 – 155
Dr Cornelius Kelly – Medical Director	90 – 95	60-65	0	0	150 – 155
*Maria O'Brien – Deputy Chief Operating Officer and Board Director for Community Services	120 – 125	0	0	0 – 2.5	120 – 125
*Grant Macdonald – Director of Improvement and Workforce	125 – 130	0	0	0	125 – 130
Non Executive Directors					
David Walker – Deputy Chair	10 – 15	0	0	0	10 – 15
David Roberts – Non Executive Director	15 – 20	0	0	0	15 – 20
Tom Kibasi – Non Executive Director	10 – 15	0	0	0	10 – 15
Helen Edwards – Senior Independent Director	10 – 15	0	0	0	10 – 15
Michael Nutt – Non Executive Director	15 – 20	0	0	0	15 – 20
Dr Reva Gudi – Non Executive Director	10 – 15	0	0	0	10 – 15

Ian Mansfield – Non Exectuive Director (from 8th Oct 2018)	5 – 10	0	0	0	5 – 10
Amanda Harrison – Non Executive Director (left on 4th May 2018)	0 – 5	0	0	0	0 – 5

No 'Golden Hellos', compensation for loss of office or other remuneration from the Trust was received by any of the above during 2018-19. All benefits in kind payments relate solely to the provision of cars.

*Not full Board members

Name and Title	2017-18				
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind (Rounded to the nearest £100)	Pension Benefit (bands of £2500)	Total (bands of £5000)
Chairman					
Prof Dorothy Griffiths	50 – 55	0	0	0	50 – 55
Chief Executive					
Claire Murdoch	185 – 190	0	0	5 – 7.2	190 – 195
Executive Directors					
Jane McVey – Director Director of People and Organisational Development (Up to 31 Dec 2017)	65 – 70	0	0	NA	65 – 70
Dr Cornelius Kelly – Medical Director (Up to 15 Dec 2017 and from 19 Dec 2017)	105 – 110	70 – 75	0	NA	175 – 180
Hardev Virdee – Chief Finance Officer	125 – 130	0	0	0 – 2.5	125 – 130
John Vaughan – Director of Strategy and Performance	110 – 115	0	0	0 – 2.5	115 – 120
Robyn Doran – Chief Operating Officer	120 – 125	0	1,900	0 – 2.5	125 – 130
Andrew Mattin – Director of Operations & Nursing	110 – 115	0	10,200	2.5 – 5	120 – 125
Maria O'Brien – Deputy Chief Operating Officer and Board Director for Community Services (From 1 Jun 2017)	95 – 100	15 – 20	0	0	110 – 115
Grant Macdonald – Director of Improvement	30 – 35	90 – 95	0	0	120 – 125

Non Executive Directors					
David Walker – Deputy Chair	10 – 15	0	0	0	10 – 15
David Roberts – Non Executive Director	15 – 20	0	0	0	15 – 20
Tom Kibasi – Non Executive Director	10 – 15	0	0	0	10 – 15
Helen Edwards – Senior Independent Director	10 – 15	0	0	0	10 – 15
Michael Nutt – Non Executive Director (From 24 Apr 2017)	5 – 10	0	0	0	5 – 10
Amanda Harrison – Non Executive Director (From 1 Jun 2017)	5 – 10	0	0	0	5 – 10
Dr Reva Gudi – Non Executive Director (From 12 Feb 2018)	0 – 5	0	0	0	0 – 5

No 'Golden Hellos', compensation for loss of office or other remuneration from the Trust was received by any of the above during 2018-19. All benefits in kind payments relate solely to the provision of cars.

Pension entitlement of senior managers

Name and title	Real increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2018 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2019 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers contribution to stakeholders pension £000
Chief Executive								
Claire Murdoch	0	0	105 – 110	315-320	2,275	2,560	216	28
Executive Directors								
John Vaughan – Director of Strategy and Performance	0 – 2.5	0-2.5	40 – 45	130 – 135	978	0	0	16
Robyn Doran – Chief Operating Officer	0 – 2.5	2.5 – 5	20 – 25	70 – 75	483	564	67	18
Andrew Mattin – Director of Operations and Nursing	0 – 2.5	5-7.5	55 – 60	170 – 175	1,060	1,252	160	17
Maria O'Brien – Deputy Chief Operating Officer and Board Director for Community Services	0 – 2.5	2.5 – 5	45 – 50	140-145	862	1,008	121	18
Hardev Virdee – Chief Finance Officer	0 – 2.5	10-12.5	30 – 35	95 – 100	440	588	134	22

2017 – 2018							
Name and title	**Real increase in pension at age 60 (bands of £2500)**	**Real increase in pension lump sum at age 60 (bands of £2500)**	**Total accrued pension at age 60 at 31 March 2018 (bands of £5000)**	**Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5000)**	**Cash Equivalent Transfer Value at 31 March 2018 £000**	**Real Increase in Cash Equivalent Transfer Value £000**	**Employers contribution to stakeholders pension £000**
Chief Executive							
Claire Murdoch	5 – 7.5	20 – 22.5	100 – 105	310-315	2,275	255	27
Executive Directors							
John Vaughan – Director of Strategy and Performance	0 – 2.5	5 – 7.5	40 – 45	125 – 130	978	84	16
Robyn Doran – Chief Operating Officer	0 – 2.5	2.5 – 5	20 – 25	65 – 70	483	32	18
Andrew Mattin – Director of Operations and Nursing	2.5 – 5	7.5-10	50 – 55	160 – 165	1,060	118	16
Jane McVey – Director Director of People and Organisational Development (Up to 31 Dec 2017)	NA	0 – 2.5	45 – 50	140 – 145	0	NA	10
Maria O'Brien – Deputy Chief Operating Officer and Board Director for Community Services (From 1 Jun 2017)	NA	NA	45 – 50	135-140	862	NA	16
Dr Cornelius Kelly – Medical Director	NA	0 – 2.5	80 – 85	270-275	0	NA	17
Hardev Virdee – Chief Finance Officer	0 – 2.5	0 – 2.5	25 – 30	80 – 85	440	18	18

Expenses

In addition to the Remuneration Report, the Companies Act 2006 requires disclosure, in a note to the accounts, of the aggregate of remuneration and other benefits receivable by directors during the financial year. This information is required even where entities prepare a Remuneration Report, although in such cases the disclosure requirements in the accounts are correspondingly fewer. The requirements for disclosing directors' remuneration are set out in section 412 of the Act and in Regulation 8 and Schedule 5 to the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410). In summary, the disclosures comprise the aggregate amounts of each of the following:

- Total remuneration paid to directors for the year ended 31/03/2019 (in their capacity as directors) totalled £1.10 million (2017-18 £1.14 million);
- Employer contributions to the NHS Pension Scheme for Executive Directors for the year ended 31/03/2019 totalled £118k, (2017-18 £138k);
- The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 6.
- No other remuneration was paid to directors in their capacity as directors and there were no advances or guarantees entered into on behalf of directors by the Trust.

No 'Golden Hellos', compensation for loss of office or other remuneration from the Trust was received by any of the above directors during 2018-19. All benefits in kind payments relate solely to the provision of cars.

The HM Treasury Financial Reporting Manual (FReM) requires disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director (as defined as a senior manager in paragraph 7.28 and paragraphs 7.34 to 7.38 of the Annual Reporting Manual whether or not this is the Accounting Officer or Chief Executive). The calculation is based on permanent staff of the reporting entity (excludes Agency or Bank staff) at the reporting period and date on an annualised basis.

The highest paid director earns approximately 5.64 times the median staff salary figure of £33,910/annum (2017-18 calculated at 5.63 times the median salary of £33,058/annum). Last year's numbers have been restated to reflect a revision in the calculation of the median.

The Trust's accounting policy for pensions and other retirement policies can be found in Note 1.4 of the notes to the accounts.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Expenditure on Consultancy

The total expenditure on consultancy was £2.3m in 2018-19 (2017-18 £2.3m).

Claire Murdoch CBE
Chief Executive
28 May 2019

Staff Report

Staffing Group	Total 2018-19	Permanent 2018-19	Other 2018-19	Total 2017-18	Permanent 2017-18	Other 2017-18
Medical and dental	395	248	147	431	261	170
Ambulance staff	0	0	0	0	0	0
Administration and estates	1,294	1,208	86	1,327	1,210	117
Healthcare assistants and other support staff	1,143	1,050	93	1,151	1,045	106
Nursing, midwifery and health visiting staff	1,988	1,948	40	2,079	1,879	200
Nursing, midwifery and health visiting learners	54	36	18	48	30	18
Scientific, therapeutic and technical staff	1,135	1,004	131	1,149	959	190
Healthcare science staff	0	0	0	0	0	0
Social care staff	74	68	6	71	60	11
Other	0	0	0	0	0	0
Total average numbers	**6,083**	**5,563**	**520**	**6,255**	**5,443**	**812**
Of which:						
Number of employees (WTE) engaged on capital projects	13	13	0	6	6	0

FTE by contract type	
Assignment category	**FTE**
Fixed term temp	459.30
Locum	13.10
Permanent	5650.33
Grand Total	**6122.73**

FTE by gender job role		
Gender	**Pay band category**	**FTE**
Female	Director	3.83
	Others	4,532.45
	Senior Manager**	87.70
Female Total		**4,623.97**
Male	Director	8.20
	Others	1,446.46
	Senior Manager**	44.10
Male Total		**1498.76**
Grand Total		**6,122.73**

**Senior Managers have been classified as Pay Band 8C and above

Staff Sickness absence	31 Mar 19	31 Mar 18
	2018-19	2017-18
	No.	No.
Total days lost	42,669	40,679
Total staff years	6,100	5,944
Average working days lost (per WTE)	7	7

Sickness % for CNWL												
Month	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
In Month %	3.02%	3.18%	3.34%	3.10%	3.18%	2.99%	3.08%	3.06%	3.15%	3.42%	3.55%	2.94%
YTD Rolling %	3.12%	3.16%	3.21%	3.21%	3.19%	3.20%	3.20%	3.22%	3.19%	3.13%	3.17%	3.17%

Staff policies and actions applied during the financial year

The Trust has applied its recruitment and selection policy to the assessment of disabled persons' job applications and as a disability symbol user the Trust does ensure that all applicants with a disability and who meet the minimum criteria for the role are guaranteed an interview.

With regard to the continuing employment, training, career development and promotion of disabled persons the Trust has applied the following policies: sickness absence equality, diversity & human rights (employment), disability (employment) . In addition, staff have been referred to Occupational Health who advise managers and staff on disability and fitness to work including reasonable adjustments such as accessing access to work support.

The Trust emails all staff on a weekly basis to provide information on matters of concern to them in addition to ensuring that staff have access to appraisals and supervision. In addition, information is made available to staff in team meetings through the "Team Brief" management information cascade and via the intranet. Through such measures staff are involved in discussions regarding the Trust's performance.

Where staff will be materially affected by decisions they and their representatives are under the change management policy by line managers with support from HR.

The Trust provides support to staff on health and safety matters such as the control of substances hazardous to health (COSHH), manual handling, pregnancy and work, working with computers and occupational dermatitis and latex allergy. The Occupational Health service provides managers with support on fulfilling their duty of care, sickness absence and return to work, disability and adjustments to work and promoting a safe, healthy workplace. The service also assists employees to stay fit and protect their health at work as well as to handle illness or disability with minimum effects on their health and performance at work.

The Trust is committed to tackling Fraud and applies an Anti-Fraud Policy which makes clear the reporting lines and support available to employees wishing to raise concerns of fraud or corruption. The Trust provides access to an independent person to advise staff who wish to raise concerns and all new staff are introduced to this person during their induction to the Trust.

Trade Union Duties

The Trust employs six individuals working in total 3.2 WTE as trade union officials. Of these three spend all their working time on trade union duties, one 50% and two 10%. This is at a cost of £199k or 0.7% of the paybill.

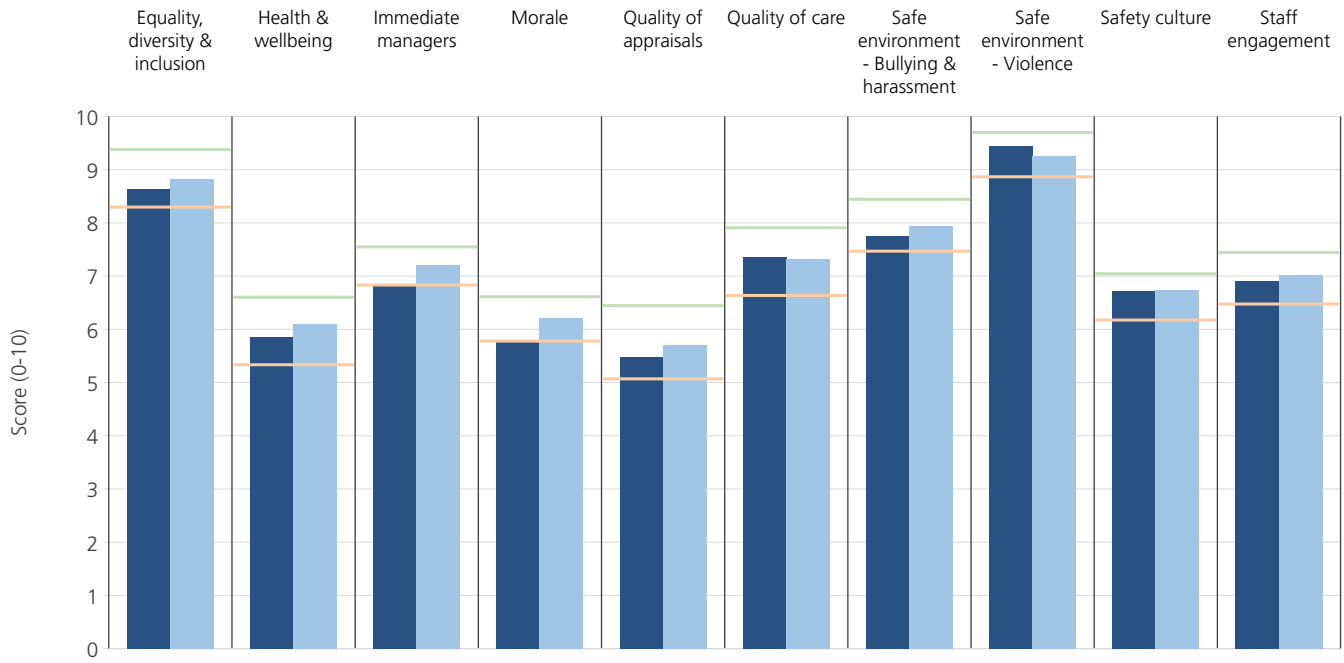
Staff Survey

The NHS Staff Survey was carried out in October 2018 with 47% of CNWL staff responding.

Staff at CNWL were encouraged to fill out the survey through a mix of all-staff emails, via divisional blogs, posters and a reminder on the staff pay packet.

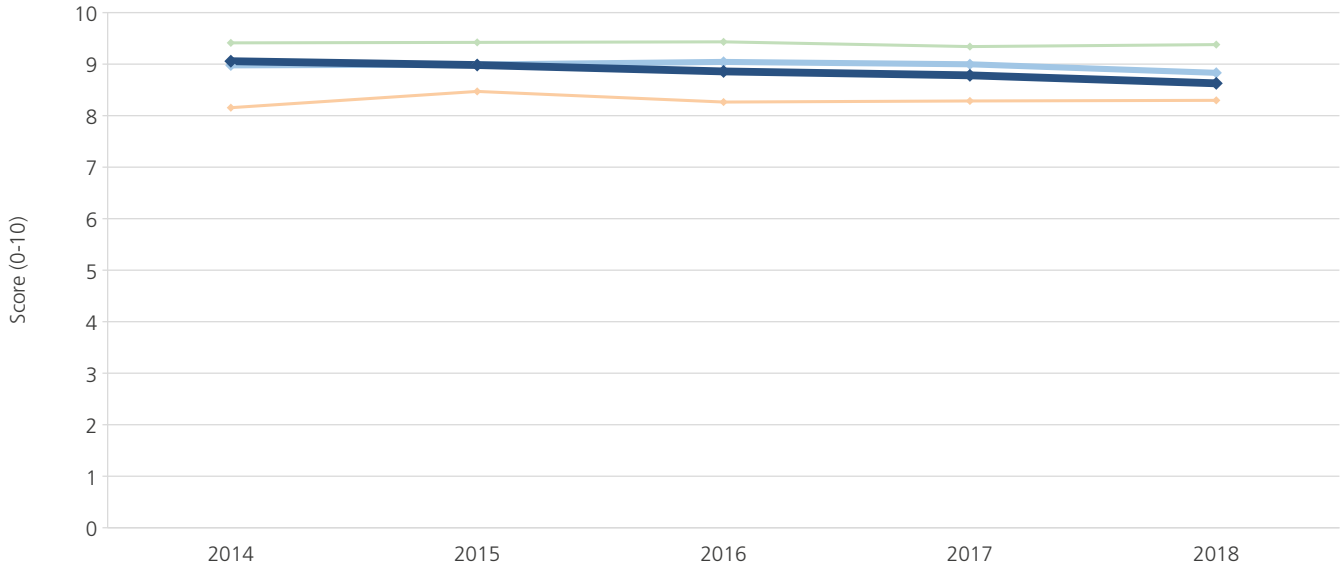
A steering group meets in partnership between management and trade unions to consider how to promote completion of the survey and develop action plans following its publication.

Trust Overview



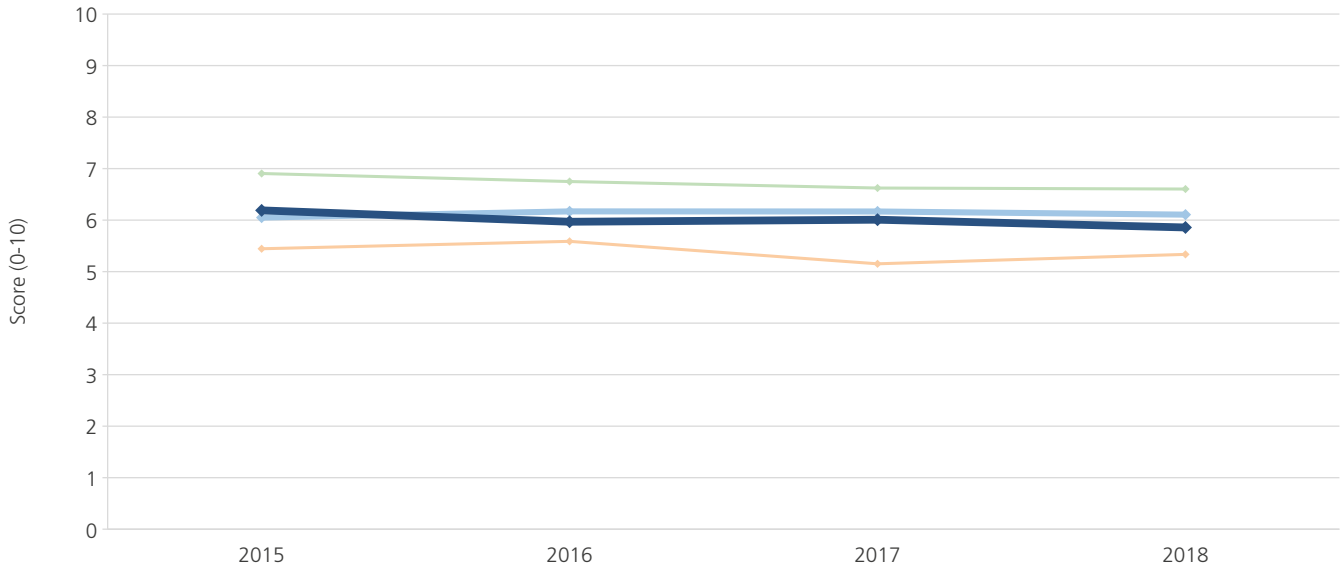
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	8.6	5.9	6.8	5.8	5.5	7.4	7.8	9.4	6.7	6.9
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
Responses	2,891	2,929	2,941	2,859	2,446	2,635	2,856	2,847	2,890	2,997

Equality, diversity and inclusion



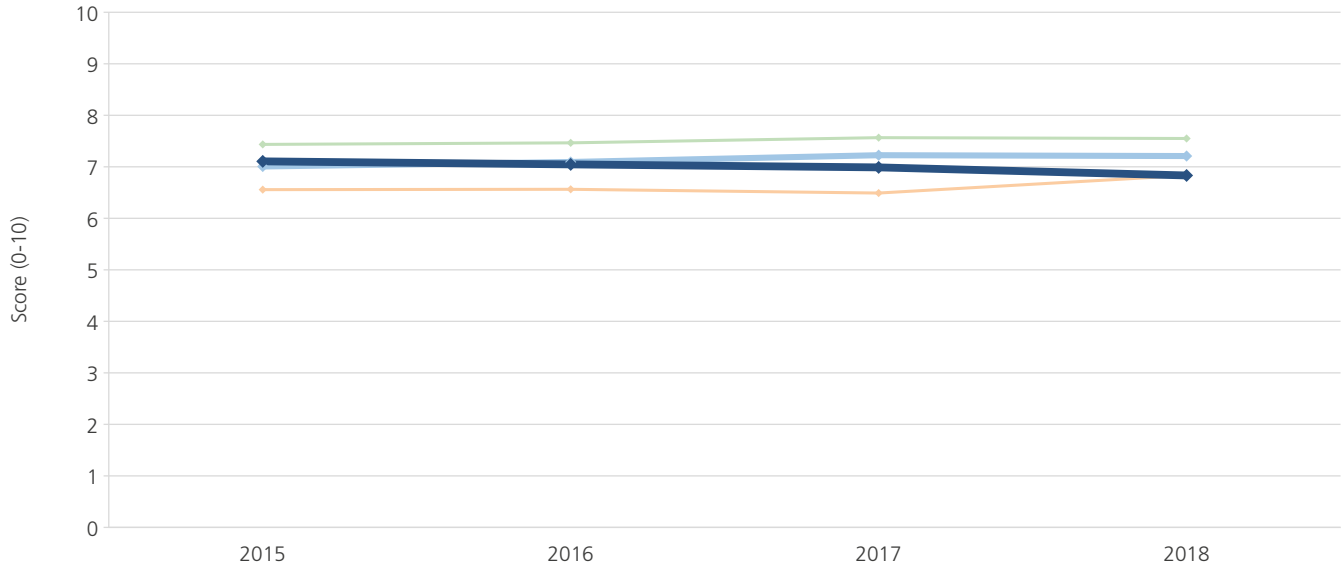
	2014	2015	2016	2017	2018
Best	9.4	9.4	9.4	9.3	9.4
Your org	9.1	9.0	8.9	8.8	8.6
Average	9.0	9.0	9.0	9.0	8.8
Worst	8.2	8.5	8.3	8.3	8.3
Responses	2,517	2,089	2,216	2,919	2,891

Health and wellbeing



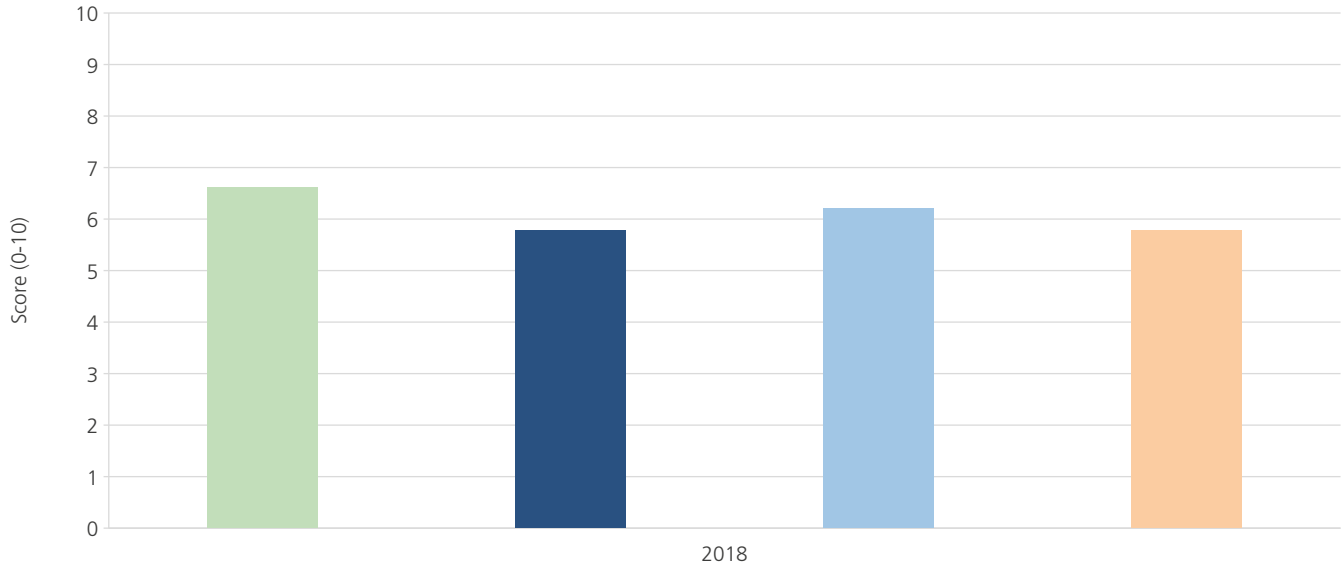
	2015	2016	2017	2018
Best	6.9	6.7	6.6	6.6
Your org	6.2	6.0	6.0	5.9
Average	6.0	6.2	6.2	6.1
Worst	5.4	5.6	5.2	5.3
Responses	2,113	2,239	2,939	2,929

Immediate managers



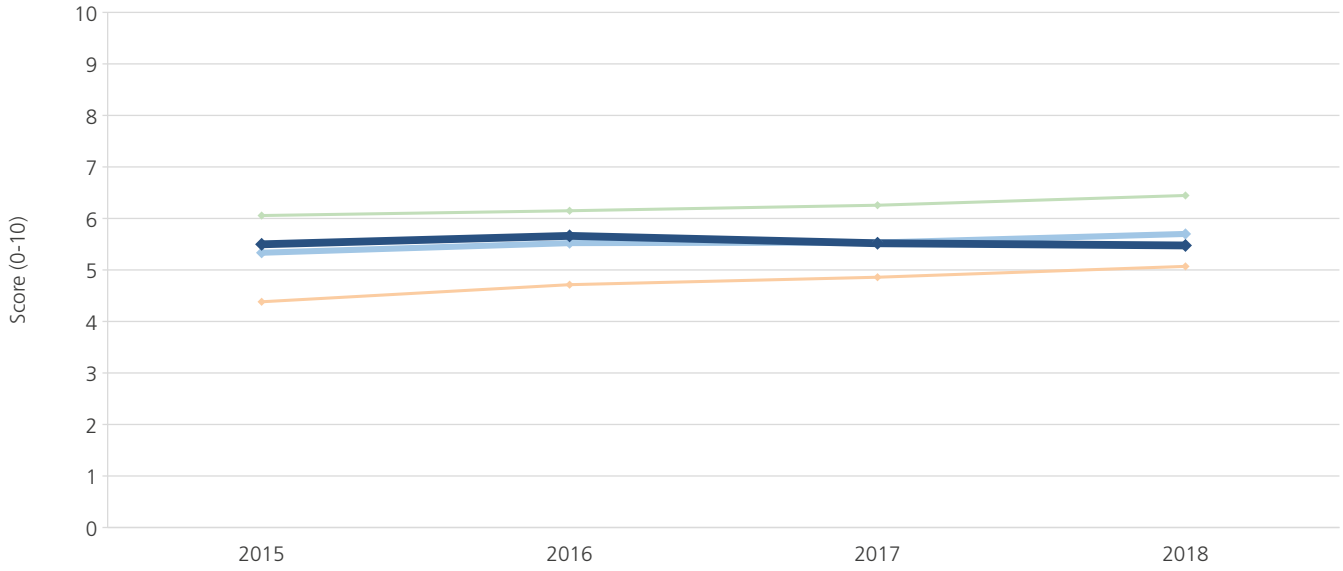
	2015	2016	2017	2018
Best	7.4	7.5	7.6	7.5
Your org	7.1	7.0	7.0	6.8
Average	7.0	7.1	7.2	7.2
Worst	6.6	6.6	6.5	6.8
Responses	2,112	2,240	2,952	2,941

Morale



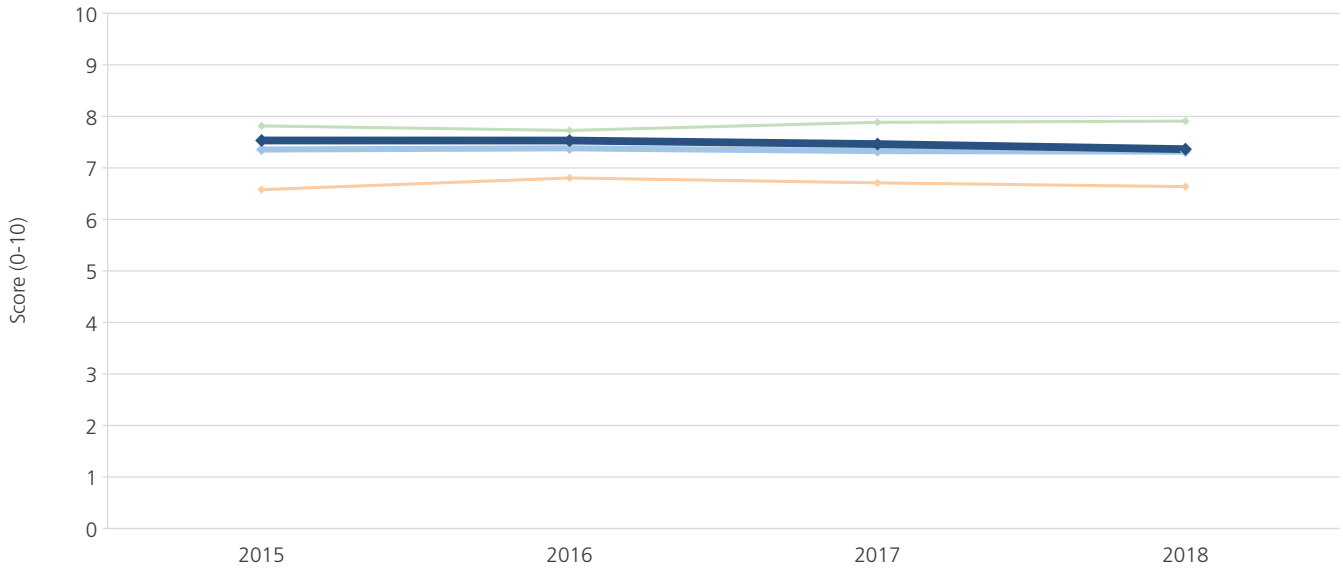
	2018
Best	6.6
Your org	5.8
Average	6.2
Worst	5.8
Responses	2,859

Quality of appraisals



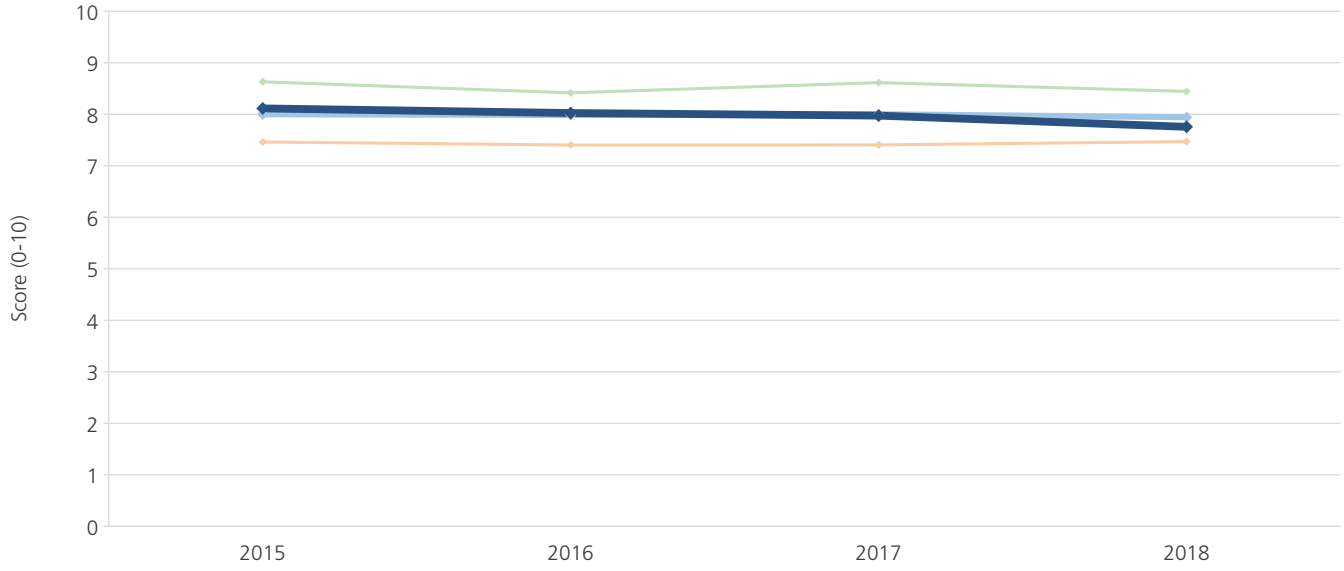
	2015	2016	2017	2018
Best	6.1	6.1	6.3	6.4
Your org	5.5	5.7	5.5	5.5
Average	5.3	5.5	5.5	5.7
Worst	4.4	4.7	4.9	5.1
Responses	1,818	1,909	2,431	2,446

Quality of care



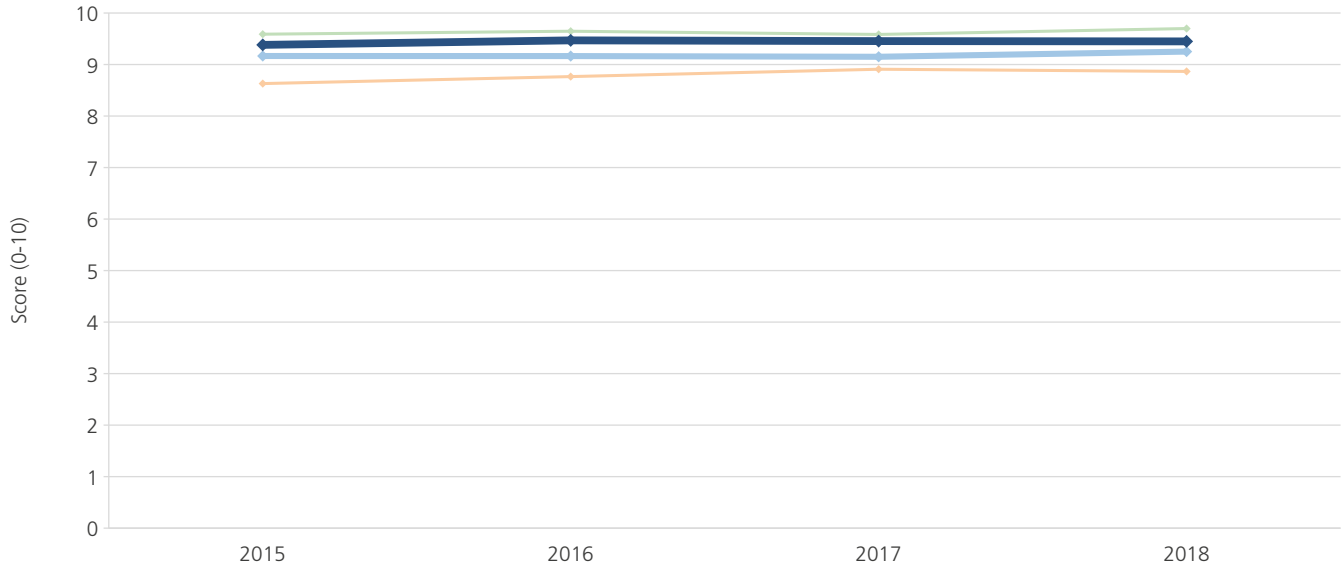
	2015	2016	2017	2018
Best	7.8	7.7	7.9	7.9
Your org	7.5	7.5	7.5	7.4
Average	7.4	7.4	7.3	7.3
Worst	6.6	6.8	6.7	6.6
Responses	1,785	1,908	2,562	2,635

Bullying and harassment



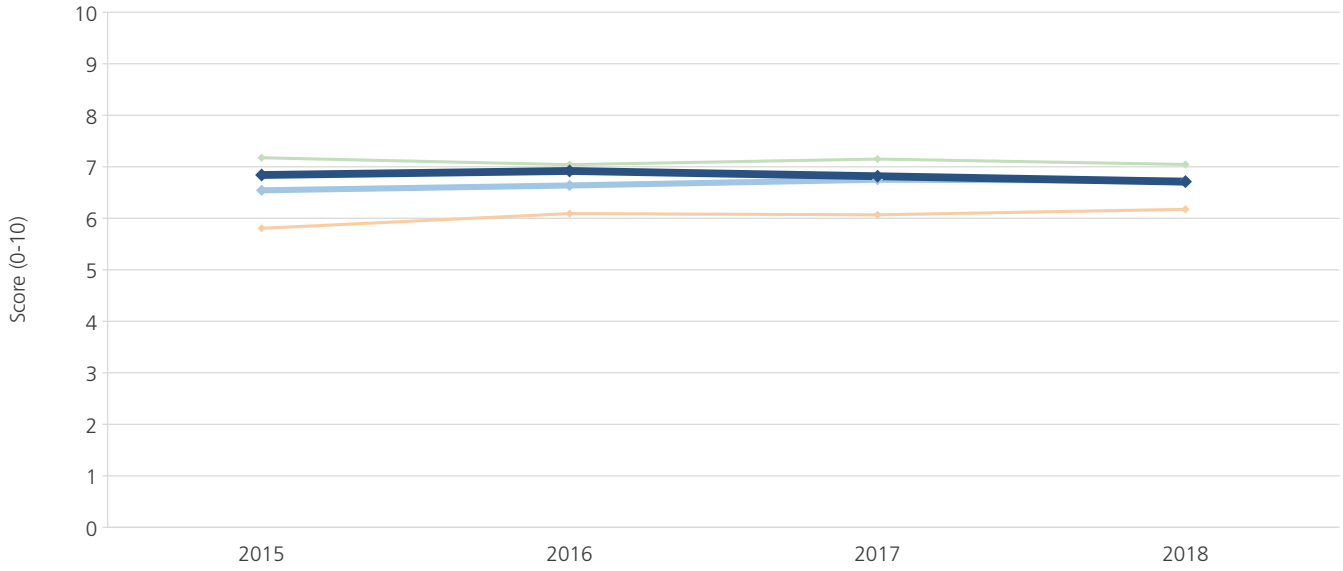
	2015	2016	2017	2018
Best	8.6	8.4	8.6	8.4
Your org	8.1	8.0	8.0	7.8
Average	8.0	8.0	8.0	7.9
Worst	7.5	7.4	7.4	7.5
Responses	2,090	2,212	2,902	2,856

Violence



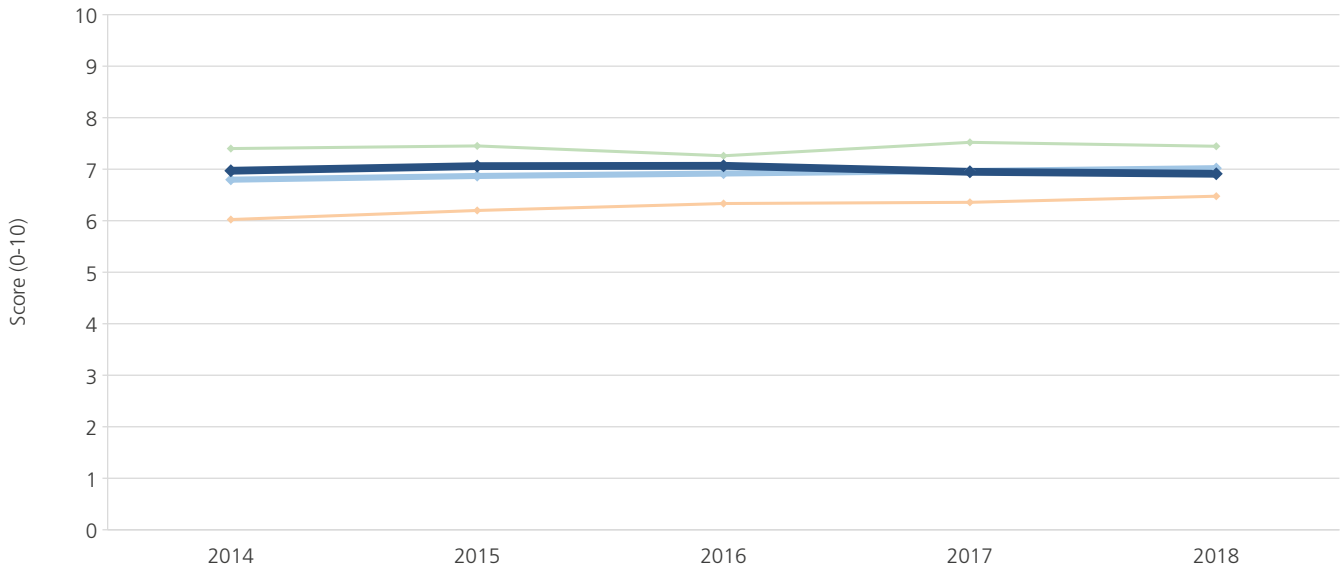
	2015	2016	2017	2018
Best	9.6	9.6	9.6	9.7
Your org	9.4	9.5	9.5	9.4
Average	9.2	9.2	9.2	9.3
Worst	8.6	8.8	8.9	8.9
Responses	2,086	2,223	2,914	2,847

Safety culture



	2015	2016	2017	2018
Best	7.2	7.0	7.2	7.0
Your org	6.8	6.9	6.8	6.7
Average	6.5	6.6	6.7	6.7
Worst	5.8	6.1	6.1	6.2
Responses	2,098	2,233	2,945	2,890

Staff engagement



	2014	2015	2016	2017	2018
Best	7.4	7.5	7.3	7.5	7.4
Your org	7.0	7.1	7.1	6.9	6.9
Average	6.8	6.9	6.9	7.0	7.0
Worst	6.0	6.2	6.3	6.4	6.5
Responses	2,554	2,123	2,265	2,983	2,997

Statement of the Chief Executive's responsibilities as the Accounting Officer of Central and North West London NHS Foundation Trust

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

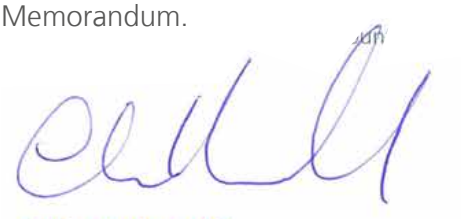
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Central and North West London NHS Foundation 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 Group Accounting Manual and in particular to:

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

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 requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



Claire Murdoch CBE
Chief Executive
28 May 2019

Central and North West London NHS Foundation Trust

Annual Governance Statement 2018-19

Scope of Responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Central and North West London NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Central and North West London NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and adhering to the guidance issued by NHS Improvement and the Department of Health in respect of governance.

The Executive Board, which I chair, has the remit to ensure the adequacy of the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board. The Board has considered its risk appetite and has been clear that it does not tolerate risks to the quality of service provision.

Day-to-day management of risks is undertaken by operational management, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors, relevant committees and governance groups for risks where there are difficulties in implementing mitigations.

To ensure all staff are aware of their responsibilities for risk, training is provided incorporating aspects of risk management and senior staff have been trained in the identification and management of clinical risk. In particular the training provides guidance for staff on the actions they can take once they identify a risk from tolerating a risk through to deciding it is so significant that immediate action is required. Staff are advised on how to escalate but are also reminded that this does not lessen their personal ownership. The development of local risk registers has served also to promote awareness and understanding of the identification of risks and their management across the Trust. The Internal Auditor reviews the Trust's risk management processes annually and advises us on developments to our practice in accordance with best practice.

Many of the risks in service line risk registers also appear on the top risk register, reflecting that the issues local services are facing are being recognised and captured corporately, and concurrently that local services are recognising the main difficulties being discussed corporately. All services review their risks regularly in their management meetings, which are jointly led by a Divisional Director and Divisional Medical Director and Divisional Nursing Director. The Executive Board reviews each Division quarterly and assessment of their ongoing risks is an integral part of these reviews.

The Risk and Control Framework

The Risk Management Policy sets out the organisation's approach to risk management, describes the structures for the management and ownership of risk.

Key to the effectiveness of risk management in the Trust is the Executive Board, comprising all the Executive Directors. This membership recognises the importance and high profile of risk management in the organisation and facilitates ownership at that level of the identification and management of risks on a continuing basis. Each Division is reviewed on a quarterly basis and the Executive Board considers the key risks identified within the division and the actions in place to mitigate them. This facilitates an integrated approach to governance and risk management issues.

Every year the Board of Directors reviews its key objectives for the coming years in the context of its appetite for risk and these are included in its Annual Plan. The Trust has an Assurance Framework, which provides it with a simple but comprehensive oversight of the management of the principal risks to meeting its objectives. This ensures the board is sighted through its performance management framework on the areas that represent the greatest threat to its strategic objectives. The Audit Committee reviews the Assurance Framework and underlying sources of assurance.

Local services are responsible for identifying local risks and these are assessed and recorded in Trust-wide risk registers. The risk registers contains details of risks including those relating to clinical, financial, health and safety and organisational risks.

Top risks are identified by Executive Directors and reported at every meeting of the Board of Directors. They are graded, in accordance with the process set out in the Risk Management Policy and actions developed to address them. Awareness of the top risks facing the organisation enables the Board to review the operation of the Trust and potential business opportunities in a way that helps them determine the level of risk appetite they have at any time. The Board is mindful of the need to consider its risk appetite when taking strategic decisions and the Audit Committee looks at risk appetite in the context of the Assurance Framework.

During 2018-19 the top risks facing the Trust have continued to include a range of business, quality and financial risks, all of which were considered at the Board's bi-monthly meetings. The Business and Finance Committee, the Quality and Performance Committee and the Informatics Committee review, at their monthly meetings, key risks identified by services relating to their particular spheres of interest.

The Trust has strong quality governance in place. This starts with the Trust strategy, which aims to put the patient at the heart of everything we do. The board itself starts each meeting with a patient's story and spends a significant proportion of Board time on quality. The Trust has an integrated dashboard which is used from team level up to the Board. Performance is assessed against national standards, previous performance and against benchmarking where this is available. Where performance dips against any of these indicators it will be scrutinised at local level, by the Divisional management and by the Quality and Performance Committee who will keep the Board informed of any significant variations.

The Care Quality Commission re-inspected the Trust through a number of staged inspections from February to November 2017 and gave it an overall rating of 'Good'. This validated the work undertaken across the Trust since the initial inspection in 2015 but the Trust was disappointed that the CQC found some services to still require improvement. Actions were immediately taken to address the issues raised and the Trust has continued to review its services to ensure compliance with CQC standards. The CQC is currently undertaking a Well Led review, which will conclude at the end of March 2019 but the formal report is not expected until the new financial year. Compliance is monitored by the Executive Board and the Quality and Performance Committee and we are confident that the Trust is compliant with our registration requirements. However we have had some isolated concerns about services and in each case we have taken immediate remedial action and discussed the concerns and actions taken with the Board.

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

The Trust has a culture of openness and transparency and actively encourages incidents to be reported on Datix. In the year to date there were 18,312 incidents reported of which 17,392 were of low or no harm. We believe that this enables staff to identify potential safety risks at an early stage and put in place mitigating actions.

The Trust has had a very successful year working with our QI partner. Over 900 staff have now joined our online QI community, Life QI Platform, and 30 projects have been completed. Currently 270 projects are being undertaken. We are very pleased that front line staff have seen the benefits to both their own working practice and to patient experience derived from these projects. Although the skills and experience of our partner have been valuable to us our ongoing

activity is seen very much as the CNWL way rather than something that belongs to a third party.

The Trust engaged Deloitte to undertake a well led review in line with NHSI requirements. This review was completed in December 2018 and was considered by the Board at its January meeting. Overall the report was very positive. It found that the Divisional structures were working well with good systems of accountability and responsibility from the front line through to the Board. It also found that the Trust has improved its use of data and in particular found that the Tableau system which enables staff to see real time performance information has been developed so as to make it accessible to front line staff and management teams alike. The reviewers noted that despite considerable engagement activity some staff remain dissatisfied and the Trust will continue its efforts to address this situation.

Workforce is on our top risk register and the recruitment, retention and training of our staff remains our top priority. Services have bespoke action plans to deal with particular service issues and there is an overarching Trust initiative on recruitment and retention. It continues to be a significant priority to ensure that all our staff have regular training on key policies and procedures. We have been successful in our efforts, which include introducing recruitment incentives and making our bank proposition more appealing to reduce reliance on agency staff and are now consistently within the NHSI target for agency. There are some remaining hotspots where recruitment remains difficult including our prison services but we are now making sustained progress in these areas. We are reviewing the shape of our workforce and the focus in the coming year will be on developing new types of roles and employment models to enable us to meet future demands. This includes physician associates, apprenticeships, nurse rotations and peer support workers.

The Trust complies with the 'Developing Workforce Safeguards' recommendations in a number of ways. It is of course a priority to deploy sufficient suitably qualified staff in all our services. We are of course affected by national shortages of some specific professional groups and we deploy these professionals in such a way as to effectively manage service delivery. Our commitment to developing alternative roles and our engagement with the apprenticeship scheme demonstrates our commitment to developing effective multidisciplinary teams. We have a systematic approach to determining the number of staff required by our wards and report to the Quality and Performance Committee and the Board on our compliance with safer staffing on our wards. The Director of Workforce and Strategy ensures that the Trust remains compliant with any legislative changes and guidance issued by our regulators. Our Divisions review the workforce requirements for their services and report through their quarterly reviews on any identified risks. Any reductions in workforce require a quality impact assessment prior to implementation. We are developing a new People Strategy which has been discussed by the Quality and Performance Committee and is due to be completed by April 2019. This will fully reflect the NHS Long Term Plan and the ambitions of our STPs.

The Executive Board will monitor both the achievement of workforce targets and the outcomes associated with them. For instance the percentage of staff trained and the patient feedback on their experience. The Quality and Performance Committee will regularly interrogate workforce information and will also check on how far this information is being utilised by front line teams. The Executive Board will continue to drive the workforce agenda as the programme board for workforce.

The financial and business risk presented by the health economy nationally and locally is an ongoing one, and is being addressed through significant senior management time being invested in relationship management and engagement with the Trust's main commissioning partners and other stakeholders. 2018-19 has again been a very challenging year, but we have achieved the NHSI control total. We have established a Finance Savings Group as an additional measure to give focus and support to achieving tighter financial control across the Trust. We have a monthly executive scrutiny process and the Business and Finance Committee monitors financial performance monthly and reports to the Board. NHS Improvement are assured that the Trust is doing all it can to effectively manage its financial position while meeting quality priorities.

The Board is mindful of the changes in the NHS landscape and is committed to the Trust working in partnership with other agencies to develop approaches to place based care which best meet the needs of the population it serves. This includes working collaboratively with other providers to deliver contracts, being an active partner in Accountable Care Partnerships and working with STPs to design and deliver care systems. The Trust has ensured that its priorities are aligned with those of its STPs.

Prevention – including a focus on children's mental and physical health care; maternity; Development of community provision (mental and physical health) including local authority and primary care; Mental health; Cancer; Redesign of hospital care; Response – urgent and emergency care. Our key enablers are Digitisation; System architecture; Workforce; Estates and Engagement.

The Board is also mindful of its responsibility to maintain clear lines of accountability particularly in respect of governance, quality governance and financial control.

The Trust has established a wholly-owned subsidiary to manage its estates and facilities as we believe that this will be the most effective way to ensure that we can continue to provide high quality environments for our patients and staff. Our service will also be available to other service providers particularly those within our STP areas.

The Trust has upgraded its ICT infrastructure and has now introduced a new clinical system across the Trust. This system went live in January 2019 and work is ongoing to ensure it is fully embedded. As our current model of provision has not met expectations the Trust has decided that it is now the right time to move to a new model of ICT provision adopting a best of breed model to our ICT components rather than contracting the entire system from one supplier. This transition will be complete by November 2019. The costs of the existing system and projected costs for the new model do pose a cost pressure. The Informatics Committee meets monthly to review progress and report issues to the Board. We are very keen to ensure interoperability with our commissioners and other providers in our heath economies. We are also focussing on utilising our new equipment and the additional capacity it provides to deliver better patient care. We have a Chief Clinical Information Officer in post to ensure that developments are clinically led. Many of our services already use leading edge technology and we intend to spread such innovation across the Trust. One of the drivers behind the major ICT programme was to put the Trust in a position where it is using leading edge equipment including high standards of data security. We continue to ensure that all staff undergo annual IG training and routinely share learning across the Trust on any IG breaches that take place. The number of IG incidents is used to assess the success of the training and learning. We have appointed a Statutory Data Protection Officer to ensure that we are fully compliant with the requirements of GDPR.

The Trust is able to assure itself of its compliance with the NHS Improvement licence as regards governance through having a well-established board committee structure, schedule of matters reserved to the board and its committees and a scheme of delegation explaining its corporate governance arrangements, roles and responsibilities, reporting lines and accountabilities throughout the organisation. Operational and financial performance and effectiveness and compliance with healthcare and other regulatory standards are monitored monthly by the Executive Board and bi-monthly by the Board. The remit of the Board, its committees and the Executive Board includes oversight of Trust business planning processes and risks to their achievement, quality standards and risks to their achievement and there are systems in place for escalating and resolving issues of concern, which include incident reporting and management of serious incidents, near misses, complaints and concerns. The Board is assured about the effectiveness of these systems through regular review by the Trust's internal auditors.

Prior to agreeing its annual governance statement the Board reviews evidence against the NHSI code of quality Governance and the NHSI code of governance It also reviews its scheme of delegation including the terms of reference of its committees. The Board reviews the accountability framework, which sets out the way divisional governance operates within the Trust and receives assurance from the divisional directors that the framework is being applied. The Board also annually reviews its own performance.

The annual governance statement itself is reviewed by the Audit Committee with both External and Internal Audit being asked for comment. It is then reviewed by the Board prior to self-certification to the regulators and its inclusion in the Annual Report and Accounts.

The Trust has a Divisional Structure in place. All Divisions operate in line with the Accountability Framework, which sets out clear expectations for how quality is managed at team/ward level and how issues are then escalated to the Divisional Board. Operational, Clinical and Nursing management are working closely together at each level in the organisation. The Divisions report in detail on their performance to the Executive Board on a quarterly basis. Non Executive Directors are welcome at these sessions.

All major changes and any savings proposals are required to include a quality impact assessment. These are reviewed by the Medical Director and the Director of Nursing and Quality and are then reported to the Quality and Performance Committee.

Public stakeholders are involved in managing risks which impact on them through a range of different means. The regular service user surveys produce a large amount of data that illustrate service user experiences, which contribute to the formation of actions to drive up quality and ultimately reduce risk. The Board of Directors receive a report on service user experience at each meeting held in public. A Carer Council, has also been established.

Service users and carers have been involved in monitoring key quality indicators as part of the Quality Account through involvement in local care quality groups. The Trust holds regular meetings with its CCGs where performance against quality indicators is monitored. Some of these are directly connected to risk in terms of ensuring that our services are provided with clear attention to patient safety and active management of risk. Local Implementation teams/partnership groups are coordinated by our commissioners and feed into the prioritisation of services.

The Trust has published an up-to-date register of interests for decision making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place, which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaption requirements are complied with.

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

The Trust has a range of processes to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff, regular reporting to the Board on quality, operational performance and finance, with further review and scrutiny on a monthly basis at meetings of the Quality and Performance Committee and Business and Finance Committee of the Board of Directors.

The Trust has an agreed risk-based annual audit programme with the Trust's internal auditors. These audit reports are aimed at evaluating our effectiveness in operating in an efficient and effective manner and are focused on reviewing our operational arrangements for securing best value and optimum use of resources in respect of the services we provide.

The Trust continues to make an active contribution to the pilot phase of Lord Carter's efficiency work with mental health and community trusts. Learning from the Carter pilot work alongside our drive to improve the efficiency of our back office has since a cost reduction in the region of 10%. Our ongoing work to improve the efficiency of the back office and enable productivity in its customers is drawing on NHSI's Corporate Services Productivity programme. We have put in place additional governance systems to both challenge and support operational and corporate staff in identifying and delivering the required level of savings. The Executive Board will monitor progress on a monthly basis

Information Governance

The Trust has an Information Governance Programme Board, chaired by the Director of Strategy and Performance, which is the principal body overseeing the management of information risks. This group has a reporting line into the Executive Board. It oversees the Trust's Information Governance Toolkit action plan. Exception reports and serious incidents relating to information management are reported to the Information Governance Programme Board.

The following level 2 incidents were reported to the Information Commissioner in 2018-19.

14-05-2018 – one screening form containing confidential information was mislaid.

We now ensure that all screening forms are electronic on encrypted lap tops and staff have been reminded of this requirement. The subject of the breach has received an apology and the ICO has not requested any further action.

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. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

- The Board has a Quality and Performance Committee chaired by a Non Executive Director with board director membership. The annual quality report is considered by the Quality and Performance committee and includes input from a wide range of internal and external stakeholders to ensure it presents a balanced view
- The Quality and Performance committee reviews its performance against the NHS Improvement Quality Governance framework
- The Trust employs a range of staff that possess the skills, experience and capability to deliver the quality priorities
- Quality priorities are identified both external by key stakeholders and internally within the Trust. Key performance indicators and targets are set to measure delivery, which are reported to and monitored by the Quality and Performance committee in the joint quality and performance report which is published quarterly. This is also considered by the Council of Members and made public via the Trust website
- There is ongoing investment in information technology to deliver better patient care and provide performance and management information to review and report on our quality indicators is an integral part of our strategy and a priority workstream which will enhance data quality, management reporting and support our transformation programme going forward

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and Quality and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by internal and external audit reports and the core standards self assessment declaration. This is in addition to the work of executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

The Assurance Framework has been reviewed by the Trust's Internal Auditors. They have confirmed that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2018-19 Annual Governance statement and provides substantial assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The Board maintains continuous oversight of the effectiveness of the Trust's risk management and internal control systems. It meets every other month, with all of the meetings being open to the public. It has as a standing item on the agenda reports on the areas of financial management, risk management and performance management. It regularly receives the

minutes of meetings or reports of its committees and an update on progress against its strategic objectives.

The Audit Committee oversees the effectiveness of the overall system of integrated governance, risk management and internal control. On behalf of the Board, it independently reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. Responsibility for risk management rests with the Executive Board. The Audit Committee regularly receives reports on internal control and risk management matters from the internal and external auditors.

There is a full programme of clinical audit which is agreed by the Quality and Performance Committee. The Trust has been the subject of a review by the CQC and has been rated as 'Good'. The Trust has actions in place to address areas of residual underperformance identified by the inspectors.

The Trust reviews growth opportunities as they arise and continues to acquire discreet services, as they are put out to tender. We look for services that complement our existing portfolio and where we feel that the Trust has the skills and experience to provide for the service user group. Once new services are acquired, policies and procedures are safely aligned and although the NHSLA no longer operates the regime of assessing trusts against Levels 1, 2 and 3 the Trust continues to aspire to having systems and processes in place, which would have been consistent with Level 2. All new services will have a 100 day plan to ensure that all quality and governance issues are addressed until the service is safely integrated into a divisional structure.

Conclusion

No significant control issues have been identified but the Trust is committed to the continuous improvement of its governance and assurance arrangements to ensure that systems are in place which ensure risks are correctly identified and managed and that serious incidents and incidences of non-compliance with standards and regulatory requirements are escalated and subject to prompt and effective remedial action so that the patients, service users, staff and stakeholders of Central and North West London NHS Foundation Trust can be confident in the quality of the services we deliver and the effective, economic and efficient use of resources. I am satisfied that the systems outlined in this statement provide assurance and that we have effective systems of internal control. The Board recognises that the coming year is likely to be exceptionally challenging and in that environment it will be more important than ever to ensure that our governance and control systems are in place and actively utilised.

Claire Murdoch CBE
Chief Executive
28 May 2019

Quality Account 2018-19

Part 1 – Letter from our Chief Executive
Letter from our Chief Executive
Independent Auditor's report to Council of Governors of Central and North West London NHS Foundation Trust on the annual Quality Report

Part 2 – Our priorities for improvement and a Statement of Assurance from the Board
A review of our performance against our quality priorities in 2018-19;
Quality Priority 1: Patient and Carer Involvement
Quality Priority 2: Staff Engagement
Part 2.1 – Quality Priority Plans for 2019-20
2.1.2 – Monitoring and sharing how we perform
Part 2.2 – Statements of assurance from the Board.

Part 3 – Reporting against Core Indicators
Annex 1 – Statements provided by our commissioners, Overview and Scrutiny Committees (OSCs) and Health watch
Annex 2 – 2018-19 Statement of directors' responsibilities in respect of the Quality Account

Glossary of terms
QAP: Quality account priorities
CNWL: Central and North West London NHS Foundation Trust
CPA: Care Programme Approach
CQC Care Quality Commission
CQUIN: Commissioning for Quality and Innovation
FFT: Friends and family test
GP: General Practitioner
LD: Learning Disability services
MDT: Multi-disciplinary team
NHS: National Health Service
NICE: The National Institute for Health and Care Excellence
OSC: Overview and Scrutiny Committee
POMH: Prescribing Observatory for Mental Health
Q3: Quarter 3
YTD: Year-to-date; an aggregation of performance data over 2018-19

Part 1
Letter from our Chief Executive

I want to acknowledge all that we have achieved together this year and recommit our energy, skill and passion to the ever present need to improve the care and treatment we provide. Our priorities have been about engagement and involvement for quality of care for patients, their families and our staff, without any of whom we cannot hope to deliver the best standards of care.

We have worked hard to use feedback to make improvements and ensured that patients and families know about the changes made. We have tested this further by asking patients whether or not the care they receive helps them achieve the things that matter to them and we continue to score highly in this area.

Our staff feedback has helped us shape the way we do things. We had a focus on improving the 'health and well-being' of our staff right across the Trust and we've been accredited "excellent" for the London Healthy Workplace Charter awarded by London Mayor. In our Well Led Review, Deloittes told us that they had seldom seen a Trust providing more staff benefits and support. We are especially proud that CNWL was the only NHS Trust in the top 50 organisations in the LGBTQ equality charity Stonewall. Working with our inspiring local communities, including in prisons and the street homeless, as well as our excellent staff networks, we continue to challenge inequalities in healthcare. This remains a high priority.

We opened Lavender Walk in South Kensington, a unit for young people who require inpatient mental health care. This came out of the collaboration between West London NHS Trust other partners, families and young people themselves as part of the nationally leading North West London CAMHS New Models of Care programme.

It gives us immense satisfaction in knowing that this unit means fewer children are treated miles from home or have to wait longer for an admission. We will add to this capacity later this year with Crystal House, an adolescent inpatient unit for people with a learning disability.

Our community services have also been leading edge and hardworking. For example in Hillingdon we opened an end of life 24/7 helpline, in Milton Keynes we are working closely with the emerging Primary Care Networks to implement Integrated Community Care Support Teams and in Surrey our Integrated Contraceptive, Sexual Health and HIV Service has launched a scheme to allow residents to screen for sexually transmitted infections from the comfort of their own home. In Camden, our expanded Rapid Response/Discharge to assess service are supporting reduction in acute activity and enabling patients to leave hospital earlier. We were joined by more colleagues in Harrow and Central London providing 0-19 services. We are excited to be joined by colleagues from Ealing Community Services this year.

Many of our services right across the Trust have worked for and received independent accreditation for quality and effectiveness. Also many have been shortlisted for national awards.

At the time of writing this Quality Account we are waiting for the outcome of our recent Care Quality Commission Well Led Inspection. We told them what we are proud of, about our excellent staff, colleagues and the incredibly talented patients, carers, and partners whose support we value so much. We also told them about our challenges and areas where we want to improve and do better for our patients. I close this year's Quality Account on behalf of our Board where I begin the coming years with celebration of what we are proud of and determination to maintain and improve quality in the year ahead.

Claire Murdoch CBE
Chief Executive
28 May 2019

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Central and North West London NHS Foundation Trust to perform an independent assurance engagement in respect of Central and North West London NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral; and
- inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 3 May 2019;
- feedback from local Healthwatch organisations, dated 3 May 2019;
- feedback from Overview and Scrutiny Committee, dated 3 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 28 June 2018;
- the latest national patient survey, dated November 2018;
- the latest national staff survey, dated 26 February 2019;

- Care Quality Commission Inspection, dated 18 August 2017;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 14 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Central and North West London NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Central and North West London NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Central and North West London NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

29 May 2019

Part 2
Our priorities for improvement and a statement of assurance from the Board

A review of our performance against our quality priorities in 2018-19;

In this section of the report, we set out to provide a summary of our achievements against our Quality Priorities. We outline our Quality Priorities for 2018-19, our improvement actions, how well we have done and how our performance this year compares with our previous year's performance.

Our Quality Priorities for 2018-19 were:

1. Patient and carer involvement

2. Staff engagement

These two Quality Priorities have run for three years and we reported our annual performance and progress against each priority in our last two quality account reports. In this report, we focus on achievements this year and, where data is available, we benchmark our performance against last year.

We have undertaken a number of actions in relation to our two Quality Priorities and are pleased to report that we have made considerable gains in the last year. Our focus has been on embedding achievements from the previous two years and taking actions in the areas we identified as requiring further work. In the following sections, we highlight key achievements and some of the actions we have taken this year against each of the above Quality Priorities.

Quality priority 1 – patient and carer involvement

We believe that the best health services are ones that are planned, shaped and delivered by patients, carers and staff working together. People with lived experience of health services understand what works well and what doesn't, so our aim is to continually increase the role they have in the design, delivery and improvement of services. In CNWL we do this by involving patients and carers in both central, Trust-wide decision making processes and in local engagement initiatives. Bringing staff, patients and carers closer together to oversee and improve our services has many advantages. It encourages a collective sense of ownership and it helps shift the culture away from 'us and them', encouraging closer working in clinical settings and better clinical outcomes. In the 2018-19, we took a number of actions to help us achieve more partnership working and below are some highlights:

Patients and carers are overseeing CNWL services through Trust-wide and local governance groups

Patients and carers are more involved in boards, committees and working groups, including the Trust-wide Patient Involvement Forum and Carers Council, which now have new terms of reference. Patients and carers also sit on many local governance and performance committees across divisions and services, acting as 'critical friends' to challenge the Trust and hold us to account. This has helped increase transparency and openness and has led to more partnership working where staff, patients and carers solve problems together. We have provided training and guidance to staff on the importance of involving patients and carers in a meaningful way to make sure we avoid tokenistic involvement. We will roll out more of this training in 2019-20 as part of our new Involvement Strategy. We are also making sure that service users and carers are shaping future changes to CNWL, including our transformation work around Community Mental Health Services and changes to the Care Programme Approach.

Patients and carers are leading the way in making local changes

There are many local groups of patients and carers meeting regularly, providing innovative ideas to improve patient and carer experiences. One example is the Hillingdon Mental Health Service User and Carer Involvement Group, a group supported by the Trust but led by patients and carers, including Peer Support Workers (these are people with lived experience of a mental illness or a learning disability who are able to give support to one another). In 2018-19, this group produced the newsletter 'Hope in Hillingdon' as well as an information leaflet for service users about using technology apps for wellbeing. The group also co-produced a discharge information booklet 'Staying Well when Leaving the Ward', based on feedback about how discharge could be improved. Because groups like this are service user and carer led, they focus on what matters most to local people, directly leading to better patient experience. These initiatives show that when staff empower service users and carers to take

more of a lead in making local changes, engagement and outcomes can be improved. We will support more areas of CNWL to create user-led groups like this in 2019-20.

Patients and carers are becoming increasingly involved in Quality Improvement (QI)

We ran a successful project to increase the number of patients and carers involved in QI projects – in April 2018, just 17 projects had service user involvement and, at the time of writing, this number had risen to over 70 projects. To make sure that involvement has maximum impact, we coproduced guidance and training for staff and delivered user-led training for patients and carers. In recognition of our work in this area, a service user from CNWL was selected to present a plenary session at an international QI conference about the value of involving patients and carers in QI.

Patients and carers are running local social and wellbeing groups

We have seen an increase in the number of local groups being set up and run by service users and carers to enhance the wellbeing of individuals and communities. For example, in Kensington and Chelsea, a service user set up a garden propagation group with the Westway Gardeners Yard Volunteer group, teaching gardening skills to other patients and carers. Other areas of the Trust are setting up similar allotment groups, as well as craft, cultural, theatre and sporting groups. These activities are based on the interests of local patients and carers and play an important role in achieving our mission of 'wellbeing for all'. Not only can these groups help improve people's physical, emotional and mental health; they also strengthen relations between staff, patients, carers and communities, helping to break down barriers and engage people in services. This is an exciting and important cultural shift and one which we will develop further in the coming year.

More service users are being trained to use their experience to inspire and support others

We have a growing number of Peer Support Workers who have been trained to use their lived experience of recovery to support the delivery of Recovery and Wellbeing College courses and clinical work. The Recovery College provides a range of educational courses, workshops and resources for people who use CNWL services or have been discharged from these services in the previous 12 months, their supporters (friends, family or carers) and CNWL staff. As a Trust we have been recognised for our innovative work in this area and presented at various national conferences and meetings over the past year. CNWL Peer Support Workers have specialist skills, qualities and competencies and play a key role in improving partnership working between staff, patients and carers. In the coming year we plan to add to our numbers of Peer Support Workers. We will also expand our use of volunteers, including volunteers with lived experience of using services. One clinical work example is where Peer Support Workers on acute mental health wards orientate newly admitted patients to the ward and provide support to them.

Patients and carers are helping us recruit compassionate, respectful staff

In 2018-19 a record number of patients and carers were involved in recruiting CNWL staff, including to some of the most senior positions in the organisation. Across the Trust, patients and carers sat on stakeholder groups and interview panels, helping write interview questions and making decisions about who should be offered the job. This helped make sure that we only recruit staff who can demonstrate they meet Trust values. As one consultant said, "Service users play a vital role in recruiting staff and we will only select a candidate if patients and carers are happy with the decision." When selecting service users and carers to attend interview panels, we look for a diverse mix of experiences and backgrounds

Patient and carer stories are being used to influence practice

Patient narratives or stories are accounts told in a person's own words and are described by the King's Fund as "highly effective when it comes to influencing, because they have real power to change hearts and motivate people". At CNWL we have involved more patients and carers than ever in telling their stories – at training conferences for staff, divisional festivals, local and Trust-wide workshops and events.

A patient story is presented at the beginning of every Board meeting. We have developed more short films to communicate these stories to a wider audience across and beyond the Trust. A service user was also supported by staff for her Media course at college to make a film about stigma in mental health.

The tree below displays some of our other highlights from 2018-19;

Our approach has been to support patient and carer involvement with local services as this is where key interactions take place. In the following section, we present examples of patient and carer involvement at Speciality, Service and/or Borough level.

A snapshot of some patient and carer involvement activities in different localities is presented in Table 1 (this list is not exhaustive):

Table 1: Examples of involvement across Trust Services

Area of CNWL	Examples of involvement
Addictions Services	There are monthly Strategic Service User Group meetings where service users lead on audits and QI projects. The Addictions Service also ran another successful, service-user-led conference in 2018. Attended by 110 people, the day included many examples of how service users, staff and families can work together to overcome addiction. Described as 'truly inspirational' and 'a deeply touching' event, this is an excellent example of how user-led events can inspire other patients and staff.
Brent Mental Health Services	Brent hosts the co-designed Enrich (Enhanced discharge from inpatient to community mental health care) project. This project brings together staff, Peer Support Workers and service users to help reduce unnecessary inpatient admissions, improve recovery-focused outcomes and empower individuals to have an increased say in how they engage with services. The Hendon Football Club (FC) Mental Health Project, run jointly by CNWL's Brent Early Intervention Service and Hendon FC, received the award for Community Project of the Year.

Camden Community Services	A baby Hub was set up by the Health Visiting team to provide parents with more opportunities to talk about their child's physical, social and emotional development; a good example of how creating an informal environment can encourage parents to ask questions and engage with treatment. In Children's Services, staff and families jointly produced a multi-disciplinary team (MDT) report template.
Children and Adolescents Mental Health Services (CAMHS) and Eating Disorder (ED) London	Young people, parents and families were heavily involved in the design of the new inpatient unit, Lavender Walk, and were also involved in making changes to the CAMHS clinic in Hillingdon. In CAMHS, a welcome event was also held to engage parents. Carers of people using ED services are involved in local Clinical Quality Group (CQG) meetings, helping to advise on and shape services
Community Independence Services (CIS)	Patients are included in the staff induction programme, in addition to being involved in the design of a new leaflet and reablement videos that are being used across the Trust.
Harrow Mental Health Services	A carer and service user co-production forum has been developed and supported by the Head Occupational Therapist. The group makes suggestions to the Community Mental Health Teams (CMHT) on what could be improved. The Carer Leads have also produced a local carer's support leaflet.
Hillingdon Community Services	The District Nursing Service has carer representatives attending the End of Life strategy group, who provide valuable input into the service redesign, which is having a direct impact on patient and carer experience.
Hillingdon Mental Health Services	A particular achievement is the breadth and consistency of involvement. All staff recruitment now includes service user or carer input. The number of Peer Support Workers has increased with at least one on each ward and in all Community Mental Health Services, including the Early Intervention in Psychosis Team
Learning Disability Services	Quarterly Service User and Carer Events occur in the Kingswood Centre. Bespoke training sessions also take place, including a session on how service users and carers can help keep themselves safe – a good example of empowering service users to develop greater awareness and positive behaviours skills. Service users also planned a carnival and various religious festivals, bringing together staff and service users, enabling people to use their organisational and creative skills.
Milton Keynes Community Services	In response to a patient consultation exercise, the District Nursing service introduced a single point of access. In Dental Services, photo boards, with Makaton symbols and 'easy read' leaflets have been developed.
Milton Keynes Mental Health	The use of Peer Workers has grown and this is having a direct impact on patient experience, with Peer Workers transforming the programme of activities available on inpatient wards. Peer Workers have also been involved in the design and delivery of an on-site Recovery and Wellbeing College. Locally, service user, patient and carer involvement is increasingly embedded across services, strengthening links between staff, service users and the community. The Directorate successfully engaged with Black, Asian, and Ethnic Minority (BAME) communities through invitations to local community group meetings.
Offender Care Services	Service user representatives have been appointed across the service, with many projects underway, including at Her Majesty's Young Offender Institution (HMYOI) Cookham Wood, where young people designed a work of art. The project helped improve the environment of the Health and Wellbeing Team's appointment rooms and encouraged young people to engage with services. The young people involved had restricted access to a standard prison regime because of risk to themselves or others, however, staff found innovative ways for them to participate in the art project. Several young people are now engaging more with the health service, and specifically Art Therapy. This has demonstrated how staff overcame barriers and engaged patients in their own wellbeing.

Perinatal Services	In preceptorship nurse training (this is a period to guiding and supporting newly qualified practitioners to make the transition from student to develop their practice further) , three days are dedicated to patient experience, where service users and carers share powerful personal accounts of journeys and experiences of services, resulting in greater staff awareness of patient needs. Perinatal services have also engaged with the local Maternity Voices group. This has helped with the co-production of service information and links are being made with Cocoon, a user-led organisation and NHS England, to discuss a pan-London approach to involving women in shaping perinatal services.
The Royal Borough of Kensington and Chelsea Mental Health Services	Highlights include the design of the new service user led café and the many co-produced creative activities taking place, including play reading, theatre visits and re-decorating the ward environment. These are good examples of partnership working, innovative thinking and local enthusiasm for connecting service users with their community. Joint working with local organisations is strong, including the CONNECT project run with the local Mind service, which is helping to improve people's experience of transitioning between secondary and primary care services.
Rehabilitation Services (Mental Health)	In Rehabilitation services, training continues to be provided to service users on various topics, for example Basic Life Support. Outings are also arranged to help people engage with the local community. Rehabilitation teams also work closely with Employment Services, empowering people to develop skills and find work, an important part of the recovery journey.
Sexual Health Services	In Surrey there is now a refreshed Service User Strategy and group and closer links with the community. The work of the peer-led 'Bloomsbury Network' continues – each year they help many people newly diagnosed with HIV access confidential peer support and advocacy. They also produced a user-led short film to tackle perceptions of HIV and encourage others to live proudly.
Westminster Mental Health Services	Service users and carers are involved in the Older Adults Service User Group and the business meetings at the Waterview Centre. Several social and creative events have taken place across the Borough and service user presence on staff recruitment panels has increased.

Measuring and tracking our progress based on patient feedback; how did we do against our indicators for patient and care involvement. Table 2 compares this years' performance with last years.

Table 2: Comparison of Patient and Carer Indicators 2018-19 and 2017-18

		2018-19					2017-18			
	Indicator	**Target**	**Q1 18-19**	**Q2 18-19**	**Q3 18-19**		**Q1 17-18**	**Q2 17-18**	**Q3 17-18**	**Q4 17-18**
1	Patients report feeling involved in their care or treatment (definitely and to some extent)	85%	96% n4947	97% n6416	96% n5722	96% n5847	95% n3975	96% n3959	95% n4941	95% n4700
2	Patients report their care or treatment helped them achieve what mattered to them	85%	95% n4947	97% n6158	96% n5530	96% n5642	94% n3661	95% n3530	95% n4625	95% n4472

As illustrated above in table 21, we have seen an increase in the number of people giving us feedback this year compared to last year. Our response rate has also improved from 2.5% last year to 3.1% this year. We continue to analyse all of the feedback broken down to borough and service level, which helps staff to prioritise

improvements locally. We continue to encourage more use of the Friend and Family Test (FFT) cards. A new monthly newsletter has been developed which gives the FFT headlines for the Trust including an overview of who is using the system and celebration of good practice. We have trained more staff in analysing FFT responses and new ways of collecting FFT data are being trialled including the use of tablets.

We have seen increased use of the 'You Said. We Did.' boards across the Trust this year, demonstrating that action is being taken. Our Patient Feedback and Complaints Service provided training to all divisions on how to respond well to complaints and we will continue this into 2019-20. Our emphasis for next year will be on supporting patients, carers and staff to work together to resolve concerns locally and quickly. We will encourage more dialogue and closer partnership working between patients, families and staff. We believe this will result in better services and increased patient experience resulting in fewer concerns and complaints.

Next steps: the aims of our refreshed patient and carer involvement strategy

Between 2019 and 2023 and in line with national NHS policy, we will develop, support and expand a partnership approach between staff, patients and carers across CNWL services. We will increase partnership working opportunities for staff, patients and carers and put involvement at the heart of the way we design, improve and deliver services. The CNWL Patient and Carer Involvement Team, Carers Council and Patient Involvement Forum will work with other staff, patients, carers and local community organisations to deliver a partnership approach. The diversity of our involvement work is very important to us and we plan to build on this in 2019-20. We are recruiting more people with physical health conditions to our patient and carer involvement groups to make sure their voices are heard. We are producing guidance for local services on involving patients and carers from often overlooked and underrepresented groups to help them identify and break down barriers to involvement. We will also encourage our services to work more closely with local charities and 3rd sector organisations.

Our ultimate aim is to improve engagement and create more opportunities for people to work together as equal partners. Some examples of best practice and different levels of working are shown:

Quality priority 2 – Staff engagement

Staff engagement is central to delivering a quality service. We undertook a number of actions to ensure our staff feel well supported, trained, committed and engaged. To understand whether our actions were having the desired impact, we sought feedback from staff using the Staff Friends and Family test. We also monitored our staff turnover. In the following section, we highlight some of the work undertaken and what our measures tell us.

Reducing turnover on band 5 clinical staff: We focused our efforts on reducing the turnover of band 5 clinical staff from 25% turnover to at least the average turnover of 16% within two years; To enable us achieve this, we have created new roles of retention facilitators based in each of our divisions which offer ongoing preceptorship support, one-to-one personal support and professional development.

We continued to broaden our accommodation offer and support to new starters as well as promoting our staff benefits offer which is all part of our retention programme. We have developed relationships with accommodation providers e.g. Catalyst, Geneisha, Peabody and have gained nomination rights to give our staff access on a preferential basis as key workers. We have also contracted with Benivo an external organisation which gives boarding support and can provide staff with advances to cover "key in hand loans" as well as information about suitable places to live conveniently close to Trust services.

We have expanded our benefits offer including salary sacrifice, online hub, training and development opportunities. We're also improving our wellbeing

offer to support staff at work and improve retention. We are launching a new online wellbeing portal called POWR, which will support staff who are looking to improve their wellbeing. Staff will evaluate areas of their wellbeing such as: work, mind, active, food, life and sleep, and set targets to make improvements. Other initiatives include offering subsidised Slimming World membership to help staff with weight management, offering Headspace to teach staff mindfulness and meditation techniques and PhysioMed which educates staff on body conditions/injuries and rehabilitation with the hope of reducing time off work'

Staff engagement events: We ran more Trust-wide staff engagement and listening events in partnership with staff side to enable staff to provide clear feedback on their experiences at work and to ensure that there is a structure for considering issues and responding to them in a timely fashion. Our quarterly corporate engagement events were designed and delivered in partnership with Trade Unions, with positive feedback from staff attending and from the London Partnership Forum which reviews initiatives across London. Listening events have been run across the divisions, and feedback from these events considered by divisional management teams who then communicate back on the feedback provided and what is planned to be done to address concerns raised. In addition, the Trust has launched Team Brief to support staff in team meetings to discuss the business of the Trust, for managers to consider what issues are being raised by teams in response and to provide feeding back on this to the Executive Team with the feedback then being included in the next brief along with details of actions taken.

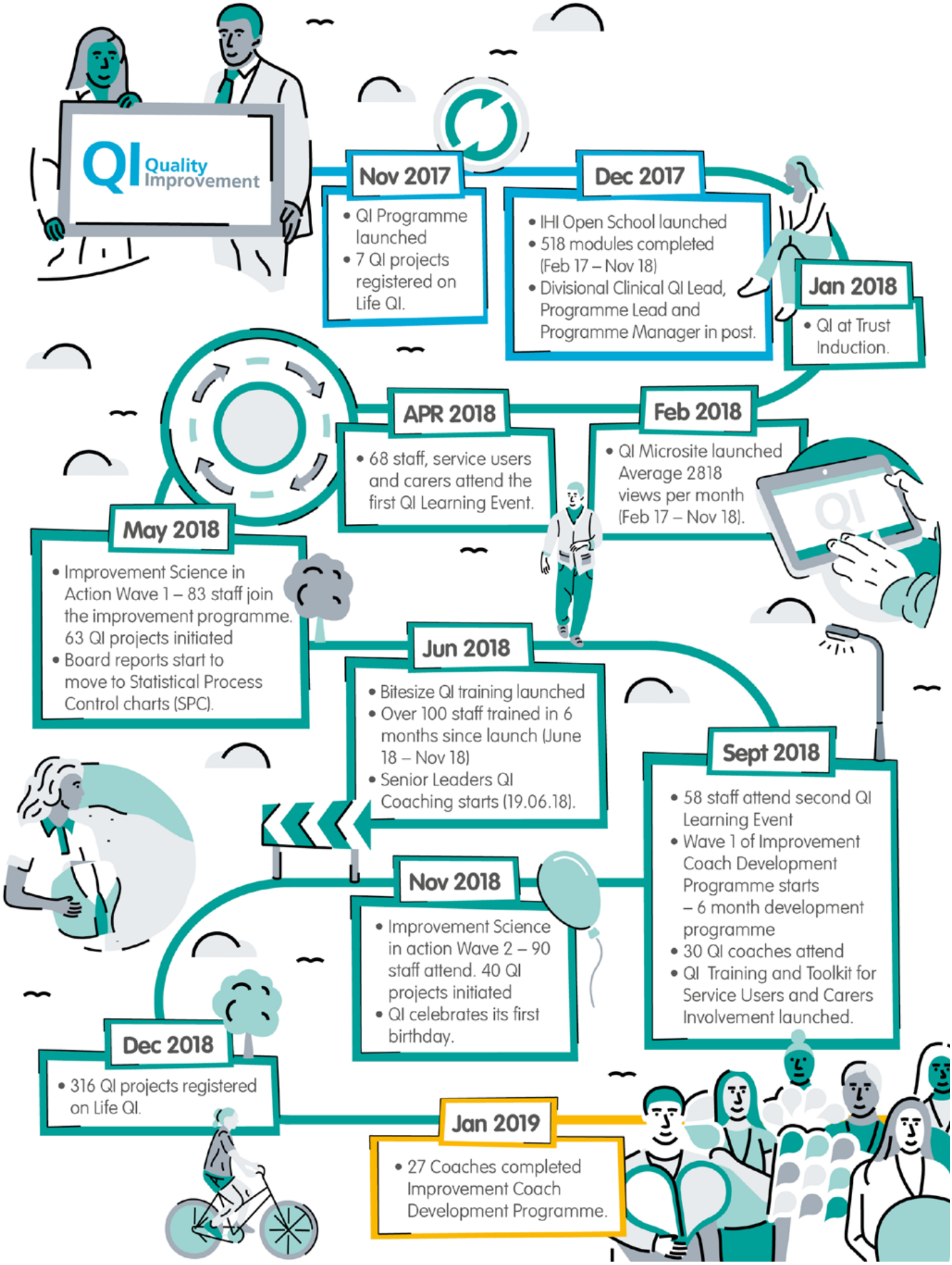
Staff wellbeing: We promoted a holistic approach to health and wellbeing, ensuring that the Recovery College is promoted as a resource for both service users and staff. We also promoted our Occupational Health service and Employee Assistance Programme and have achieved a take up rate much higher than the industry average. In the last year we were accredited as "excellence" for the London Healthy Workplace Charter awarded by the Mayor of London.

Our Stress Pathway was designed in response to employee's needs, making use of Health and Safety Executive's management standards and making them as accessible as possible as resources for both managers and employees. We run a series of roadshows to promote Staying Well at Work, and the Stress Pathway. We have also launched a number of exercise campaigns e.g. steps to the moon, climbing Kilimanjaro, as a good way of encouraging competition between teams. We are working on ensuring that all of the vending machines around the Trust will become healthy ones. Furthermore, we ensured that there is good visibility of senior management to demonstrate both role-modelling and senior buy-in. We have engaged with line managers within the organisation, conducting a survey on attitudes towards and barriers for flexible working. Taking this feedback into account, we have reviewed our Flexible Working Policy, ensuring that any flexible working requests that are refused have a review conducted by a senior manager.

Quality Improvement (QI) Training: We held a number of Trust-wide QI Learning Events to engage staff in QI; with two events at Trust Headquarters in April 2018 and September 2018. Both events were booked to capacity and attended by staff, service users and carers. These provided an opportunity for group learning and sharing of QI across the Trust. Additionally, we delivered a QI Training and Development Programme for staff to increase their QI capacity and capability. The online QI training is available to all staff through the Institute for Healthcare Improvement Open School. In 2018-19, 487 courses were completed. In addition to online training, the QI Programme held a number of centrally organised training events over 2018-19, these included:

- Bitesize QI launched in June 2018. This monthly half day training course provides a brief introduction to the Trust's chosen QI methodology. The course has 20 places available on a monthly basis.
- Two waves of Improvement Science in Action with 83 attendees in May 2018 and 90 attendees in September 2018. This is a four-month professional development program is specially designed for people actively involved in health care improvement projects. Over the duration of the course staff are guided to run a QI project with support and training from Institute for Healthcare Improvement (IHI) – our QI partners.
- The first wave of Improvement Coach Development programme. This six month development programme was attended by 30 staff. This programme provides formal training in coaching and facilitating improvement teams in order to coach staff and employees in how to apply improvement concepts, methods, and tools to daily work,help teams gather ideas and carry out an improvement project,help coach and advise people to development measures and analyse data for improvement projects

Some of the highlights are presented below;



Freedom to speak up: Raising Concerns (Whistle Blowing): We are committed to enabling a culture of openness and honesty where staff feel they can constructively challenge practices they think fall below an acceptable standard. We have a policy in place which explains mechanisms for raising concerns, including whistle blowing. We hold a central record of concerns received and dates when we have given feedback on actions taken to address the issues raised. The Trust has Speak Up Guardians in place to help facilitate this process and their details are listed within the weekly "Three Minute Read" (a communication that is sent out to all staff on a weekly basis).

Measuring and tracking our progress based on staff feedback: how did we do against our indicators for Staff engagement. Table 2 compares this years' performance with last years.

Table 3: Comparison of Staff Engagement Indicators 2018-19 and 2017-18

Quality Account Priorities		2018-19				2017-18			
	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Staff recommending the Trust as a place to receive treatment	70%	73.1% n897	72.9% n866	65.4% ^n3025	73% n958	73.6% n157	75.61% n924	64% ^n2896	71% n901
Staff recommending the Trust as a place to work	70%	58.0% n897	59.7% n866	56.2% ^n3025	60% n958	62% n157	55.5% n924	56% n=2902	58.7% n901
Staff turn over	15%	16.9%	17.4%	16.5%	15.6%	16.6%	16.7%	16%	

This is based on the national Staff Survey.

We have made progress on staff turnover, and note that this improvement has been sustained. However, our scores on staff recommending CNWL as a place to receive treatment and work remain lower than we would like; albeit that this year we had our highest quarterly scores of the last two years. Staff engagement, while not one of the Quality Priorities next year, remains of the highest importance for the Trust. We are finalising our new People Strategy and associated actions that will primarily be aimed at improving staff engagement.

Part 2.1 – Quality Priority Plans for 2019-20

In developing our priorities for the year ahead, we are guided by four principles; we want to focus on what matters most, we want to deliver improvement as part of business as usual, we want to align our quality priorities across all our services and we want to ensure that improvement is sustained.

With these principles in mind, we consulted widely with our stake holders (both internally and externally) and held a consultation event on the 1 March 2019. Together, we agreed to focus on the following Quality Priorities for the year ahead:

1. Reducing Falls
2. Improving the Management of the deteriorating patient
3. Reducing violence and aggression for staff and patients
4. Improving the quality of supervision

We also agreed to plan how we aim to meet these priorities over three years to ensure we sustain improvements in the above four areas, while continuing the conversation with our stakeholders so they remain sighted on our progress.

In Tables 4 to 7, we provide our rationale for selecting these priorities and state our action/s and how we will monitor our progress.

Table 4: Quality Priority 1: Reducing Falls

Why are we doing this? Falls are responsible for premature deaths and have an adverse impact on patients' and carers' quality of life and health. They are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the United Kingdom. NHS organisations are required to take action to prevent falls and reduce the resultant fractures and other conditions associated with falls.	
What do we want to achieve? For all inpatients over 65 undertake a multifactorial assessment which identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.	
Year	**Actions**
1	We will use an audit of current falls risk assessment practice to inform a "Falls Risk Assessment" QI programmes.
2	The programme will be managed by the CNWL Falls Board and it will have oversight of the relevant division-specific QI Projects. The aim of the programme will be to improve completion of Falls Risk Assessment on admission to 85% by March 2021. The Falls QI programme will aim to improve the quality of interventions delivered to those at risk of falls
3	The Falls QI programme will extend its remit to include completion of falls risk assessment by CNWL staff working in Integrated Community Services.
Monitoring Progress	
Year 1	We will monitor completion rates of falls risk assessment on admission. Progress will be reported quarterly to the Quality and Performance Committee
Year 2 & 3 will be informed by learning from Year 1	

Table 5: Quality Priority 2: Improving the management of deteriorating patient

Why are we doing this? Effectively managing deteriorating patients helps to reduce avoidable physical deterioration, morbidity and mortality.	
What do we want to achieve? We want to reduce the risk to patient's physical health by ensuring early identification and prompt management of deteriorating health.	
Year	**Actions**
1	We will roll out of NEWS2 – the early warning tool to detect signs of deteriorating physical health and ensure appropriate prompt action is taken. This involves a training programme. We will review and update our policy, procedures and training on emergency responses.
2	We will roll out a revised approach to management of emergency responses and ensure the structure and resources are fit for purpose. We will ensure competencies are in all new job descriptions (JD's) for staff joining the Trust.
3	Review and amend the standards and procedures in light of the current national guidance. We will ensure there is an internal reporting framework to help monitor progress in managing our most unwell patients so we can measure the progress of our three year plan.
Monitoring Progress	
Year 1	We will monitor compliance with Physical Health Training and use of NEWS2. We will aim to achieve 95% compliance in the relevant staff groups. Progress will be reported quarterly to the Quality and Performance Committee.
Year 2 and 3 will be informed by learning from Year 1.	

Table 6: Quality Priority 3: Reducing Violence and Aggression

Why are we doing this? Incidents of physical assault are the most common type of incidents reported within the Trust. This priority aligns to the national strategy to reduce incidents of violence against staff and wider patient safety initiatives to reduce the use of restrictive interventions.	
What do we want to achieve? Reduce incidents of physical assault involving staff and service users (Trustwide) by 30% by 31st March 2022	
Year	**Actions**
1	We will co-produce (at Ward, Service and Trust levels) vision/ownership and a structure and strategy for Violence Reduction using a QI Approach. We will build capability and capacity for QI for Safety Improvement.
2	Review progress at early adoption sites. Develop spread to other services where improvement is required. Build capability and capacity for QI for Safety Improvement.
3	We will review progress of improvement work at Ward and Service levels using the descriptive statistics and tools for measurement like run charts. We will Identify areas of achievement and success. Build capability and capacity for QI for Safety Improvement.
Monitoring Progress	
Year 1	The Quality and Performance Committee will receive quarterly reports which will include data showing incident reporting trends.
Year 2 and 3 will be informed by learning from Year 1.	

Table 7: Quality Priority 4: Improving the Quality of Supervision

Why are we doing this?

Supervision* is an important part of staff support and professional development. It provides an opportunity for staff to reflect on and review their practice, discuss individual cases in depth, change or modify their practice and identify training and continuing development needs. Supervision underpins the very essence of good care.

People who use our services will experience safe, effective treatment and care because all staff are supported to carry out their roles through high-quality supervision.

*This term is used through out to describe all forms of supervision to which each staff member is entitled, including managerial, clinical, professional and safeguarding supervision.

Year	Actions
1	We will; Review and re-issue our Policy Standards for Supervision, providing clear definitions of clinical supervision. We will clarify individual responsibilities in relation to Supervision and reinforce the importance of reflective learning in improving the quality of care. We will pilot the use of the CNWL Learning & Development Zone LDZ to support managers in recording and tracking supervision. Concurrently we will re-evaluate current arrangements in all Divisions in order to identify best practice and any gaps. Review current provision of Supervision training and establish a consistent Trust-wide programme.
2	We will: Complete QI supervision projects in each Division. These will be based on a priority set in Year 1. Hold a Supervision Best Practice Summit to share learning and celebrate best-practice and progress. Develop supervision to ensure it takes an developmental approach to staff wellbeing. We will survey staff on their experiences of supervision and use that learning as part of our year 3 review and continuous improvement.
3	We will: Re-evaluate supervision-arrangements in all Divisions to check that all staff are receiving Supervision which meets their needs, in-line with Trust and professional standards
Monitoring Progress	
Year 1	The Quality and Performance Committee will receive quarterly reports on progress being made in driving actions listed above.
Year 2 and 3 will be informed by learning from Year 1	

2.1.2 Monitoring and sharing how we perform

Measuring and monitoring of the clinical safety, effectiveness and experience of our patients, carers and staff is a top priority. The quality, safety, effectiveness and patient experience of our services is overseen by the Trust Quality and Performance Committee (chaired by a Non Executive Director, and made up of Executive and other Non Executive Directors), who in turn provide assurance and recommendations to the Board of Directors.

CNWL services are governed locally by three divisions: Jameson, Goodall and Diggory. These divisions are locality and specialist service based, which means better accountability and closer local relationships with our local public, commissioners, local authorities, Healthwatch and other local health and social care partners. Divisions have the responsibility to monitor and report on their key quality and performance indicators and put in place improvement actions where necessary. This is overseen by monthly Divisional Boards, which report to the Executive Board. The Quality and Performance Committee and Divisions have a variety of tools and information streams to effectively triangulate intelligence to and facilitate monitoring of safe and high quality services. For example:

- An integrated dashboard which brings together key performance indicators from NHSI targets, Quality Priorities, complaints, incidents, workforce and finance information;
- Our organisational learning themes which are extrapolated from the analysis of our incidents, complaints, claims, audits, feedback and other information streams;
- Divisional Quality Governance Reports which assess their compliance against the CQC's standards or 'key lines of enquiry'; and
- Our learning walks, internal Quality Inspections and visits by the CQC and their findings.

Benchmarking

CNWL is part of the NHS Benchmarking Network and takes part in the annual national mental health inpatient and community, CAMHS, learning disabilities, community health, bespoke eating disorder, perinatal and secure services benchmarking projects. The Trust also utilises benchmarking information published on the London Mental Health Dashboard, CQC Mental Health insight report as well as NHS Improvement's Model Hospital Dashboard for comparative and insight purposes. The Trust's business intelligence tool (Tableau) has enabled the Trust to more effectively utilise data published nationally by NHS digital to develop internal benchmarking dashboards that allow us to compare ourselves with our peers, as well as enable benchmarking within the Trust by facilitating comparisons across services, localities and teams.

Part 2.2 – Statements of assurance from the Board

Review of services

During 2018-19 CNWL provided and/or sub-contracted seven healthcare services.

These included:

- Mental health (including adult, older adult, CAMHS, and forensic services)
- Offender care services
- Sexual health/HIV Services
- Community physical health services
- Eating disorder services
- Learning disabilities services
- Addiction services

CNWL has reviewed all the data available on the quality of care in all of these healthcare services. The income generated by the NHS services reviewed in 2018-19 represents 100% of the total income generated from the provision of NHS services by CNWL for 2018-19.

Participation in Clinical Audit

During 2018-19, CNWL participated in 16 National Audits and one National Confidential Enquiry which covered health services that Central and North West London provides.

During that period, CNWL participated in 93.8% (15-16) of the National Clinical Audits and 100% (1/1) of the National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that CNWL was eligible to participate in during 2018-19 are as follows:

- National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England

- Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls (NAIF)
- Learning Disability Mortality Review Programme
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
- National Audit of Intermediate Care
- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
- National Clinical Audit of Anxiety and Depression (NCAAD)
- NCAAD Psychological Therapies Spotlight Audit
- NCAP – Early Intervention in Psychosis (EIP) Spotlight Audit
- National Asthma and COPD Audit Programme (NACAP)
- National Diabetes Audit – Diabetic Foot Care Audit
- POMH-UK: 16b Rapid tranquilisation
- POMH-UK: 6d Assessment of the side effects of depot antipsychotics
- POMH-UK: 18a Prescribing clozapine
- POMH-UK: 7f Monitoring of patients prescribed lithium
- Sentinel Stroke National Audit Programme (SSNAP)].

The National Clinical Audits and National Confidential Enquiries that CNWL participated in during 2018-19 are;

- [National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England
- Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls (NAIF)
- Learning Disability Mortality Review Programme
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
- National Audit of Intermediate Care
- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
- National Clinical Audit of Anxiety and Depression (NCAAD)
- NCAAD Psychological Therapies Spotlight Audit
- NCAP – EIP Spotlight Audit
- National Asthma and COPD Audit Programme (NACAP)
- National Diabetes Audit – Diabetic Foot Care Audit
- POMH-UK: 16b Rapid tranquilisation
- POMH-UK: 18a Prescribing clozapine
- POMH-UK: 7f Monitoring of patients prescribed lithium
- Sentinel Stroke National Audit Programme (SSNAP)].

We did not take part in (POMH-UK: 6d Assessment of the side effects of depot antipsychotics) because the audit cycle came relatively close to the 2018 NCAP report which covered similar items. This decision was taken with advice from our pharmacy team.

The National Clinical Audits and National Confidential Enquiries that CNWL participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England – all eligible cases were submitted
- Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls (NAIF) – data collection from January 2019, no eligible cases thus far
- Learning Disability Mortality Review Programme – 19 cases between April 2018 and March 2019 inclusive
- National Audit of Care at the End of Life (NACEL) – all 23 relevant units submitted organisational audit forms. No eligible patients were identified for the clinical audit phase
- National Audit of Intermediate Care – two of the three services eligible to participate did so, the third withdrew due to ongoing service transformation. Of those participating, the returns were as follows:
  - Home based services – Service User Questionnaires: 377/480 (78.5%)
  - Home based services – Patient Reported Experience Measures: 97/480 (20.2%)
  - Bed based services – Service User Questionnaires: 161/200 (80.5%)

  - Bed based services – Patient Reported Experience Measures: 67/200 (33.5%)
  - Re-ablement services – Service User Questionnaires: 297/400 (74.3%)
  - Re-ablement services – Patient Reported Experience Measures: 70/400 (17.5%)
- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) – Four cases submitted by the Hillingdon Service. No eligible cases for MK Service or Camden Service
- National Clinical Audit of Anxiety and Depression (NCAAD) – 100% of cases
- NCAAD Psychological Therapies Spotlight Audit – 100% of cases
- NCAP – EIP Spotlight Audit – 100% of cases
- National Diabetes Audit – Diabetic Foot Care Audit – Data is submitted to the partner Acute Trust for each CNWL service and becomes part of their submission. The Hillingdon Service has submitted 57 cases via their partner Acute Trust. The Camden Service has submitted 67 cases via their partner Acute Trust
- POMH-UK: 16b Rapid tranquilisation – 100% of cases
- POMH-UK: 18a Prescribing clozapine – Submitted data for 63 patients, from 8 clozapine clinics, meeting the audit requirement of a minimum of five patients per clinic
- Sentinel Stroke National Audit Programme (SSNAP) – A total of 69 patients were submitted to the 2017-18 audit, reported in November 2018.

The reports of 13 National Clinical Audits were reviewed by CNWL in 2018-19 and CNWL intends to take the following actions to improve the quality of healthcare provided:

- National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England: A topic-specific report from NCISH on risk assessment in Mental Health settings was published in October 2018. The key messages from this report are reflected in the interim Trustwide Clinical Risk Assessment and Safety Planning Policy. The Assessment of Clinical Risk in Mental Health Services 2018 Report findings are also reflected and referenced in the Trust's Suicide Prevention Strategy and the Zero Suicide Ambition Plan for Mental Health Inpatient Wards, which are currently out for consultation.
- NCEPOD Child Health Clinical Outcome Review Programme – Chronic Neurodisability: NCEPOD published its report in March 2018 and following assessment by the Community Paediatrics Teams for relevance and any required actions, it was determined that the Teams are compliant with all but two recommendations. Partial compliance was declared for recommendations relating to coding for children with a neurodisabling condition, and regarding transition from children's to adult's services, as the pathway is currently being finalised. Draft transition guidance will be made available whilst the co-production of a Transition Policy is undertaken. Completion of the Policy is anticipated by the end of 2019.
- National Audit of Cardiac Rehabilitation: In response to the 2018 Report, the service is trying to increase uptake of cardiac rehabilitation with women by offering more home exercise programmes and exercise DVDs. To improve attendance rate, text message reminders for exercise classes have been introduced. The service is working closely with and meeting other services in a multidisciplinary team approach, to meet with the certification standards.
- National Audit of Intermediate Care; Reports were received in Q3. Both Hillingdon and Camden Services have drawn up local implementation action plans which will be monitored during 2019.
- National Clinical Audit of Psychosis: Findings have been presented to Operations Board and QPC in separate reports, and actions are integrated into a larger programme of work steered by the Physical Health Steering Group. A monthly report on physical health is now instituted and is taken to the Quality and Performance Committee. Actions relating to aspects other than physical health, such as access to psychological therapies, medicines, and recovery, have been addressed by relevant work streams.
- Early Intervention in Psychosis Audit: The final reports for each of the four Early Intervention Services in CNWL were published in May 2018 by the Royal College of Psychiatrists and reported in the Clinical Audit Annual Report 2017-18. The reports were further reviewed by the respective services and the Physical Health Steering Group, with an additional focus on the 'domains of care', for which the four EIP Teams achieved the same results:

  - Timely access – top performing (level 4)
  - Effective treatment – needs improvement (level 2)
  - Well-managed service – greatest need for improvement (level 1)
  - Overall assessment – needs improvement (level 2)
- National Asthma and COPD Audit Programme: Reports were published in April 2018. For Camden, eight of 10 standards were achieved. For the two not achieved, the service is not commissioned to provide these services. A business case had been put to Camden CCG in 2016 but was not funded. This is to be re-considered.
- National Diabetes Audit – Diabetic Foot Care Audit; A review of the Third Annual Report by Camden Podiatry Services demonstrated the effective management of diabetes patients, including pathways into the local acute Trust and access to specialist care within 24 hours, for a more complex caseload than the national average. In Hillingdon, an action plan has been formulated and is in the process of being implemented. The purchase of an infrared thermometer has supported patient assessment at high risk clinics by CNWL skilled technicians. It should be noted that CNWL doesn't contribute to this national audit in its own right, but provides data to partner acute secondary care trusts for inclusion in their submissions.
- POMH-UK: 15b Prescribing valproate for bipolar disorder

Recommendations

- Improve documentation of monitoring of physical health parameters throughout treatment.
- Fully implement the MHRA recommendations regarding the safe use of valproate in women of child bearing potential, including documentation of provision of advice to women of childbearing age about the potential risks of the use of valproate in pregnancy, and contraception advice (as part of the ongoing programme of work via the Safety Team, this practice is now better supported by the templates in the clinical systems).
- All patients should be offered written medicines information, preferably prior to commencing treatment; women of childbearing potential should be offered the MHRA approved Patient Guide and Card as part of the Pregnancy Prevention Programme.
- POMH-UK: 16b Rapid tranquilisation; the audit report was received and reviewed at Medicines Management Group in February 2019. Overall CNWL's practice was better than the national picture, and in some areas was notably good, but in other areas there are some concerns as practice varied between wards. Recommendations being taken forward include to improve the recording of monitoring of physical health parameters, and patient refusals, and that ECGs should be conducted wherever possible prior to administering IM haloperidol.
- POMH-UK: 18a Prescribing clozapine.

Recommendations

- All clinics should monitor and record patients' lipids and glycaemia control.
- All patients should have an annual physical examination.
- All patients should be reviewed at least annually by a senior clinician to assess their response to clozapine and optimise its efficacy.
- CNWL prescribers and clozapine clinic staff should advise GPs to add clozapine to the patients' Summary Care Record for a full and safe understanding of prescribing.
- Work towards consistency in operational practices across the trusts clozapine clinics, overseen by the clozapine forum.
  - Sentinel Stroke National Audit Programme (SSNAP): The SSNAP data is monitored at Unit level by the Clinical Lead, who also receives detailed local analysis, enabling targeted actions and implementation of change where indicated.
  - UK Parkinson's Audit: Since this audit, Milton Keynes has obtained key equipment, improved written patient information and is currently modifying documentation templates to include all domains of Parkinson's assessment. In Hillingdon, a Parkinson's Education and Exercise programme called 'Get Up and Go' is being promoted, and screening for osteoporosis is being introduced alongside education for patients on bone health. A self-management course, following on from 'Get Up and Go' and running bi-monthly, is also being developed. Multidisciplinary team meetings have been established within the team. Advanced care planning with regards to end of life care requirements is being developed.

Trustwide audits

The Trust undertook a number of Trust-wide audit programmes. These audits included the following:

- Quarterly Controlled Drugs Audit
- Quarterly Antimicrobial Audit
- Safe and Secure Handling of Medicines
- F10 prescriptions Audit
- Hand Hygiene audits
- Physical health check monitoring following administration of rapid tranquilisation
- Compliance with the Valproate Patient Safety Alert
- Covert Administration of Medicines
- High Dose Antipsychotics Therapy for MH Rehab Services
- Prescribing of Benzodiazepines

Outcomes from all of these audits are reported and monitored at the divisional boards and action plans are agreed, implemented and monitored as appropriate. Learning from clinical audit is shared in a variety of ways including Clinical Messages of the Week.

Goals agreed by commissioners: A proportion of CNWL income in 2018-19 was conditional on achieving quality improvement and innovation goas agreed between CNWL and other bodies in a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. In 2017-18, CNWL's CQUIN income equated to approximately £5,970k and CNWL achieved 98%. For 2018-19 CNWL's CQUIN income equates to approximately £6,082k.

Research

The number of patients receiving relevant health services provided or sub-contracted by CNWL in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee was 1,122 participants.

CQC Reviews of Compliance

CNWL is required to register with the Care Quality Commission (CQC) and our current registration status is 'unconditional registration'. CNWL has no conditions on its registration. The CQC has not taken enforcement action against CNWL during 2018-19 and CNWL has not participated in any special reviews or investigations this year.

In January and February 2019, the CQC carried out inspections in our Community Mental Health Services, our Older Adult Wards and Acute Wards for Adults of working age. At the time of writing this report the outcome of these inspections had not been published. The CQC carried out a series of inspections in our Offender Care and Specialist services across the year and feedback has been positive overall. Where recommendations have been made, there are actions in place to address these.

CNWL's rating based on the latest published inspections is presented below;

Data quality

NHS number and General Medical Practice Code Validity

CNWL submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 96% for admitted patient care;
- 99% for out-patient care; and
- N/A for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 97% for admitted patient care;
- 100% for outpatient care; and
- N/A for accident and emergency care.

Information Governance Toolkit attainment level

CNWL information Governance Assessment Report overall score for all mandatory assertions for the 2018-19 CNWL Data Security & Protection Toolkit were confirmed as satisfactory.

Clinical coding error rate; CNWL was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission

CNWL is taking the following actions to maintain and improve data quality: Data standards are set through consistent definitions of data items which are in line with national standards and we have a care records audit in place. Additionally, We have developed a Data Quality Improvement Plan which is clear on strategic oversight with a short term and long term plan; below are some of the key point of this plan;

Strategic oversight

- Focused Operations Board oversight and scrutiny;
- Executive accountability for delivery of improvement plans;
- Building strong data quality leadership at all levels within the Trust
- Extensive staff engagement
- A rigorous Quality Improvement (QI) approach throughout the organisation
- Supported Programme and specific Project management
- Support for staff, and work with all elements of and contributors to the data entry process
- An evidence based and systematic monitoring, feedback and improvement process

Medium term – April to end 2019

- Review Data Quality Policy
- Review Data Quality Improvement Program progress over first 2 months
- Identify Data Quality delivery issues across system configuration, training, staff actions and reporting processes and requirements
- Identify and agree key performance indicators (KPI's) for sustained monitoring and delivery
- Establish Data Quality Forum with identified Executive, Divisional and Service leads
- Consolidate and update Data Quality issues metrics to be tracked, and update targets
- Identify and deliver system optimisation requirements and improved data entry processes
- Scope Care pathways standardisation and optimisation requirements

Long-term – Data Quality Improvement and Maintenance Plan:

- Establish and Develop Care Pathways review process
- Consolidate and standardise care pathway delivery across the Trust, with associated system functionality
- Consolidate the importance of mandatory Data Quality awareness in face to face and online Training, and at Induction
- Continue to optimise the clinical system to best support clinicians and other staff in high quality data entry and reporting
- Ensure Data Quality is reported regularly at Divisional and Operations Boards, with responsible leads owning Data Quality

Learning from Deaths

CNWL established its Mortality Review Group in January 2016 following which a number of improvements have been made to our systems. As a provider of Mental Health, Learning Disability and Community Physical Healthcare Services, including End of Life community based services, our systems reflect the variation in these services and have been designed in a way that complement our incident and serious incident arrangements. All deaths where a person has been under the care of a CNWL Mental Health or Learning Disability service are reported and investigated. In addition we undertake mortality reviews every quarter for a number of cases within our Community Health Services each quarter.

Table 8 shows the number of death and case reviews in 2018-19

Measure		Data source	2018-19			
1	The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	Datix / Clinical Systems	**Q1**	**Q2**	**Q3**	**Q4**
			Community Health Services – 785 Mental Health and Specialty Services – 97	Community Health Services – 707 Mental Health and Specialty Services – 81	Community Health Services – 790 Mental Health and Specialty Services – 93	Community Health Services – 555 Mental Health and Specialty Services – 100
2	The number of deaths included in Number 1 above which were subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.		184	222	208	220
3	An estimate of the number of deaths during the reporting period included in number 2 above for which a case record review or investigation has been carried out which is judged as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.		CESDI Grade 3 0 CESDI Grade 2 2	CESDI Grade 3 0 CESDI Grade 2 4	CESDI Grade 3 0 CESDI Grade 2 2	CESDI Grade 3
4	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item number 2 (above) in the relevant document for that previous reporting period.		18			
5	An estimate of the number of deaths included in Number 4 (above) which the Trust judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this		CESDI Grade 3 0 CESDI Grade 2 1			
6	A revised estimate of the number of deaths during the previous reporting period stated in item 3 (above) of the relevant document for that previous reporting period, taking account of the deaths referred to in item 5 (above)		CESDI Grade 3 0 CESDI Grade 2 10			

During 2018-19 a total of 3,108 CNWL patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 882 in the first quarter;
- 788 in the second quarter;
- 883 in the third quarter;
- 555 in fourth quarter

During 2018-19, 847 case record reviews and 459 investigations have been carried out in relation to 3,108 of the deaths included in number 1 in the above table. In 433 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 187 in the first quarter;
- 230 in the second quarter;
- 235 in the third quarter;
- 220 in the fourth quarter;

No patient deaths during the reporting period are judged to more likely than not, been due to problems in the care provided to the patient

These numbers have been estimated using the CESDI framework and Trust serious incident policy. In writing this report we have understood the NHS Improvement definition of "those deaths which were judged as a result of the review or investigation to more likely than not to have been due to problems in the care provided" as equivalent CESDI Grade 3. Our review process shows no CESDI Grade 3; to aid transparency we have also presented the number of cases where we believe that the death might have been as a result of problems in the care provided i.e. CESDI Grade 2 and the data below reflects this.

In relation to each quarter, this consisted of:

- 2 representing 0.2% for the first quarter;
- 4 representing 0.5% for the second quarter;
- 2 representing 0.2% for the third quarter;
- 1 representing 0.2% for the fourth quarter;

The table below provides an overview of the CESDI grade classifications as per the CNWL Policy.

CESDI GRADES
Grade 0 – Unavoidable death, no suboptimal care
Grade 1 – Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
Grade 2 – Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
Grade 3 – Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

Learning from case record reviews and investigations this year: Investigations and mortality reviews shows that the Trust will continue to focus on our previously identified areas for improvement, Physical Healthcare within Mental Health and Learning Disability Services and the need to reduce instances where the death of a person is suspected to be suicide.

During this period the following actions being taken:

- A review of deaths reported by Learning Disability Services during 2017-18 was completed by the Clinical Director for Learning Disability Services; this was presented at the Trust Mortality Review Group in June 2018 and highlighted both areas of good practice and improvement opportunities
- A further review of the 18 cases reported during 2018-19 is scheduled to be presented to the Mortality Review Group in July 2019. This will also provide an update on the outcome of work completed during 2018-19 including improvements around information sharing and physical healthcare
- The Trust held a Bereavement Conference which was attended by multi-professional staff across all Divisions and was co-created by bereaved relatives
- Our case note reviews for Community Physical Health Services continue to be completed each quarter and we have extended the sample size completed to increase the opportunity for learning
- A Quality Improvement Project within a Community Mental Health Team was undertaken, this has supported improvements in this locality whilst also providing learning for wider changes to the clinical system and policy
- Based on the above, alongside the launch of SystmOne – our new Clinical System, the Trust has

reviewed and implemented a revised Clinical Risk Assessment and Safety Planning Policy taking into account feedback from service users and carers who were involved in the above project

- We have developed our Suicide Prevention Strategy and have a draft plan for Zero Suicides on Inpatient Wards (this is scheduled for sign off in March 2019)
- A new Task and Finish Group to oversee both risk assessment and suicide preventions has been established and will also be used to ensure that system wide changes are considered and made where required
- Our Strategy for Physical Health in Mental Health has been agreed with work streams and leads set up.
- There are clear monitoring arrangements in place with tracking and reporting to the Quality and Performance Committee.

An assessment of the impact of the actions described

Our work to improve physical health care across our learning disability and mental health services has shown demonstrable improvements in the monitoring and recording of assessment and interventions for cardio metabolic rates and tobacco and alcohol use. In addition our recording of Body Mass Index (BMI), blood pressure, glucose and blood sugar levels has also improved significantly.

Following the CNWL Bereavement Conference, the Trusts Nurse Consultant in Palliative Care Services has produced a Policy for Compassionate Care after Death, this Trustwide policy was developed with the support of ten bereaved relatives whose family members passed away whilst in receipt of care from a CNWL service.

Our arrangements to improve risk assessment and safety planning means that our approach to managing risk is now fully aligned to best practice. An example of this is that we do not use "assessment tools or a scale designed to give crude indication of risk" NHS Resolution – Learning from Suicide Related Claims, September 2018.

As part of our plan for Zero Suicide on Inpatient Wards the Trust has undertaken an extensive review of its policy for the identification and management of ligature suspension points. As part of this we have increased the frequency of our audits and assessments whilst simultaneously strengthening the governance arrangements for this important environmental work.

Part 3 – Reporting against Core Indicators

The following section describes how we have performed against core indicators required by NHS England, NHS Improvement (our regulator) and our current and previous years' Quality Priorities. The indicators are grouped in tables as per the three care quality dimensions of patient safety, clinical effectiveness and patient and carer experience.

Our national priorities and Quality Priorities (current and historical) performance tables.

Table 9: Patient Safety:

Measure		Data Source	Target	2018 -19	2017 -18	2016 -17	2015 -16	Benchmark (where available): National average; and highest and Lowest Scores
1.CPA 7-day follow-up	What percentage of our patients, who are on Care Programme Approach, did we contact within seven days of them leaving the hospital?	Clinical systems	95%	93.9%	98%	97.6%	96.7%	National Average: 97%
2.Infection control	The number of cases of MRSA (MRSA bacteraemia) annually (YTD M12)	Internal database	N/A	0	0	0	0	Not available
	The number of cases of Clostridium Difficile annually	Internal database	N/A	3	8	6	5	Not available
3.Incidents	Number of patient safety incidents for the reporting period	Datix	N/A	20,058	20,148	18,556	16,635	335,828 (based on the most recent OPSIR NRLS reports from NHSI)
	Percentage of patient safety incidents that resulted in severe harm or death	Datix	N/A	125 (0.62%)	141 (0.70%)	157 (0.85%)	141 (0.85%)	3734 (1.11%)

Measure 1 CPA 7-day follow up: Evidence suggests that people with mental health problems are particularly vulnerable in the period immediately after they have been discharged from a mental health inpatient ward. This measure is in place to ensure our patients remain safe and have their needs cared for after discharge from hospital to community care, and reduce risk of relapse or incident. During 2018-19, 93.9%% of CPA patients received a follow-up contact within seven days of discharge, narrowly missing the target.

CNWL considers that this percentage is as described for the following reasons: On January 28 2019, our London MH services started to use a new system to record clinical information. This was a significant change in both data capture and recording processes and it presented a new way of working for our wards and community teams. The impact of this is that whilst staff get used of using the system, we have seen some recording and reporting errors which has resulted in a drop in performance in February and March. We carried out a case by case investigation on this and have identified that this is not a true reflection of actual performance and we did in fact achieve the 95% target. We are expecting that performance reporting will be back in line with pre-go live standards by the end of Quarter 1 2019-20.

Measure 2 Infection control: We have a duty of care to ensure that our patients do not get any avoidable healthcare associated infections (HCAI's) while in our services. Year to date, we are pleased to report that we did not have any MRSA bacteraemia cases. Three cases of Clostridium difficile (C.diff/CDI) across the year. This is a reduction of 5 from the previous year. Lapse in care was not identified following the undertaking of RCA's for the c.diff cases.

Each CDI case is discussed at meetings with the relevant clinical teams.

Aspects of care are explored to see what could have been done differently which might have led to a different outcome. In the cases identified, RCA's were undertaken, Lessons learnt were shared with the team and shared at the divisional subgroup meetings, quality governance meetings and at the IPCC. The rationale is to continuously improve patient safety.

The Infection Prevention and Control Team (IPCT) adhere to national guidelines and strictly scrutinises practices when managing HCAI's. Robust systems, quarterly audits and actions are in place to ensure that avoidable HCAI's within the Trust are kept to a minimum by undertaken the following audits and actions:

- Cleaning and clinical environmental audits
- Essential Steps audit tool: Our services monitor their own practice and provide assurance against the fundamental principles of infection control, for example, hand hygiene, safe disposal of sharps and appropriate use of personal protective equipment
- Antimicrobial auditing and stewardship monitoring
- Alert Organism Surveillance
- Outbreak management investigation
- All IPC polices are reviewed and updated accordingly with best practice and national guidelines
- Mandatory IPC training programme for staff is yearly for clinical staff and three yearly for non-clinical staff.
- Quarterly IPC Link Practitioner meetings are held across all Divisions. The rationale being to encourage best IPC practice locally across CNWL
- Quarterly newsletters are published across all Divisions, to inform staff of recent IPC issues and national updates on IPC surveillance, upcoming events and practical application of best practice in IPC.

Measure 3 Incidents: A decrease in the number of incidents relating to severe harm and death is noted year to date. CNWL considers that this data is as described for the following reasons; there are robust governance arrangements within each Division. This has led to a greater depth of analysis and understanding in relation to severity grading, enabling teams and services to identify where severity has been graded incorrectly. Where it is clear that care and service delivery has not contributed to the incident, the severity is decreased; this then correctly reflects the incident grading. Additionally, the Trust's Mortality Review Group (MRG), led by the Medical Director has clinical oversight of all deaths, which have occurred across the Trust. This includes the identification of themes, trends and where indicated the development of key work streams to support learning to enhance patient safety.

Table 10: Clinical Effectiveness:

Measure		Data Source	Target	2018 -19	2017 -18	2016 -17	2015 -16	Benchmark (where available): National average; and highest and Lowest Scores
4.Crisis Resolution Team gate keeping	The percentage of patients admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission	Clinical system	95%	95.6%	100%	99.3%	98.9%	National Average: 100%
5.Re-admission rates	Percentage of patients were re-admitted to hospital within 28 days of leaving	Clinical system	<8.1%	6.9%	5.5%	4.6%	5%	Source NHS Digital
	a. For patients aged 0 – 15			0.0%	0.0%	1.2%	1.4%	

	b. For patients aged 16 or over			6.8%	5.6%	4.7%	5.1%	Not available
6.Early intervention in psychosis (EIP)	% of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral		50%	86.5%	87.2%	72%	N/A	
7.Improving access to psychological therapies (IAPT):	Proportion of patients completing treatment who move to recovery (From IAPT minimum data set)	IAPTUS	N/A	54.3%	54%	N/A	N/A	
	% of people with common mental health conditions referred to the IAPT programme treated within 6 weeks of referral		75%	96.5%	93%	94%	N/A	National Average: 60.7% (MHSDS)
	% People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral		95%	99.7%	100%	99.9%	N/A	
8.Routine delivery of Cardio metabolic assessment and treatment for people with psychosis	In patient services	NCAP and EIP National Audit	Awaiting report	45.1%	N/A	N/A	N/A	a) National Average: 49.9% b) min: 23% c) max: 86%
	EIP Services			29.8%	N/A		N/A	
	Community Mental health services		Awaiting report					a) National Average: 89.7% b) min: 38%, max: 100% Source: NHS Digital
				30.3%	N/A	N/A		a) National Average: 98.8% b) min: 67%, max: 100% Source: NHS Digital

Measure 4 – Crisis resolution teams gate-keeping: Our crisis resolution teams assess patients when they are in crisis to quickly determine if they are suitable for home treatment rather than being admitted to hospital. It is important to treat our patients in the most appropriate settings to ensure their safety and that they receive the effective treatment. Our performance against this indicator was 95.6% achieving the target of 95%. CNWL considers that these percentages are as described for the following reasons; Performance is monitored daily via the Trust's Business Intelligence Systems which identifies all admissions and all associated gate-keeping information. The Crisis Resolution Team (CRT) policy is published and shared with all staff to support operational delivery of gate-keeping activity and the business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. CNWL has taken the following actions to improve this number, and so the quality of its services, by: Where this target is not met results are discussed and reviewed at local care quality groups, senior management team meetings or the Divisional Board. The CRT Operational Policy clearly indicates the procedure for gate-keeping is widely circulated and published on our staff Intranet. There are clear Business Rules, which are published ensuring accurate data recording across all Trust teams. This measure is also reported monthly via the integrated performance dashboard, which is reviewed by the Quality and Performance Committee. The Trust plans to continue undertaking these activities to aid in compliance throughout the coming year.

Measure 5 – Readmission rates: Readmission rates describe how many patients get readmitted to hospital within 28 days post their discharge. It is important to monitor this as action is required if it indicates patients are being discharged before they are ready or not given the appropriate support in the community. We are pleased to report that our readmission rates are below the 8.1% target at 6.9%. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally via the Trust's Business Intelligence Systems which identifies all patients who were re-admitted. The business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. This indicator is also published monthly via an internal integrated dashboard, which is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings. Performance of this indicator is monitored on a weekly basis by the operational ward teams, using the appropriate business intelligence reports. Where a patient has been re-admitted within 28 days, the local team investigates the causes, looking across the patient pathway and shares lessons learnt at quality and operational management meetings. Exceptions are also reported monthly to the Trust board and quality and performance committee. The Trust plans to continue undertaking these activities to aid in compliance throughout the coming year.

Measure 6 – Early interventions in psychosis (EIP): this national target measure ensures that patients with a suspected first episode of psychosis commence treatment with a nice approved care package within 2 weeks of referral. Performance was above 86.5% against a 50% target. Performance is monitored daily via the Trust's Business Intelligence Systems. This indicator is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings.

Measure 7 – Improving access to psychological therapies (IAPT): This measure monitors the percentage of people with common mental health conditions referred to the IAPT programme treated within six weeks of referral and those treated within 18 weeks of referral. CNWL considers that these percentages are as described for the following reasons; Performance is monitored via the Trust's Business Intelligence Systems. This indicator is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings.

Table 11: Patient, carer and staff experience:

Measure		Source	Target	2018 -19	2017 -18	2016 -17	Benchmark (where available): National average; and highest and lowest scores
Admission to adult facilities of patients under 16 years old	Number of patients under 16 who were admitted to adult facility	Datix	N/A	3	0	N/A	National Average: 1.7 Upper Quartile: 2.0 Lower Quartile: 1.0 benchmarking
The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	Were you given enough time to discuss your needs and treatment?	National survey results	N/A	^	71.2%	86%	N/A
	Did the person or people you saw understand how your mental health needs affect other areas of your life?		N/A	^	67.6%	83%	N/A
	Did you feel that you were treated with respect and dignity by NHS mental health services?		N/A	^	79.8%	89%	
Out of area placements	Inappropriate out of area placements		N/A	790	217	N/A	N/A
Care/treatment plans	Quality Account Priority 2018-19: Patients report that they were involved as much as they wanted to be in decisions about their care/treatment (definitely and some extent) n= 21819	Local systems	85%	96%	95%	95%	N/A

	Quality Account Priority 2018-19: Patient report that their care or treatment helped them to achieve what mattered to them (Yes, definitely + Yes, to some extent) n=20988			96%	95%	95%	N/A
	Patients report that they were treated with dignity and respect n=16840		95%	98%	97%	98%	N/A
Service satisfaction/ Friends and Family Test	Patient FFT: Patients report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment n=23823)	Optimum Meridian	90%	MH 87%	MH 86%	MH 86%	National Avg MH: 90%
				CH 95%	CH 96%	CH 95%	National Avg CH:96%
	Staff FFT (internal survey +national survey): Staff report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment (n=5746)	Internal system	70%	68.7%	74%	65%	65.9%

	Staff FFT (national survey): Staff report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment (score reported out of 5, with 10/10 being the maximum possible)	staff Survey	10	6.9	3.69	3.74	National Average: 7
	Staff recommending the Trust as a place to work n=5746	Staff Survey	70%	59.5%	57%	60%	57.3%

Key

^; Data has not been published

N/A; Not Applicable

CH; Community Health

MH; Mental health

Admission to adult facilities of patients under 16 years old: 1 child under 16 was admitted to an adult ward in the reporting period. We work proactively in trying to reduce the number of admissions to an adult ward. An adult ward is only used as a last place of safety when all other options have been explored.

Out of area placements: CNWL considers that this data is as described for the following reasons; Demand for acute inpatient admissions has meant that where a service user is assessed as requiring an inpatient admission and there is no bed availability within the Trust, the service user may require an Out of Area Placement for a short period of time until a bed within the Trust becomes available. To minimise the need for Out of Area Placements, CNWL has implemented the Reducing Bed Occupancy programme. This has included implementation of the Bed Usage Index reporting methodology to provide transparency and accountability for each borough to manage their bed usage. A Discharge Planning Tool has been embedded within the services, which is completed by wards on a daily basis to drive effective discharge planning with community services and reduce bed occupancy. The Trust have also implemented processes to ensure effective monitoring and escalation of Delayed Transfer of Care (DToC), and processes to ensure effective management of Out of Area Placements – establishing preferred providers, daily reviews and a proficient escalation process.'

Care/treatment plans:

- Patients report that they were involved as much as they wanted to be in decisions about their care/treatment (definitely and some extent) this was Quality Account Priority for 2018-19 and is explained in Part 2. We are pleased to report that we have achieved the target for this indicator.
- Patient report that their care or treatment helped them to achieve what mattered to them (Yes, definitely + Yes, to some extent: This was a Quality Account Priority for 2018-19 and is explained in Part 2. We are pleased to report that we have achieved the target for this indicator.
- Dignity and respect: This indicator forms one of our core patient reported outcome measures which we include on all questionnaires as it provides

assurance that our patients are being treated with professionalism at all times, and would provide an early warning to where service improvement is needed. We are pleased to report that overall we have achieved 98%.

Service satisfaction/Friends and Family Test: We monitor whether patients and staff would recommend our services to family or friends if they needed similar care or treatment (known as the 'Friends and Family Test' or FFT) and the reasons that they gave for this. This gives us a good indication of what needs improvement, and a key source of intelligence for the setting of our Quality Account Priorities for the forthcoming year.

Patient FFT results: As at Q3 results show that 92% of our patients would be likely or extremely likely to recommend Trust services, achieving our target.

Staff FFT results: Our staff survey showed that 68% of our staff would be likely or extremely likely to recommend Trust services as a place to receive treatment. This is against our target of 70%.

Table 12: Local performance against our patient reportable indicators (Patient and Carer involvements) 2018-19

Measure	Target	Mental Health Services						Specialist services						Community physical Health services			
		Brent	Harrow	Hillingdon	K&C	Westminster	Milton Keynes	CAMHS	Eating Disorder	Learning Disability	Rehabilitation	Addictions	Offender care	Camden	Hillingdon	Milton Keynes	Sexual Health
Patients report feeling involved in care & treatment (definitely and to some extent)	85%	94% 1711 /1815	94% 526/ 562	92% 252/ 274	91% 563/ 619	91% 499/ 551	97% 1406/ 1448	96% 411/ 427	93% 125/ 134	93% 140/ 151	88% 213/ 243	95% 1058 /1109	88% 1423/ 1626	96% 2525/ 2637	98% 2348/ 2390	99% 2572/ 2600	99% 4668/ 4719
Patients report their care & treatment helped them achieve what matters to them (definitely & to some extent)	85%	94% 1644/ 1750	91% 497/ 545	90% 246/ 273	90% 559/ 618	90% 501/ 555	96% 1377/ 1434	95% 407/ 429	91% 117/ 128	98% 145/ 148	92% 226/ 245	95% 1050/ 1103	87% 1330/ 1535	97% 2320/ 2386	98% 2280/ 2315	99% 2563/ 2587	98% 4330/ 4440
Patients who report being treated with dignity and respect (Yes always + yes sometimes	95%	97% 1769/ 1832	98% 531/ 544	94% 251/ 267	95% 592/ 623	95% 528/ 557	99% 1391/ 1402	99.8% 425/ 426	99% 133/ 135	97% 146/ 151	97% 233/ 240	99% 1050/ 1060	95% 1504/ 1583	99.5% 2590/ 2602	99.7% 2328/ 2334	99.6% 2448/ 2457	98% 118/ 120
Patient FFT: How likely are you to recommend CNWL services to family or friends if they needed similar care or treatment? (extremely likely likely)	90%	87% 1613/ 1860	90% 542/ 605	82% 343/ 420	84% 624/ 741	81% 521/ 640	93% 1499/ 1619	88% 878/ 1000	85% 122/ 144	85% 129/ 152	87% 244/ 282	93% 1177/ 1269	79% 1310/ 1660	96% 3541/ 3703	97% 2485/ 2557	97% 2612/ 2680	93% 3718/ 3979

Annex 1 – Statements provided by our commissioners, overview and Scrutiny Committees (OSCs) and Health watch

Our commissioners

Harrow CCG (North West London collaboration of eight CCGs)

The North West London Collaboration of eight CCGs (NWL CCGs) has welcomed the opportunity to review your Quality Accounts Report for 2018-19. We are pleased that the Trust has made the effort to take on board the relevant comments requested by the NWL CCGs and incorporated these in the final version of the report.

We confirm that we have reviewed the information contained within the Account and it is compliant with the Quality Account guidance for NHS Trusts as set out by the Department of Health and NHS Improvement. The purpose of the Quality Account is that it provides a balanced report on the quality of services which identifies the areas in which the Trust has achieved success and where there needs to be improvements.

We acknowledge the work that the Trust has completed arising from the two quality priorities identified in the previous years. Furthermore, we fully endorse the approach taken by the Trust to consult with the CCGs and the other stakeholders in developing the quality priorities for 2019-20.

We are pleased that the Trust has embraced the value of patients and carers by involving them in a variety of different initiatives to help shape current and future services such as involvement in local governance groups, helping the Trust recruit compassionate and respectful staff and running local social and wellbeing groups. It has been pleasing to see good examples of engagement across the NWL and wider boroughs, involving community and mental health teams. We are encouraged by the approach taken to increase the number of quality improvement projects involving patients and carers. We welcome the Trusts efforts in increasing the number of Peer Support workers to support the delivery of Recovery and Wellbeing College courses and clinical work.

In last year's quality accounts, the NWL CCGs requested information on individual borough performance and is pleased that the Trust has provided this information through the Clinical Quality Group meetings (CQG). The NWL CCGs look forward to seeing CNWL's continued and sustained involvement by patients and carers Trust -wide in the coming years. We are pleased that the Trust will continue to develop, support and expand a partnership approach between staff, patients and carers across all their services between 2019 and 2023.

The NWL CCGs is supportive of the work the Trust is doing to improve staff engagement to ensure that they feel well supported, trained, committed and engaged. We are pleased that more listening and engagement events for staff have been held Trustwide in the past year. We note that the Trust has improved staff turnover through specific strands of work and that it has had a focus on improving the health and well-being of their staff. The NWL CCGs wish to congratulate the Trust on the accreditation received of "excellent" for the London Healthy Workplace Charter awarded by London Mayor. Whilst there has been continued improvement in the percentage of staff recommending CNWL as a place to work, over the past two years, we note that this is still short of the 70% target that has been set. We welcome the continued effort by the Trust to make improvements in this area and look forward to seeing the impact of the actions of the new People Strategy.

The NWL CCGs is pleased with the efforts of the Trust in opening Lavender Walk, a unit for young people who require inpatient mental health care. We acknowledge the work achieved through collaboration in nationally leading North West London CAMHS New Models of Care programme. We look forward to the opening of Crystal House, an adolescent inpatient unit for children with a learning disability. We share the Trust's view that these units will mean that fewer children will be treated miles from home or have to wait longer for an admission.

The Trust has identified four quality priorities over the next three years.

- Reducing Falls
- Improving the Management of the deteriorating patient
- Reducing violence and aggression for staff and patients
- Improving the quality of supervision

The NWL CCGs support the above quality priorities and the Trust's plan over the next three years to ensure that they sustain improvements in these important areas. We believe that these quality priorities will improve the safety and the quality of care for our patients. We are looking forward to continued work with the Trust to monitor progress against the set

priorities for 2019-20 through the CQG meetings. This will help the NWL CCGs gain assurance of continuous quality improvement of mental health services provided across the North West London Population.

Milton Keynes CCG

Thank you for forwarding a copy of the Quality Account for Central and North West London (CNWL) NHS Foundation Trust to the Milton Keynes Clinical Commissioning Group (CCG) which has been read with interest. CNWL – Diggory division has continued to work alongside MKCCG to sustain and further improve the quality of services provided.

The content of the report is well structured and presented, with a good balance between quantative and qualitative data and information. Although Milton Keynes services are not specifically mentioned in detail, the report does focus on where the organisation has achieved its quality goals overall and acknowledges where further improvements could be made.

The review of quality improvements in 2018-19 documents achievements in relation to a number of quality indicators. This includes a range of examples of how service user's and carers have been involved in Trustwide and local governance groups. Good examples of how peer support workers are helping service users on their own journeys, offering first hand insight and understanding. This has helped to ensure In addition the organisation has once again sustained an excellent approach to infection prevention and control, which has enabled the continuation of zero cases of Clostridium difficile and zero cases of MRSA across Milton Keynes.

Considerable effort and commitment from both individuals and teams has taken place throughout the year in order to improve quality and patient experience. The teams within CNWL have worked collaboratively with the CCG to achieve quality outcomes and shared learning. The CCG commends and supports CNWL in its commitment to implement integrated community care and support via close working with emerging primary care networks. The CCG endorses the 2019-20 priorities for improvement set out in the Quality account.

The CCG are pleased to see falls prevention and care of the deteriorating patients amongst these priorities. Both aimed at improving patient safety and in line with National CQUIN's and the drive to improve Sepsis management. The importance of staff wellbeing and development is also included with the inclusion of quality of supervision and reduction in violence and aggression.

MKCCG can confirm, to the best of our knowledge, that the Quality Account contains accurate and transparent information in relation to the range of services provided, and the quality of services that CNWL provides. The information provides both positive achievements and opportunities for improvement. During 2017-18 the MKCCG looks forward to working collaboratively with CNWL to continually develop quality services for the residents of Milton Keynes.

NHS Camden CCG

As a co-ordinating commissioner NHS Camden Clinical Commissioning Group (Camden CCG) has welcomed the opportunity to provide this statement for the Central North West London NHS Foundation (CNWL) Trust Quality Account 2018-19.

Camden CCG has worked collaboratively with the Trust clinicians and managers during 2018-19, ensuring that patient outcomes and experiences remain a fundamental part of best practice. The quality and performance of these services are monitored through the Clinical Quality Review Group and Contract Review Group meetings.

It is positive to note the work undertaken by the Trust to proactively engage with patients and carers, ensuring that they are involved in boards, committees and working groups, including the Trust-wide Patient Involvement Forum and Carers Council. CNWL have provided training and guidance to staff on the importance of involving patients and carers in a meaningful way to make sure we avoid tokenistic involvement, which is positive.

Camden CCG were invited to take part in a stakeholder event in March 2019 to reflect on the Trust priorities delivered during 2018-19. CNWL used this opportunity to consider with the stakeholders the priorities to be taken forward as part of the Trust Clinical and Quality Strategy over the next three years. We are pleased to see that CNWL's chosen priorities include expanding on the work already undertaken to improve the quality of services. The Trust are committed to supporting their workforce and are using Quality Improvement (QI) methodology to empower staff to feel engaged and motivated to take improvement initiatives at a local level. CNWL have focused on developing a number of Quality Improvements throughout the year, some of this work includes Pressure Ulcers, Falls, managing the Deteriorating Patient and Reducing Violence and Aggression for staff and patients.

We recognise the challenges faced by the NHS to recruit and retain a high quality workforce especially within London. We anticipate the Trust will continue with their efforts to improve recruitment and retention and the work they have carried out including, running a number of Trust-wide staff engagement and listening events. CNWL Operational Managers are engaging in CCG hosted sessions to support the development of integrated working for adults.

We hope the Trust will work with us to align Quality Improvement approaches across primary and community services and to deliver our priorities for Quality, Innovation, Productivity and Prevention which include falls, rapid response and neighbourhood level integrated care.

Overall we are pleased with the Trusts achievements against the Quality Account priorities for 2018-19 and the selected priorities for 2019-20. Camden CCG will continue to work collaboratively with CNWL, to ensure that quality, safety and positive patient experience remain a fundamental component of services commissioned and delivered by the Trust.

Our local Healthwatch

Healthwatch Central West London

Healthwatch Central West London (HWCWL) welcomes the opportunity to provide this statement on the draft Central and North West London (CNWL) NHS Foundation Trust Quality Account for 2018-19, and to comment on the quality of the services commissioned locally to meet the needs of residents in Kensington & Chelsea (K&C) and in Westminster (W).

General comments

In general, our members felt that the Quality Account does not give enough detail on the very broad range of services that CNWL provides over a very wide geographical area. HWCWL are only able to comment on the services which CNWL provides in Kensington & Chelsea and in Westminster, which are the ones that our members have experience of. They include:

- Community Independence Service (KCW)
- Sexual Health Service (KCW)
- Schools Service (KCW)
- Community Mental Health Forensic Service (offender care) (KCW)
- IAPTS Talking Therapies
- Primary Care Clinical Mental Health Services
- Inpatient, secondary care community and specialist MH services (KCW)

Our members were disappointed with how little information the Quality Account contained on these services. This was also a request from our members for CNWL's Quality Account report 2017-18.

Urgent (Crisis) Care Pathways Coproduction workshops

In our statement for CNWL's Quality Account report 2017-18 we said that our members were looking forward to upcoming local coproduction workshops on the Urgent (Crisis) Care Pathway that will incorporate the 'alternatives to hospital admission workstream'. We are disappointed that these failed to materialise.

Community Mental Health Teams

We are aware that there has been a high level CNWL steering group working towards a reconfiguration of the Trust's CMHT's. Our members would like information on when there will be a public consultation on this for input from local residents, service users/ carers and voluntary and community groups.

Mental Health Transformation

A recent mental health transformation stakeholder engagement event in Westminster set out the way in which mental health services are likely to change across the five London boroughs where CNWL hold mental health contracts. This included removing the boundary between primary care and developing a community offer centred around Primary Care Networks, and ultimately around the needs and aspirations of the patient. The overall mental health model is still a work in progress and will need further stakeholder engagement.

However, as this develops our members would like CNWL to be mindful that feedback from service users suggests that the focus needs to be on interventions and treatment rather than repeated assessment. There should also less focus on process measures and more focus on patient outcomes, with flexible support available around needs.

Family and Friends Support Group

From our comments in 2017-18 Quality Account, our members are disappointed that after a whole year the proposed fortnightly CNWL facilitated evening support group for family and friends at St Charles Kensington Inpatient unit is yet to be implemented.

CNWL Quality Priorities for 2018-19

Patient involvement

Our members stated that the statistics showing satisfaction ratings or involvement for patients is very high at 97%, 96% etc. The Table setting out responses to whether patients report feeling involved in their care or treatment rolled two responses 'definitely' and 'to some extent' into one statistic. Our members suggested that it would be more helpful and would give richer data to understand how involved patients did feel, for the Quality Account to report on this by separating out these answers. If a high percentage of respondents had stated that they felt involved 'to some extent', this suggests that there is still improvements to be made in this area.

Quality Improvement

Our members recognise that there has been increased involvement of service users and Carers in various areas, including involvement in Quality Improvement projects, of which there seem to be about 300 such projects across the Trust mostly at the local level. It would be useful to hear how these projects are connected to each other and using shared learning to develop service user and patient involvement further.

HWCWL would like to receive information on how our members and other interested local residents, service users and patients can get involved in the Quality Improvement projects.

Personalised Care

Our members note that personalised care, that includes care plans being co-produced with patients is still a ' work in progress' and hope to see this developed further over the coming year.

Carers Conference and Service User Conference

Our members note that the two Carer Conferences that have been held to date have been very successful and they are pleased that a Service User Conference is to be planned for next year. This was something that we had suggested in our statement for 2017-18 and our members are pleased to see this being taken forward.

Staff engagement

Staff engagement and training

Our members acknowledge that there have been several initiatives to improve staff engagement and training, leading to better staff satisfaction and performance.

CNWL Quality Priorities for 2019-20

Our members were interested to know whether Quality Improvement projects will be set up to cover each of the four new priority areas:

1) Reducing Falls
2) Improving the management of deteriorating patents
3) Reducing violence and aggression for staff and patients
4) Improving the quality of supervision

Finance

Our members are aware of the reduction in finance to CNWL's Mental Health contracts across KCW in the last few years and would like to receive information about how this may affect services in the two boroughs. As stated in our statement for CNWL's Quality Account report last year, we also want to know what patient impact assessments will be undertaken and how this will be communicated to local people.

Looking forward

HW CWL and our members would like to arrange regular liaison meetings with CNWL and commissioners around services transformation and any proposed changes in the coming year.

Healthwatch Central West London
info@healthwatchcentralwestlondon.org

Healthwatch Hillingdon

Healthwatch Hillingdon wishes to thank the Central and North West London NHS Foundation Trust (the Trust) for the opportunity to comment on the Trust's Quality Accounts for the year 2018-19.

Healthwatch Hillingdon acknowledges that the Quality Account published by CNWL lies within the requirements framed by the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010 and the mandatory requirements set out by NHS Improvements for NHS foundation trusts.

Questioning the effectiveness of the Quality Accounts to reflect local quality, in a meaningful way for the public, is a position Healthwatch Hillingdon has taken since the inception of the Quality Accounts.

Healthwatch Hillingdon is pleased to see the increase in the numbers of patients and carers involved in projects. Healthwatch Hillingdon strongly agrees with

CNWL, 'that when staff empower service users and carers to take more of the lead in making local changes, engagement and outcomes can be improved'.

CNWL provide over 30 services in Hillingdon; community health care; mental health services for both adults and children; and adult addiction services. Healthwatch Hillingdon maintains that for the Quality Account to give the public assurances of the quality of Hillingdon services and drive local quality improvement, it requires a Hillingdon specific section. This should include quality priorities set against local improvement needs and should outline how improvement will be achieved and reported. This would also be an opportunity to celebrate the quality of provision provided by CNWL to the Hillingdon public. Healthwatch Hillingdon does not feel that the CNWL Quality Account 2018-19 provides this. This is a point that Healthwatch Hillingdon has raised for a number of years and it was, therefore, extremely pleasing to see CNWL produce a Hillingdon Services Annual Report for 2016-17. This initiative provided a combined report of all the CNWL services delivered in the Borough and went a long way to providing the Hillingdon public with the assurances that, in the view of Healthwatch Hillingdon, the 2018-19 Quality Account fails to provide. It is therefore, sad to see that the initiative has not continued.

Healthwatch Hillingdon strongly recommends to CNWL that this document is replicated for all the geographical areas that CNWL is commissioned to serve and that these form the basis of the future Quality Account.

Should the Trust require any further information or clarification on the content of this response please contact Mr Turkay Mahmoud, Interim Chief Executive Officer.

Healthwatch Milton Keynes

Healthwatch Milton Keynes response to Central and Northwest London NHS Foundation Trust Quality Account 2018-19.

Healthwatch Milton Keynes (HWMK) would like to thank CNWL NHS Foundation Trust for inviting us to comment on the Quality Account 2018-19.

In 2018-19 HWMK were pleased to see that CNWL's Primary Care Plus service was rolled out across GP Practices in Milton Keynes. HWMK conducted a patient review of the pilot service and the extension of the programme reflected the positive experiences of patients receiving services through the PCP pilot, and patient views on the service being more widely available. HWMK were also pleased to be invited by CNWL during the 2018-19 period to undertake an Enter and View visit of the Windsor Intermediate Care Unit. The WICU team took appropriate actions against all our recommendations from the visit.

HWMK would like to note the local leadership of CNWL across all elements of service always positively engage with Healthwatch Milton Keynes and are very responsive to the queries and concerns we hear from patients and service users.

We consider that the Quality Account provides a comprehensive and well-balanced review of the range of CNWL's services, and that it is well ordered and clearly presented. There is a coherent philosophy and ethos across CNWL's activities reflected in the report.

We recognise that CNWL has a dispersed clientele, and acknowledge that it is difficult to produce a Quality Account which is specific to its individual stakeholders. We feel that it is clearer in the Quality Account this year to see where specific developments have taken place in Milton Keynes, with some clear examples of improvements to district nursing and dental services. We are particularly pleased to see how the involvement of Peer Workers is having an impact on patient experience locally, and how they have been involved in the design and delivery of the Recovery and Wellbeing College. We also note the successful engagement with Black, Asian, and Ethnic minority (BAME) communities as a postive outcome. The 'Learning from Deaths' section was a little difficult to follow in terms of the statistical data, but both the actions, and the assessment of those actions was clear and generally easy to read. Also, where data highlights that activities and outcomes have fallen short of targets, such as CPA 7-day follow up care, there are explanations for variances. However, in the case of the CPA 7-day follow up care target and similar areas, we would like to see more detailed responses where variance against targets are on a continued downward trend.

In Table 12: Local performance against our patient reportable indicators (Patient and Carer involvements) 2018-19 we would like to note how positive it is to see the markedly higher numbers of patients responding to questions about their care in Milton Keynes and note the higher levels of satisfaction in comparison to other areas of CNWL's services.

In our response to the first draft, HWMK noted an understanding that CNWL has a broad range of activities and operates on multiple sites which makes it difficult for CNWL to produce a single, general report which does justice to a single location. However, we have raised in previous years that at HWMK we are focussed on issues and achievements within our unitary authority, and we feel that it should be possible, within that general report, to provide a more focussed record of CNWL's work in the borough. As it stands there are relatively few references to Milton Keynes, and those which are included are either in a comparative table or cited as particular examples. We would welcome something more holistic, and more analytical, to which our residents can relate more easily, possibly in the form of an annex. Quality Accounts are a good opportunity for services such as CNWL to demonstrate their achievements and quality of care to patients, for patients to read.

In our review of the final draft, we must note that our previous comments still stand. To enable the public to better understand the impact of CNWL locally, and how quality and safety and patient experience have been improved in Milton Keynes we make two recommendations: Consider the addition of an overall executive summary, in easy read, for public-facing purposes; and a brief annex summarising the Milton Keynes experience, which is generally very positive judging by the data presented in the Quality Account.

Healthwatch Milton Keynes thanks CNWL for presenting their Quality Accounts for 2018-19 and look forward to continuing our collaborative and positive relationship with CNWL in the year ahead.

Healthwatch Camden

Healthwatch Camden thanks the Trust for the opportunity to comment on your Quality Accounts. We were pleased to work with the Trust in gathering feedback on community health services relating to admissions avoidance and smoother hospital discharge. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS means that we do not have the human resources to consider Quality Accounts in the detail that they deserve this year. We look forward to commenting in future years.

Healthwatch Surrey

As the independent consumer champion for health and social care, Healthwatch Surrey is committed to ensuring the people of Surrey have a voice to improve, shape and get the best from their health and social care services by empowering individuals and communities.

This year we have decided that we will not get involved in commenting on the Quality Accounts. With limited resources we do not believe this is the best way to use our time to make a difference for the people of Surrey. We have chosen to concentrate this year on ensuring we feedback what we've heard on NHS and social care services to commissioners on a regular basis; and that we have the processes and relationships in place to escalate any cases of particular concern to the providers involved and seek outcomes.

Over the past year we feel we have had a collaborative relationship with the Trust. We have shared experiences from the public with them where necessary; and we have collaborated in holding Listening Events and talking to patients as part of our ongoing engagement and project work. The Trust have been receptive to our insight and feedback.

Our Overview and Scrutiny Committees

The Royal Borough of Kensington and Chelsea

We welcome the opportunity to respond to the CNWL Quality Account for 2018-19. We recognise that the Quality Account is a key tool in ensuring that healthcare providers review their services objectively and identify their shortfalls and successes. It is therefore right that the Quality Account should record achievements and also discuss areas where the Trust could improve.

Priorities for Improvement 2018-19

We share the Trust's aspiration of involving and putting patients and carers at the heart of service development and delivery at every stage and making services more patient focused and personalised, both for NHS services and social care. We, therefore, welcome the co-production approach that CNWL has taken to empower partnership with patients, to ensure quality and to increase patient responsibility in shaping their own care. We particularly welcome the involvement of young people in the development of Lavender Walk and the opening of the Café at St Charles.

We welcome the emphasis given to recruitment and retention of staff and in particular the progress made in the Community Independence Service (CIS). When the CIS was taken over by CNWL vacancies in the service were at a high level. We understand that CNWL has made real progress with staff retention and that staff turnover, whilst above the Trust average, is on a steady decline.

Achievements and Concerns

We wish to express our appreciation for the work that CNWL, as the lead NHS provider, has carried out for Care for Grenfell. This has made and continues to make a real difference to the community in North Kensington. We welcome the good performance of CNWL in speed of access to the Improving

Access to Psychological Therapies (IAPT) programme

Last year we expressed concern about the lack of information on CNWL's performance and progress in reducing Delayed Transfers of Care (DToCs). This issue is discussed in the Quality Account this year, but we would expect to see how CNWL, as our provider of mental health services, is embracing and implementing the new Department of Health Guidance and the measures put in place to deliver local targets.

This year in RBKC, the Mental Health DToC numbers have reduced significantly, but overall in Bi-Borough CNWL's performance is poor, due to the high number of nonacute Mental Health DToCs mainly in Gordon Hospital and this could impact on the availability of beds for emergency admissions from Kensington and Chelsea. We have funded a consultant to work with CNWL to identify gaps and put in place processes and pathways to minimise delayed discharges. This has helped, but more needs to be done to embrace the new processes and reduce further DToCs. Elected Members in Kensington and Chelsea have been concerned about emergency placements of patients at a great distance from their home. We note with concern the substantial increase in the number of out of area placements. We request that CNWL give high priority to reducing the number of out of area placements.

Targets for 2019-20:

The targets for 2019-20 are

1. Reducing Falls;
2. Managing deteriorating patients;
3. Reducing violence and aggression against staff and patients;
4. Improving the quality of supervision

We welcome these targets but we should like to see more emphasis in next year's Quality Account on reducing DToCs and out of area placements, in particular placements a long way from the patient's home.

Westminster Family and People Services Policy and Scrutiny Committee

Introduction

The Westminster Family and People Services Policy and Scrutiny Committee welcomes the opportunity to comment on the Central and North West London NHS Foundation Trust's (CNWL) Quality Account 2018-19.

We would like to congratulate you on your achievements in 2018-19, particularly

- Being accredited "excellent" for the London Healthy Workplace Charter awarded by London Mayor.
- Being included in the LGBT+ equality charity Stonewall's the top 50 organisations.
- Having services receiving independent accreditation for quality and effectiveness and being shortlisted for national awards.

Quality progress 2018-19

Overall, we are pleased the Trust was rated as 'good' overall by the Care Quality Commission (CQC) in its most recently published inspection report (18 August 2017) and look forward to the outcome of inspections that took place in 2018-19. We congratulate the Trust on being rated outstanding for 'caring'. We note that the Trust was rated as 'requires improvement' for 'safe' and hope that action that has been taken sees this rating improve when the findings of the most recent inspection are published.

We are pleased to see the long list of actions the Trust has carried out to improve quality.

Quality Priority 1: Patient and Carer Involvement

We are pleased that:

- Patients and carers are being more involved in boards, committees and working groups. Patient and carer involvement in local governance and performance committees is welcomed.
  - There has been a rise in the number of projects that had service user involvement from 17 to over 70.
  - Service users and carers have been involved in the Older Adults Service User Group and the business meetings at the Waterview Centre.

We note that:

- In Q4 2018-19 96% of patients reported feeling involved in their care or treatment, an improvement on Q4 2017-18 and above target
- In Q4 2018-19 96% of patients reported that their care or treatment helped them achieve what mattered to them, an improvement on Q4 2017-18 and above target.

Quality Priority 2: Staff Engagement

We are concerned that:

- The proportion of staff recommending CNWL as a place work was 60% in Q4 2018-19. This is below target (70%) and lower than the highest quarterly score in 2017-18.
- The proportion of staff recommending the Trust as a place to receive treatment is lower than hoped, although at 73% it is above target (70%) in Q4 2018-19.

The quality account states that 'scores on staff recommending CNWL as a place to receive treatment and work remain lower than we would like; albeit that this year we had our highest quarterly scores of the last two years'. The data supplied (Table 3) shows that quarterly scores in 2018-19 were not the highest over the last two years, this should be clarified

We note a great deal of work has been undertaken to reduce staff turnover, increase staff engagement and improve staff wellbeing. However, the results of this work have not been detailed so its effectiveness cannot be judged.

We hope that, despite not being a quality priority for 2019-20, staff engagement remains a key issue for the Trust.

Clinical audits

It is difficult to comment on the clinical audits without knowing if recommendations from completed audits have been enacted or not. We ask future quality account to focus on any recommendations that have been failed to be enacted and provide the reasons.

Priorities for 2019-20

We note the priorities set for 2019-20. Thank you for the invitation to the Quality Priorities 2019-20 Consultation Event on 1 March, we hope that this approach to engagement with stakeholders continues in future years.

Targets should be quantifiable with clear outcomes, wherever possible, so they lend themselves to be comprehensively assessed. It is often difficult to see improvements when the Trust includes statements such as 'a new programme'. We would welcome more detail in the quality account citing quantifiable evidence of improvements made across the priority areas. Priority areas should also be clear about not only what action will be taken but what outcomes are hoped for. For example, 'Quality Priority 4: Improving the Quality of Supervision' states that progress will be monitored against actions taken rather than outcomes achieved.

We note the comments around monitoring and sharing information about how the Trust performs. We would also encourage the Trust to ensure that monitoring reports as accessible as possible so that patients and users can understand the information presented.

Core Indicators

We note that performance against core indicators is generally good.

We are concerned that:

- The percentage of patients who are on Care Programme Approach that were contacted within seven days of leaving hospital has fallen to 93.9% compared to 98% in 2017-18. This is also below the target (95%) and national average (97%). We note the change in recording systems that the Trust considers the reason behind the data. We hope to see improved performance in 2019-20 reporting.

The number of inappropriate out of area placements has significantly increased from 217 in 2017-18 to

790 in 2019-20. We note the increased demand for acute inpatient admissions. We also note the programmes and processes that have been put in place to ensure effective management of out of area placements and hope that these are successful.

Conclusion

Overall, the progress that the Trust has made over the last year is welcomed.

Annex 2 – 2018-19 Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018-19 and supporting guidance detailed requirements for quality reports 2018-19
- The content of the quality report is not inconsistent with internal and external sources of information including: – board minutes and papers for the period April 2018 to March 2019
  - Papers relating to quality reported to the board over the period April 2018 to March 2019
  - Feedback from commissioners dated 3 May 2019
  - Feedback from local Health watch organisations dated 3 May 2019
  - Feedback from overview and scrutiny committee dated 3 May 2019
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28 June 2018
  - The [latest] national patient survey November 2018
  - The [latest] national staff survey 26/02/2019
  - The Draft Head of Internal Audit's annual opinion of the trust's control environment dated 1 March 2019 (The final report was not available at the time of writing this section)
  - CQC inspection report dated 18/08/2017

- The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board.

Professor Dorothy Griffiths OBE, FCGI
Chair
28 May 2019

Claire Murdoch CBE
Chief Executive
28 May 2019

Annual accounts

For the year ended 31 March 2019

Independent auditor's report

to the Council of Governors of Central and North West London NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Central and North West London NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Group Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2019 and of the Group and Trust's income and expenditure for the year then ended; and

— the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

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

Overview		
Materiality: Group financial statements as a whole	£9.9m 2017-18:£9.0m 2% (2017-18: 2%) of operating income	
Coverage	100% (2017-18: 100%) of group income	
Risks of material misstatement		**vs 2017-18**
Recurring risks	**New:** Valuation of land and buildings	▲
	Recognition of NHS and non-NHS income	◄►
	New: Expenditure recognition	▲
Event driven	Valuation of intangible assets	◄►

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including 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, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of land and buildings £230.1 million; 2017-18: £221.6m *Refer to page 30 (Audit Committee Report), page 125 (accounting policy) and page 145 (financial disclosures)*	**Subjective valuation:** Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Group may consider whether the asset would be realistically built to the same specification or in the same location. The Group and Trust engaged a professional valuer to carry out a full valuation of its land and buildings as at 31 March 2019. The valuation figures included in the Group accounts are estimates. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. As part of developing the valuation the Trust makes judgments about how the asset would be replaced. A key judgment relates to whether VAT would be able to be reclaimed were the Trust to replace their current sites. The Trust has prepared its valuation net of VAT for those assets which are owned by Quality Trusted Solutions (where VAT might reasonably be reclaimed). For other assets valuations are gross of VAT. Valuations are inherently judgmental. There is a risk that the methodology, assumptions and underlying data, are not appropriate or correctly applied.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the expertise and qualifications of the valuers engaged by the Group and Trust. We inspected the instructions for preparing the valuation to confirm that it was prepared in accordance with the requirements of the RICS Red Book and the Department of Health and Social Care Group Accounting Manual; — **Tests of detail:** We evaluated the accuracy of the floor area data submitted to the valuers for the preparation of the valuation by re-performing measurements of a sample of the Group and Trust's properties; — **Methodology choice:** We used our own valuation specialist to assess the methodology used in preparing the valuation, including the choice of indices used to determine the valuation; — **Our sector experience:** We challenged the Group and Trust's assumptions used to prepare the valuation by comparing to our own expectations based on knowledge of the entity and industry norms. Specifically we challenged assumptions relating to the ability to reclaim VAT when valuing the assets; and — **Accounting analysis:** We assessed the accounting treatment of the adjustments made for the changes in valuation of the Group and Trust's land and buildings following the valuation. **Our findings** — We found the resulting valuation to be optimistic.

	The risk	Our response
Recognition of NHS and non-NHS income £465.2 million; 2017-18: £448.7 million *Refer to page 30 (Audit Committee Report), page 123 (accounting policy) and page 135 (financial disclosures)*	**2018/19 Income** Of the Group's reported total income, £440.5 million (2017-18: £385.5m) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Four CCGs and NHS England make up 30% (2017-18: 30%) of the Group's income. The Group and Trust receives income on a block contract basis so there is certainty in the future forecasts at the start of the financial year but variations can occur. Other performance based income, such as the Provider Sustainability Fund, is received from NHS Improvement (via local CCGs). This results in estimates being required at the year end. Income from NHS England and CCGs is captured through the Agreement of Balances exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Group and Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes. Income in relation to patient care activities from Local authorities was £48.5m in 2018/19 (2017/18: £47.9m). Income from local authorities presents a great risk to the Trust as this income can take longer to collect meaning there is more judgement regarding the level to recognise at the year end.	Our procedures included: **Control operation:** — For the Group and Trust's five largest commissioners we inspected documentation to confirm that contracts had been agreed for the delivery of services; — For the Group and Trust's five largest commissioners we considered whether contract activity had been agreed with the commissioners by inspecting contract meeting minutes; and — We considered the extent to which the Group and Trust had agreed the income it was entitled to for 2018-19 through its participation in the Agreement of Balances exercise. **Tests of detail:** — We inspected supporting documentation for variances over £300,000 arising from the Agreement of Balances exercise to critically assess the Group and Trust's accounting for disputed income; — For income not included within the agreement of balances exercise we inspected supporting evidence, including invoices and receipt of cash on bank statements, for a sample of transactions recorded during the year; — We inspected a sample of sales made at the end of the financial year to assess whether they had been recorded within the correct period; — We inspected bank statements and the year-end confirmation received from NHS Improvement of the Group and Trust's entitlement to Provider Sustainability Funding for 2018-19; and — We inspected the prudence applied for the Group and Trust's calculation of accrued income that had commenced but not been completed at 31 March 2019 to assess the accuracy of the data used and calculation of the income the Group and Trust was entitled to; and **Our findings** — We found no errors which are above our £300,000 reporting threshold.

	The risk	Our response
Expenditure recognition - Operating expenses (£516.8 million; 2017-18: £490.0 million) *Refer to page 30 (Audit Committee Report), page 124 (accounting policy) and page 151 (financial disclosures)*	**Effects of irregularities** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As the Group and Trust fulfils some of the characteristics of a governmental body there is as much focus on the expenditure being incurred as the generation of revenue. The risk of material misstatement due to fraud related to expenditure recognition may therefore be as significant as the risk of material misstatements due to fraud related to revenue recognition and so we have had regard to this when planning and performing audit procedures. We consider this risk to relate to the completeness of the expenditure recorded as there may be an incentive to seek to defer expenditure in order to achieve financial targets. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions. The Group and Trust agreed a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: — **Historical comparison:** We considered the trend in accruals compared to prior periods to assess the accuracy of accruals made in previous years. Where accruals had not been included we critically assessed the reason for an accrual not being made at 31 March 2019. **Tests of detail:** — We inspected transactions incurred around the end of the financial year to critically assess whether they had been included within the correct accounting period; — We inspected a sample of accruals made at 31 March 2019 for expenditure but not yet invoiced to assess whether the valuation of the accrual was consistent with the value billed after the year end; and — We inspected manual journals posted as part of the year end accounts preparation that reduced expenditure recorded by the Group and Trust to assess whether there was appropriate supporting evidence for the reduction in expenditure. **Our findings** — We found no errors which are above our £300,000 reporting threshold.

	The risk	Our response
Valuation of Intangible Assets (£30.3 million; 2017-18: £37.2 million) *Refer to page 30 (Audit Committee Report), page 127 (accounting policy) and page 143 (financial disclosures)*	**Subjective valuation** As at 31 March 2019 the Group and Trust held £30.3 million on intangible assets as a result of investment plan to update the IT Infrastructure and implement a new clinical system. During 2017/18 the IT infrastructure asset became operational. In 2018/19 the Clinical systems became operational as defined by five key criteria set out by the Informatics Committee. This transfer from assets under construction triggered a revaluation of the capitalised asset and an impairment of £11.9m to be recognised. The Trust appointed professional advisers to support its own analysis of the balance to be capitalised and to assess the potential future value of the clinical system and asset live is applied to it.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the expertise and qualifications of the valuers engaged by the Group and Trust. We inspected the instructions for preparing the valuation to confirm that it was prepared in accordance with the International Accounting Standard 36; — **Methodology choice:** we compared reported performance of the clinical system asset to the criteria identified to determine whether it was operational and to understand the asset life that has been applied to it. **Tests of detail:** — We selected a sample of intangible asset additions and agree them to supporting evidence to determine whether they were accurate and appropriate to be capitalised; — We gained an understanding of the basis on which the specialist had performed the revaluation and assessed the completeness of data sent to be reviewed; — We inspected the asset lives and understood why any changes occurred; and — We inspected the treatment of any revaluations and impairments that were recognised in the financial statements. **Our findings** — We found the resulting estimate to be balanced.

3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £9.9 million (2017-18: £9.0 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £9.8 million (2017-18: £9 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2017-18:(£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the Group's two (2018: one) reporting components, we subjected one to a full scope audits for group purposes and one (2018: none) to specified risk-focused audit procedures. The component was not individually financially significant enough to require a full scope audit for group purposes, but did present specific individual risks that needed to be addressed. The components within the scope of our work accounted for the percentages illustrated opposite.

Operating Income
£465.2m (2017-18: £448.7m)

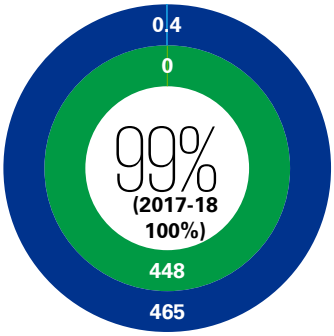
Group Materiality
£9.9m (2017-18: £9.0m)

£9.9m
Whole financial statements materiality (2017-18: £9.0m)

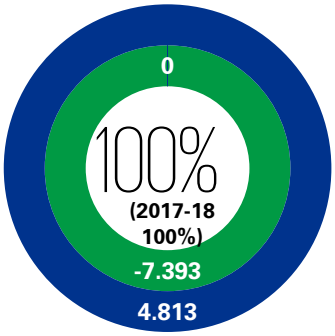
£9.8m
Parent Trust materiality (2017/18: £9.0m)

£0.3m
Misstatements reported to the audit committee (2017-18: £0.25m)

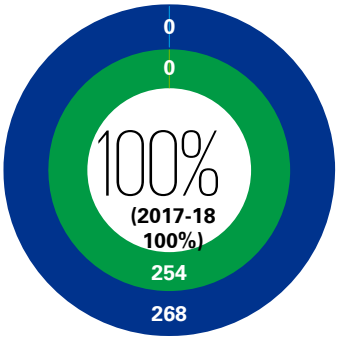
Group income

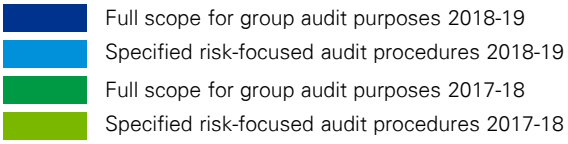


Group surplus/deficit



Group total assets





4. We have nothing to report on going concern

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

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group or the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Group's and Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1.12 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Group and Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 55, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— 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.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources..

We have nothing to report in this respect.

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Group and Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant risk	Description	Work carried out and conclusion
Achieving Value in Investment of IT	Over recent years the Trust has seen a significant increase in the balance of its intangible assets as a result of the CGI contract to transform its IT infrastructure.	Our work included: — We considered how impairments were recognised and disclosed in the losses and special payments note; — We considered how the programmes are monitored and reviewed and how qualitative outcomes are reviewed. — We inspected how the Trust applied appropriate cost control to the programmes in 2018/19 and how remaining costs will be controlled. — We inspected programme monitoring procedures through the governance structure including discussions in public papers such as Board meeting minutes. **Our findings on this risk area:** — We found the impairment had been correctly disclosed in the financial statements. Programme monitoring, review and cost control procedures were appropriate and performed at appropriate levels of the governance structure with oversight through the Board (in public and private) and through the established committee structure.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Central and North West London NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Neil Thomas
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
15 Canada Square, Canary Wharf, London, E14 5GL

29 May 2019

Foreword to the accounts

These accounts, for the year ended 31 March 2019, have been prepared by Central and North West London NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Claire Murdoch CBE
Chief Executive
Date: 28 May 2019

Statement of Comprehensive Income

		Group	
		2018-19	2017-18
	Note	£000	£000
Operating income from patient care activities	2	465,247	448,709
Other operating income	2.4	42,883	41,257
Operating expenses	3.1	(519,912)	(489,962)
Operating surplus/(deficit) from continuing operations		**(11,782)**	**5**
Finance income	8	127	51
Finance expenses	9	(64)	(73)
PDC dividends payable		(8,231)	(8,033)
Net finance costs		**(8,168)**	**(8,055)**
Other gains / (losses)	10	2,137	655
Surplus / (deficit) for the year from continuing operations		**(17,812)**	**(7,396)**
Surplus / (deficit) for the year		**(17,812)**	**(7,396)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	14.5	(15,833)	-
Revaluations	14.5	27,352	-
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive expense for the period		**(6,293)**	**(7,396)**
Deficit for the period attributable to:			
Central and North West London NHS Foundation Trust		(17,812)	(7,396)
TOTAL		**(17,812)**	**(7,396)**
Total comprehensive expense for the period attributable to:			
Central and North West London NHS Foundation Trust		(6,293)	(7,396)
TOTAL		**(6,293)**	**(7,396)**

Statement of Financial Position

	Note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	13	30,407	37,206	30,338	37,206
Property, plant and equipment	14	235,294	226,359	193,080	226,359
Receivables Loan		-	-	45,168	-
Other assets – Finance Lease		-	-	45,168	-
Total non-current assets		**265,701**	**263,566**	**313,754**	**263,566**
Current assets					
Inventories	16	166	358	166	358
Receivables	17	55,755	59,984	59,037	59,984
Cash and cash equivalents	18	19,453	16,405	17,637	16,405
Total current assets		**75,374**	**76,747**	**76,840**	**76,747**
Current liabilities					
Trade and other payables	19	(62,213)	(63,328)	(62,703)	(63,328)
Borrowings	21	(725)	(719)	(725)	(719)
Provisions	23	(227)	(1,265)	(227)	(1,265)
Other liabilities	20	(13,745)	(10,754)	(13,745)	(10,754)
Total current liabilities		**(76,910)**	**(76,066)**	**(77,401)**	**(76,066)**
Total assets less current liabilities		**264,165**	**264,247**	**313,193**	**264,247**
Non-current liabilities					
Trade and other payables		(1,935)	(2,133)	(1,935)	(2,133)
Borrowings	21	(3,956)	(4,674)	(3,956)	(4,674)
Finance Lease Liability		-	-	(45,168)	-
Provisions	23	(1,343)	(1,502)	(1,343)	(1,502)
Other liabilities	20	-	-	-	
Total non-current liabilities		**(7,234)**	**(8,309)**	**(52,402)**	**(8,309)**
Total assets employed		**256,931**	**255,939**	**260,791**	**255,939**
Financed by					
Public dividend capital		143,367	136,290	143,367	136,290
Revaluation reserve		73,214	64,157	73,214	64,157
Income and expenditure reserve		40,349	55,492	44,209	55,492
Total taxpayers' equity		**256,931**	**255,939**	**260,791**	**255,939**

The notes on pages 123 to 161 form part of these accounts.

Claire Murdoch CBE
Chief Executive
Date: 28 May 2019

Hardev Virdee
Chief Finance Officer
Date: 28 May 2019

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 – brought forward	**136,290**	**64,157**	**55,492**	**255,939**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	208	**208**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(17,812)	**(17,812)**
Other transfers between reserves	-	(1,000)	1,000	**-**
Impairments	-	(15,833)	-	**(15,833)**
Revaluations	-	27,352	-	**27,352**
Transfer to retained earnings on disposal of assets	-	(1,462)	1,462	**-**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	7,078	-	-	**7,078**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2019	**143,367**	**73,214**	**40,349**	**256,931**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 – brought forward	**135,590**	**66,226**	**60,819**	**262,635**
Taxpayers' and others' equity at 1 April 2017 – restated	**135,590**	**66,226**	**60,819**	**262,635**
Surplus/(deficit) for the year	-	-	(7,396)	**(7,396)**
Transfer to retained earnings on disposal of assets	-	(1,044)	1,044	**-**
Other recognised gains and losses	-	(1,025)	1,025	**-**
Public dividend capital received	700	-	-	**700**
Taxpayers' and others' equity at 31 March 2018	**136,290**	**64,157**	**55,492**	**255,939**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 – brought forward	**136,290**	**64,157**	**55,492**	**255,939**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	208	**208**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(17,101)	**(17,101)**
Other transfers between reserves	-	(1,000)	1,000	**-**
Impairments	-	(15,833)	-	**(15,833)**
Revaluations	-	27,352	-	**27,352**
Transfer to retained earnings on disposal of assets	-	(1,462)	1,462	**-**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	7,078	-	-	**7,078**
Other reserve movements	-	-	3,149	**3,149**
Taxpayers' and others' equity at 31 March 2019	**143,367**	**73,214**	**44,209**	**260,791**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 – brought forward	**135,590**	**66,226**	**60,819**	**262,635**
Taxpayers' and others' equity at 1 April 2017 – restated	**135,590**	**66,226**	**60,819**	**262,635**
Surplus/(deficit) for the year	-	-	(7,396)	**(7,396)**
Transfer to retained earnings on disposal of assets	-	(1,044)	1,044	**-**
Other recognised gains and losses	-	(1,025)	1,025	**-**
Public dividend capital received	700	-	-	**700**
Taxpayers' and others' equity at 31 March 2018	**136,290**	**64,157**	**55,492**	**255,939**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	Group 2018-19 £000	Group 2017-18 £000	Trust 2018-19 £000	Trust 2017-18 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(11,782)	5	(11,782)	5
Non-cash income and expense:					
Depreciation and amortisation	3.1	8,932	7,949	8,932	7,949
Net impairments	4	22,803	14,123	22,803	14,123
(Increase) / decrease in receivables and other assets		1,457	(6,551)	1,095	(6,551)
(Increase) / decrease in inventories		192	(147)	192	(147)
Increase / (decrease) in payables and other liabilities		1,500	6,689	(624)	6,689
Increase / (decrease) in provisions		(1,197)	(1,703)	(1,197)	(1,703)
Other movements in operating cash flows		(54)	1	-	1
Net cash flows from / (used in) operating activities		**21,852**	**20,365**	**19,420**	**20,365**
Cash flows from investing activities					
Interest received		127	51	127	51
Purchase of intangible assets		(12,383)	(6,088)	(12,314)	(6,088)
Sales of intangible assets		-	-	-	-
Purchase of PPE and investment property		(12,012)	(10,192)	(11,464)	(10,192)
Sales of PPE and investment property		6,482	235	6,482	235
Cash from acquisitions / disposals of subsidiaries		-	-	-	-
Net cash flows from / (used in) investing activities		**(17,785)**	**(15,994)**	**(17,169)**	**(15,994)**
Cash flows from financing activities					
Public dividend capital received		7,078	700	7,078	700
Movement on loans from DHSC		(719)	(718)	(719)	(718)
Interest on loans		(64)	(73)	(64)	(73)
PDC dividend (paid) / refunded		(7,313)	(8,519)	(7,313)	(8,519)
Net cash flows from / (used in) financing activities		**(1,019)**	**(8,611)**	**(1,019)**	**(8,611)**
Increase / (decrease) in cash and cash equivalents		**3,048**	**(4,239)**	**1,232**	**(4,239)**
Cash and cash equivalents at 1 April – brought forward		**16,405**	**20,644**	**16,405**	**20,644**
Cash and cash equivalents at 1 April – restated		**16,405**	**20,644**	**16,405**	**20,644**
Cash and cash equivalents at 31 March	**18**	**19,453**	**16,405**	**17,637**	**16,405**

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 2018-19 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the forseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.2 Interests in other entities

Charitable Funds

For the year to 31 March 2019, NHS Foundation Trusts had the option to consolidate the results of charities in which they hold a controlling interest and for which the transactions involved were considered to be material to the accounts of the Trust. The Trust is the corporate trustee of ' The Central and North West London Foundation Trust Charitable Funds'. The results of this charity have not been consolidated into the results of the Trust on the grounds of materiality. The total unaudited incoming resources for the year to 31 March 2019 were £334k and total net assets were estimated at £7,004k.

Subsidiaries

Quality Trusted Solutions (QTS) is a wholly owned subsidiary of Central and North West London NHS Foundation Trust (CNWL). QTS is a limited liability partnership (LLP) where CNWL is the predominant partner with 99.99% ownership and CNWL Holdings Limited, set up with no purpose other than acting as the other required partner to the LLP. CNWL Holdings Limited itself is wholly owned by the Trust.The company was incorporated in September 2017 but commenced trading on 1st April 2018. CNWL has produced consolidated financial statement for 2018-19 for the group and as required has incorporated the trading activities of QTS.

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

Note 1.3 Revenue

Note 1.3.1 Revenue from contracts with customers

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income

relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.3.2 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.

Note 1.3.3 Revenue from Research Grants

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.

Note 1.3.4 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.5 Other income

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

Note 1.4 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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.

Employer's pension cost 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 1.5 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 1.6 Pooled Budgets

The Trust has entered into pooled budget agreements with the London Borough of Harrow. Under the arrangements, funds are pooled under section 75 of the National Health Service Act 2006 for joint activities. Each of the pools is hosted by the Trust. Payments for services provided by the Trust are accounted for as income from Local Authorities. In accordance with IFRS12 – the Trust accounts for its share of assets. liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation

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

All land and buildings are revalued using professional valuations in accordance with IAS 16. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RCIS) Appraisal and Valuation manual. The most recent asset valuation was undertaken by external valuers GVA as at 31 March 2019.

The method of valuation used was as follows:

From the gross replacement cost for the building, a valuation judgement is made regarding the physical, functional and external obsolescence factors which can be applied to depreciate the assumed new gross replacement value of the building. These three factors are then combined and weighted according to how much influence each depreciation type is likely to have according to the type of operation that is run from the property concerned. The depreciated building value is then added to the land value.

Specialised assets:

For specialised assets, the depreciated replacement cost (DRC) method was used to arrive at a fair value. The International Valuation Standards definition of 'specialised property' is; "certain types of properties which are rarely, if ever, sold in the open market...due to uniqueness arising from its specialised nature and design, configuration, size, location, or otherwise."

The cost of the modern equivalent reflects two elements – land and buildings. The land is based on the least price that a prudent purchaser would pay for the land and is based on open market values. This is based on open market transaction evidence. The cost of providing a modern equivalent building is based on market prices that are directly observed. All assumptions follow the RICS Valuation Information Paper 10.

Non-specialised assets:

Assets valued on an existing use basis are non specialised properties which are occupied solely by the Trust for its own purposes. This includes property assets such as office accommodation. The fair values of these assets were arrived at by comparison to transactions of similar property in the market place. A market capital value per square foot was then applied to the net internal area provided to arrive at a total capital value. It is evidence therefore that the existing use values were determined directly by reference to observable market transactions.

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.

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

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

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.

Depreciation

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

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

Revaluation gains and losses

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

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.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price

- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. 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.

The income on sale of an asset is only recognised when the actual proceeds due from the sale have been received.

Note 1.7.4

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.

Note 1.7.5

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	Max life
	Years	Years
Buildings, excluding dwellings	50	75
Dwellings	-	-
Plant & machinery	5	10
Information technology	5	8
Furniture & fittings	7	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 1.8 Intangible assets

Note 1.8.1 Recognition

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

Software

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

Measurement

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

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

Subsequently intangible assets are measured at fair value. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains, 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 under IFRS 13, if it does not meet the requiremnts of IAS 40 or IFRS 5.

In 2014, a Full Business Case was approved by the Trust to procure a single clinical system across the Trust. The capital cost estimated was c£14.0 million with a new system to be delivered within 2-years. The total (nominal) capital cost incurred is £21.7m. Uplifted for inflation over the years, the inflated capital cost is £22.5m. The Trust has been spending

capital for the clinical systems re procurement and implementation since 2013-14. Since 2013-14, the capital costs have been recognised on the balance sheet as intangible assets in the course of construction (AICC). It is now agreed that the Clinical System, from an accounting point of view, will be brought in to use and as such recognised as an intangible asset and not AUC. It is now agreed that the Clinical System, from an accounting point of view, will be brought in to use and as such recognised as an intangible asset and not AUC

CNWL developed an ambitious ICT Strategy several years ago recognising that achieving the Trust's strategic goals were dependent upon the successful delivery of a number of important changes /enablers, one of the most important of which was better ICT. The Trust recognised that the infrastructure provision, developed piecemeal due to the growth of the Trust through acquisition, was not fit for purpose as it does not meet the Trust's future needs as there were significant reliability, security and operational risks inherent in the provision and unable to support the many of its clinical services plans for future development.

The ICT Strategy clearly identified the need for the provision of resilient, reliable and secure ICT infrastructure services to form the foundation for the rest of the ambitious and innovative strategic programme of work that will ultimately enable the deliver:

- efficiencies across the NHS as reflected in CNWL's internal cost improvement plans. Better ICT infrastructure is seen as a key enabler to greater efficiency across the Trust's services, for example efficiency improvements that the Trust expects to make from the Strategic Clinical Systems;
- drive towards greater integration of services both within CNWL and with other providers in the health and social care community. Integration leads to requirements such as interoperability and the ability to share electronic patient records which in turn can lead to better service quality and further efficiencies across health and social care;
- changes required to support the national ICT strategy;
- ICT infrastructure to provide a firm base to support delivery of the Trust's strategic objectives such as growth and improved engagement;
- address weaknesses in the current ICT infrastructure such as the limited ability to support remote working, limited support for end-user devices and slow response from core ICT infrastructure – this need is essential to enable transformation of clinical service delivery;
- opportunity to improve ICT user experience through improvements such as greater use mobile working and unified communications (direct messaging, presentation sharing in meetings, video conferencing etc.).

The delivery of the IT Strategy's was underpinning by several work streams; key were the upgrading of the Trust's Strategic IT Infrastructure and Strategic Clinical Systems. The successful delivery of these two strategic programmes were the cornerstone to achieving the objectives set out in the IT Strategy.

The delivery of these programmes not only required significant investment but spanned several years to complete. The IT Strategic Infrastructure programme was operational across the Trust by January 2018. The Clinical Systems programme is fully operational across the Trust as at 31st March 2019.

The cost of developing these IT Projects has been reflected in the Trust's financial statements under 'Assets In the Course of Construction' for the past few years. The Strategic Infrastructure Programme, from an accounting point of view, was brought in to use at the end of January 2018 and as such recognised as an intangible asset. Similarly, the Clinical Systems Programme has also now been brought into use in 2019 and a susch is recognised as an intangible asset.

In line with the NHS Foundation Trust Annual Report Manual (ARM) the Trust is required to follow the accounting requirements as set out in the Department of Health Group Accounting Manual (GAM). Intangible assets are initially recognised in the balance sheet at cost. Following the initial recognition of an intangible asset, accounting rules require the Trust to assess a subsequent measurement; whether there is any indication that an asset may be impaired. For subsequent measurement GAM sets out possible options for valuation; and Depreciated Replacement cost was applied as the most appropriate form of measurement for valuation.

The Trust engaged Deloitte IT Valuation team to offer expert independent valuation advice to Trust Management for the IT Strategic Infrastructure Programme and the Clinical Services Programme and to comment on the valuation at Replacement cost proposed by the Trust's IT and Finance Teams. Depreciated Replacement Cost Valuation by CNWL IT Management was £13.0m; Deloitte £15.7m.

The differential relates to costs associated with the initial discovery phase.

The DRC Valuation of Trust's IT Management has been accepted as the DRC for the IT Platform resulting in an impairment of £14.123m.

The Trust engaged Deloitte IT Valuation team to offer expert independent valuation advice to Trust Management for the IT Strategic Infrastructure Programme and to comment on the valuation at Replacement cost proposed by the Trust's IT and Finance Teams. Depreciated Replacement Cost Valuation by CNWL IT Management was £13.0m; Deloitte £15.7m. The differential relates to costs associated with the initial discovery phase.

The DRC Valuation of Trust's IT Management has been accepted as the DRC for the IT Platform resulting in an impairment of £14.123m.

Management considered the Useful Economic Lives to be 10 years, this has been based on observation of similar disclosed assets in other provider financial statements, consideration of advice from IT staff within the Trust and professional advice commissions from Deloitte.

Amortisation

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

Note 1.0.1 Useful economic life of intangible assets

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

	Min life	Max life
	Years	Years
Development expenditure	8	12
Software licences	8	10

Note 1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is take to the Statement of Comprehensive Income to match that expenditure.

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 of valuation.

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

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.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

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

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

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 1.12 Leases

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

Note 1.12.1 The Trust as lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability 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.

Note 1.12.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.13 Provisions

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

The Trust commissioned an independant firm of professional actuaries to carry out a avaluation of the pension liabilityrelating ot injury benfits on the Trust's Statement of Financial Position. This related to costs as a result of staff taking early retirement upon th eclosire of two of the Trust's hospital in teh late 1990's. The valuation was carried out at 31st March 2013 by Barnett Waddingham LLP.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 28.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are

disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 2 and 5 unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

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

At any time, 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 assets (including lottery 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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year.

In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- is the activity an authorised activity related to the provision of core healthcare?

The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;

- is the activity actually or potentially in competition with the private sector?

Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax.

- Are the annual profits significant? Only significant trading activity is subject to tax.

Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core healthcare and are not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the £50,000 tax threshold.

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. 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, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 Charitable Funds

The Charitable Funds have not been consolidated with the accounts of the Foundation Trust on the grounds of materiality; the net total assets of the Charities were valued at £7,004k as at 31 March 2019.The charities involved is Central and North West London NHS Foundation Trust Charitable Fund (Registered Charity No. 1082989) .

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018-19.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

Details of accounting standards in issue but have not yet been adopted are provided in Note 35

Note 1.25 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are reviewed regularly.

Note 1.25.1 Critical judgements in applying accounting policies

There are no material judgements, except those involving estimates, which are disclosed below.

Note 1.25.2 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:

- Intangible valuations: A full valuation is undertaken of intangible assets as they move from assets under construction into use. This valuation is based on the IAS 36 requirements and is adopted by management after analysis by an external expert.
- PPE valuations: A full valuation was undertaken as at 31 March 2019. The valuations have been undertaken under IFRS, the RICS advises that

assumptions underpinning the concepts of fair value should be explicitly stated The Market Value (MV) for each property has been considered on the basis of the definition set out in Paragraph 1.2 of VPS4 of the RICS Valuation Standards. Our Fair Values are subject to adequate service potential, which is defined as: "The capacity of an asset to continue goods and services in accordance with the entity's objectives". We have assumed that the current use/services would still be provided by the NHS in the locality of the individual properties.

- Payables: The Trust has included within the accounts £13.7m of accruals. This is considered by the Trust to contain an estimate as up to c.£6.4m of the balances contain an estimate of good and services received or provided across the Trust but not yet invoiced.

In the view of the Trust there are no further estimates or judgements which if wrong could significantly affect financial performance.

Note 1.26 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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation 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 expenses. 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.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Note 1.27 Segmental Reporting

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments. The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool. The Trust has also a single purpose in the provision of healthcare services

Note 2 Operating income from patient care activities (Group)

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

Note 2.1 Income from patient care activities (by nature)	2018-19 £000	2017-18 £000
Mental health services		
Cost and volume contract income	29,983	28,975
Block contract income	237,499	222,987
Clinical partnerships providing mandatory services (including S75 agreements)	5,878	5,820
Clinical income for the secondary commissioning of mandatory services	903	2,401
Other clinical income from mandatory services	12,764	9,806
Community services		
Community services income from CCGs and NHS England	131,751	138,299
Income from other sources (e.g. local authorities)	41,896	40,421
Total income from activities	**460,673**	**448,709**
Central funding – pay award	4,574	-
Income from activities	**465,247**	**448,709**

Note 2.2 Income from patient care activities (by source)	2018-19	2017-18
Income from patient care activities received from:	**£000**	**£000**
NHS England	83,489	81,203
Clinical commissioning groups	317,044	304,307
Department of Health and Social Care	4,933	-
Other NHS providers	10,571	12,398
NHS other	51	77
Local authorities	48,450	47,902
Non NHS: other	708	2,822
Total income from activities	**465,247**	**448,709**
Of which:		
Related to continuing operations	465,247	448,709
Related to discontinued operations	-	-

The income from the provision of goods and services for the purposes of the health service in England of total income has exceeded the income from the provision of goods and services for any other purposes. The other operating income has been mainly from activities related to education, training, research and development which have positive benefits on the provision of services in the NHS.

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

	2018-19	2017-18
	£000	£000
Cash payments received in-year	4	1
Amounts added to provision for impairment of receivables	24	128
Amounts written off in-year	-	-

Note 2.4 Other operating income (Group)

	2018-19	2017-18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	3,407	2,951
Education and training (excluding notional apprenticeship levy income)	12,423	13,448
Non-patient care services to other bodies	9,823	6,867
Provider sustainability / sustainability and transformation fund income (PSF / STF)	7,634	6,358
Income in respect of employee benefits accounted on a gross basis	-	-
Other contract income	9,596	11,633
Total other operating income	**42,883**	**41,257**
Of which:		
Related to continuing operations	42,883	41,257

Other income of £9,596k includes Training Income £1,612k, Rental and Service Charge income of £3,048k, Merit Award income of £611k and Drugs Recharge income of £817k.

Note 2.5 Additional information on contract revenue (IFRS 15) recognised in the period

	2018-19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	10,754

Note 2.6 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019
	£000
within one year	13,695
after one year, not later than five years	50
after five years	-
Total revenue allocated to remaining performance obligations	**13,745**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 2.7 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 license 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:

	2018-19	2017-18
	£000	£000
Income from services designated as commissioner requested services	416,089	397,985
Income from services not designated as commissioner requested services	49,158	50,725
Total	**465,247**	**448,709**

Note 2.8 Profits and losses on disposal of property, plant and equipment

	Parkside
	£000
Sale proceeds	**4,353**
Net book value:	
Land- AHFS	1,348
Bldg AHFS	585
BLDG depn AHFS	-
Net book value total	**1,933**
Legals	136
Selling cost	**136**
Profit on sale	**2,284**
Derecognition of lease in year	**(147)**

Note 3.1 Operating expenses (Group)

	2018-19	2017-18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,095	8,465
Purchase of healthcare from non-NHS and non-DHSC bodies	8,708	5,486
Staff and executive directors costs	347,516	337,292
Remuneration of non-executive directors	144	143
Supplies and services – clinical (excluding drugs costs)	13,733	13,018
Supplies and services – general	10,027	8,750
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	30,294	31,033
Inventories written down	-	21
Consultancy costs	2,330	2,321
Establishment	5,411	6,039
Premises	35,325	32,771
Transport (including patient travel)	4,609	3,776
Depreciation on property, plant and equipment	6,427	6,733
Amortisation on intangible assets	2,505	1,216
Net impairments	22,803	14,123
Movement in credit loss allowance: contract receivables / contract assets	(132)	-
Movement in credit loss allowance: all other receivables and investments	-	(405)
Increase/(decrease) in other provisions	-	(1,553)
Audit services- statutory audit	116	98
Other auditor remuneration (external auditor only)	21	7
Clinical negligence	1,384	1,068
Legal fees	1,375	1,327
Insurance	254	60
Research and development	3,225	3,669
Education and training	988	928
Rentals under operating leases	12,362	11,302
Early retirements	-	-
Redundancy	123	(28)
Hospitality	848	770
Losses, ex gratia & special payments	569	214
Other	3,852	1,319
Total	**519,912**	**489,962**
Of which:		
Related to continuing operations	519,912	489,962
Related to discontinued operations	-	-

Note 3.2 Other auditor remuneration (Group)

	2018-19 £000	2017-18 £000
Other auditor remuneration paid to the external auditor:		
1a. Audit Services – Statutory	79	75
1b. Audit Services – Subsidiary	18	-
2. Audit-related assurance services	13	7
3. Other non-audit services not falling within items 2 to 7 above	8	8
	118	**90**

Note 3.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1m (2017-18 £1m)

Note 4 Impairment of assets (Group)

	2018-19 £000	2017-18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	10,846	-
Other	11,932	14,123
Total net impairments charged to operating surplus / deficit	**22,803**	**14,123**
Impairments charged to the revaluation reserve	15,833	-
Total net impairments	**38,636**	**14,123**

Impairment of £11,9k above relates to the revaluation of Intangible Assets (clinical systems) that have been brought in to use in the current year. A revaluation exercise of the Trust's Estate was also carried out in 2018-19 and the related impairment is disclosed in the note above.

Note 5 Employee benefits (Group)

	2018-19 Total £000	2017-18 Total £000
Salaries and wages	273,857	263,433
Social security costs	26,966	25,859
Apprenticeship levy	1,317	1,273
Employer's contributions to NHS pensions	32,522	31,732
Temporary staff (including agency)	13,579	15,679
Total gross staff costs	**348,240**	**337,974**
Recoveries in respect of seconded staff	-	-
Total staff costs	**348,240**	**337,974**
Of which		
Costs capitalised as part of assets	724	682

Note 5.1 Retirements due to ill-health (Group)

During 2018-19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £115k (£102k in 2017-18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

Note 5.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2018-19 £000	2017-18 £000
Salary	1,108	1,141
Taxable benefits	2	12
Performance related bonuses		
Employer's pension contributions	118	138
Total	**1,228**	**1,291**

Total remuneration paid to directors for the year ended 31 March 2019 (in their capacity as directors) totalled £1.10million (year ended 31 March 2018 £1.14 million). No other remuneration was paid to directors in their capacity as directors. There were no advances or guarantees entered into on behalf of directors by the Trust. Employer contributions to the NHS Pension Scheme for Executive Directors for the year ended 31 March 2019 totalled £118k (for year ended 31 March 2018 £138k). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 6 (year ended 31 March 2018 – 6). Further details of directors' remuneration can be found in the remuneration report.

Note 6 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 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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.

CNWL offers an additional defined contribution pension scheme – the National Employment Savings Trust (NEST).

Note 7 Operating leases (Group)

Note 7.1 Central and North West London NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Central and North West London NHS Foundation Trust is the lessor.

The Trust has no operating leases as a lessor.

Note 7.2 Central and North West London NHS Foundation Trust as a lessee

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

	2018-19 £000	2017-18 £000
Operating lease expense		
Minimum lease payments	12,362	11,302
Total	**12,362**	**11,302**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
not later than one year;	12,474	10,861
later than one year and not later than five years;	25,829	20,584
later than five years.	41,318	40,315
Total	**79,620**	**71,760**
Future minimum sublease payments to be received	-	-

Note 8 Finance income (Group)

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

	2018-19 £000	2017-18 £000
Interest on bank accounts	127	51
Total finance income	**127**	**51**

Note 9 Finance expenditure (Group)

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

	2018-19 £000	2017-18 £000
Interest expense:		
Loans from the Department of Health and Social Care	64	73
Total interest expense	**64**	**73**
Total finance costs	**64**	**73**

Note 9.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

There was no late payment of commercial debt in 2018-19

Note 10 Gains/losses on disposal/derecognition of non-current assets (Group)

	2018-19 £000	2017-18 £000
Gains on disposal of non-current assets	2,137	655
Net gains on disposal of non-current assets	**2,137**	**655**

Note 11 Discontinued operations

There were no discontinued operations in the current year.

Note 12 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £17.1 million (2017-18: £7.4 million). The trust's total comprehensive expense for the period was £5.5 million (2017-18: £7.4 million).

Note 13 Intangible assets – 2018-19

Group	Software licences	Development expenditure	Intangible assets under construction	Total	Trust
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 – brought forward	**3,898**	**21,181**	**17,475**	**42,553**	**42,553**
Additions	-	3,324	4,310	7,634	7,565
Impairments	-	-	(11,928)	(11,928)	(11,928)
Reclassifications	-	9,856	(9,856)	-	-
Valuation / gross cost at 31 March 2019	**3,898**	**34,361**	**-**	**38,259**	**38,190**
Amortisation at 1 April 2018 – brought forward	**1,851**	**3,496**	**-**	**5,347**	**5,347**
Provided during the year	389	2,116	-	2,505	2,505
Amortisation at 31 March 2019	**2,240**	**5,612**	**-**	**7,852**	**7,852**
Net book value at 31 March 2019	**1,658**	**28,749**	**-**	**30,407**	**30,338**
Net book value at 1 April 2018	**2,047**	**17,685**	**17,475**	**37,206**	**37,206**

All intangible assets are owned by both the Trust and Group

Note 13.1 Intangible assets – 2017-18

Group	Software licences	Development expenditure	Intangible assets under construction	Total	Trust
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 – as previously stated	**7,661**	**4,832**	**36,184**	**48,677**	**48,677**
Prior period adjustments	-	-	-	**-**	
Valuation / gross cost at 1 April 2017 – restated	**7,661**	**4,832**	**36,184**	**48,677**	**48,677**
Gross cost at start of period for new FTs	**-**	**-**	**-**	**-**	
Transfers by absorption	-	-	-	**-**	
Additions	-	-	8,305	**8,305**	8,305
Impairments	-	-	(14,123)	**(14,123)**	(14,123)
Reversals of impairments	-	-	-	**-**	
Revaluations	**-**	**-**	**-**	**-**	
Reclassifications	(3,459)	16,349	(12,890)	**-**	-
Transfers to / from assets held for sale	**-**	**-**	**-**	**-**	
Disposals / derecognition	(304)	-	-	**(304)**	(304)
Transfer to FT upon authorisation	-	-	-	**-**	
Valuation / gross cost at 31 March 2018	**3,898**	**21,181**	**17,475**	**42,553**	**42,553**
Amortisation at 1 April 2017 – as previously stated	**4,161**	**275**	**-**	**4,436**	**4,436**
Prior period adjustments	-	-	-	**-**	
Amortisation at 1 April 2017 – restated	**4,161**	**275**	**-**	**4,436**	**4,436**
Provided during the year	389	827	-	**1,216**	1,216
Reclassifications	(2,394)	2,394	-	**-**	-
Disposals / derecognition	(304)	-	-	**(304)**	(304)
Amortisation at 31 March 2018	**1,851**	**3,496**	**-**	**5,347**	**5,347**
Net book value at 31 March 2018	**2,047**	**17,685**	**17,475**	**37,206**	**37,206**
Net book value at 1 April 2017	**3,500**	**4,557**	**36,184**	**44,241**	**44,241**

Note 14 Property, plant and equipment – 2018-19

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Trust (Buildings exduding dwellings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2018 – brought forward	**70,944**	**163,304**	**1,698**	**1,295**	**0**	**1,705**	**2,827**	**241,773**	**163,304**
Additions	-	15,005	384	307	8	416	760	16,879	14,810
Impairments	(3,776)	(12,337)	-	-	-	-	-	(16,113)	(12,337)
Reversals of impairments	-	280	-	-	-	-	-	280	280
Revaluations	15,180	(12,038)	(29)	-	-	-	-	3,113	(12,038)
Reclassifications	-	1,737	(2,052)	15	-	295	6	0	1,737
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	(1,348)	(1,092)	-	-	-	-	-	(2,440)	(43,111)
Valuation/ gross cost at 31 March 2019	**81,000**	**154,858**	**0**	**1,617**	**8**	**2,416**	**3,593**	**243,491**	**112,644**
Accumulated depreciation at 1 April 2018 – brought forward	**-**	**12,647**	**-**	**516**	**0**	**1,379**	**872**	**15,414**	**12,647**
Provided during the year	-	5,773	-	149	2	206	297	6,427	5,773
Impairments	1,032	11,011	29	-	-	-	-	12,072	11,011
Reversals of impairments	(28)	(1,169)	-	-	-	-	-	(1,197)	(1,169)
Revaluations	(1,004)	(23,207)	(29)	-	-	-	-	(24,240)	(23,207)
Disposals / derecognition	-	(279)	-	-	-	-	-	(279)	(279)
Accumulated depreciation at 31 March 2019	**-**	**4,777**	**-**	**665**	**2**	**1,585**	**1,169**	**8,198**	**4,777**
Net book value at 31 March 2019	**81,000**	**150,081**	**0**	**952**	**6**	**831**	**2,424**	**235,294**	**107,867**
Net book value at 1 April 2018	**70,944**	**150,657**	**1,698**	**779**	**0**	**326**	**1,955**	**226,359**	**150,657**

There are no differences between values of Group and Trust above, except for Buildings excluding dwellings. The Trust numbers above reflect the transfer of assets to the subsidiary under the disposal line.

Note 14.1 Property, plant and equipment – 2017-18

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Trust
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 – brought forward	71,455	155,910	87	3,405	281	8,055	2,737	**241,930**	241,930
Additions	-	8,662	1,682	167	-	50	365	**10,926**	10,926
Reclassifications	-	(4)	(72)	-	-	66	10	**-**	-
Transfers to / from assets held for sale	(210)	(496)	-	-	-	-	-	**(706)**	(706)
Disposals / derecognition	(300)	(769)	-	(2,278)	(281)	(6,465)	(284)	**(10,376)**	(10,376)
Valuation/ gross cost at 31 March 2018	**70,944**	**163,304**	**1,698**	**1,295**	**0**	**1,705**	**2,827**	**241,773**	**241,773**
Accumulated depreciation at 1 April 2017 – brought forward	-	6,647	-	2,669	281	7,549	906	**18,053**	18,053
Provided during the year	-	6,065	-	124	-	294	250	**6,733**	6,733
Transfers to / from assets held for sale	-	(27)	-	-	-	-	-	**(27)**	(27)
Disposals / derecognition	-	(38)	-	(2,278)	(281)	(6,465)	(284)	**(9,346)**	(9,346)
Accumulated depreciation at 31 March 2018	**-**	**12,647**	**-**	**516**	**0**	**1,379**	**872**	**15,414**	**15,414**
Net book value at 31 March 2018	**70,944**	**150,657**	**1,698**	**779**	**0**	**326**	**1,955**	**226,359**	**226,359**
Net book value at 1 April 2017	**71,455**	**149,263**	**87**	**735**	**0**	**506**	**1,830**	**223,877**	**223,877**

Note 14.2 Property, plant and equipment financing – 2018-19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total	Trust (Buildings excluding dwellings
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019											
Owned – purchased	81,000	150,081	-	-	952	6	831	2,424	-	235,294	107,867
NBV total at 31 March 2019	**81,000**	**150,081**	**-**	**-**	**952**	**6**	**831**	**2,424**	**-**	**Total Group 235,294**	**Total Trust 246,451**

Note 14.3 Property, plant and equipment financing – 2017-18

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total	Trust
	£000	£000	£000	£000	£000	£000	£000		£000	£000
Net book value at 31 March 2018										
Owned – purchased	70,944	150,657	-	1,698	779	-	326	**1,955**	226,359	226,359
NBV total at 31 March 2018	**70,944**	**150,657**	**-**	**1,698**	**779**	**-**	**326**	**1,955**	**226,359**	**226,359**

All assets as reported are owned by the Trust and none are attributable to government grants or funded by finance leases.

Note 14.4 Donations of property, plant and equipment – 2018-19

There were no donations received from any parties for any purchase of assets.

Note 14.5 Revaluations of property, plant and equipment

	2018-19	2017-18
	£000	£000
Revaluation reserve at 1 April 2018 – brought forward	**64,157**	**66,226**
Net impairments	**(15,833)**	**-**
Revaluations	**27,352**	**-**
Transfer to I&E reserve upon asset disposal	**(1,462)**	**(1,044)**
Other recognised gains and losses	**(1,000)**	**(1,025)**
Revaluation reserve at 31 March 2019	**73,214**	**64,157**

Note 15 Disclosure of interests in other entities

Quality Trusted Solutions(QTS) is a wholly owned subsidiary of Central and North West London NHS Foundation Trust (CNWL).QTS is a limited liability partnership (LLP) where the CNWL is the predominant partner with 99.99% ownership and CNWL Holdings Limited, set up with no purpose other than acting as the other required partner to the LLP. CNWL Holdings Limited itself is wholly owned by the Trust. The company was incorporated in September 2017 but commenced trading on 1st April 2018. CNWL has produced consolidated financial statement for 2018/19 for the group and as required incorporate the trading activities of QTS.

Note 16 Inventories

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Drugs	42	262	42	262
Energy	55	55	55	55
Other	69	41	69	41
Total inventories	**166**	**358**	**166**	**358**

Inventories recognised in expenses for the year were £1,836k (2017-18: £2,306k).
Write-down of inventories recognised as expenses for the year were £0k (2017-18: £21k).

Note 17 Receivables

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Contract receivables*	50,029		51,232	-
Trade receivables*		41,848		41,848
Capital receivables	-	2,129		2,129
Accrued income*		9,247		9,247
Allowance for impaired contract receivables / assets*	(3,757)		(3,757)	
Allowance for other impaired receivables	-	(4,672)	-	(4,672)
Prepayments (non-PFI)	8,409	9,472	8,035	9,472
PDC dividend receivable	-	852	127	852
VAT receivable	153	723	2,300	723
Other receivables	920	386	1,101	386
Total current receivables	**55,755**	**59,984**	**59,037**	**59,984**
Of which receivable from NHS and DHSC group bodies:				
Current	37,795	39,415	37,795	39,415
Non-current	-	-	-	-

*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. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 17.1 Allowances for credit losses – 2018-19

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2018 – brought forward		**4,672**		**4,672**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	4,465	(4,672)	4,465	(4,672)
New allowances arising	1,700	-	1,700	-
Changes in existing allowances	73	-	73	-
Reversals of allowances	(1,906)	-	(1,906)	-
Utilisation of allowances (write offs)	(575)	-	(575)	-
Allowances as at 31 Mar 2019	**3,757**	**-**	**3,757**	**-**

Note 17.2 Allowances for credit losses – 2017-18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group	Trust
	All receivables	All receivables
	£000	£000
Allowances as at 1 Apr 2017 – as previously stated	5,077	5,077
Prior period adjustments		
Allowances as at 1 Apr 2017 – restated	**5,077**	**5,077**
Transfers by absorption		
Increase in provision	2,077	2,077
Unused amounts reversed	(2,482)	(2,482)
Allowances as at 31 Mar 2018	**4,672**	**4,672**

Note 17.3 Non-current assets held for sale and assets in disposal groups

There were no assets held for sale and no assets in disposal groups.

Note 18 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.

	Group		Trust	
	2018-19	2017-18	2018-19	2017-18
	£000	£000	£000	£000
At 1 April	**16,405**	**20,644**	**16,405**	**20,644**
Net change in year	3,048	(4,239)	1,159	(4,239)
At 31 March	**19,453**	**16,405**	**17,564**	**16,405**
Broken down into:				
Cash at commercial banks and in hand	1,889	89	5	89
Cash with the Government Banking Service	17,564	16,316	17,632	16,316
Total cash and cash equivalents as in SoFP	**19,453**	**16,405**	**17,637**	**16,405**
Total cash and cash equivalents as in SoCF	**19,453**	**16,405**	**17,637**	**16,405**

Note 18.1 Third party assets held by the trust

Central and North West London NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Bank balances	310	641
Monies on deposit	800	800
Total third party assets	**1,110**	**1,441**

Note 19 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	26,159	24,805	28,958	24,805
Capital payables	8,204	8,086	1,878	8,086
Accruals	13,734	17,418	17,881	17,418
Receipts in advance and payments on account	141	5	141	5
Social security costs	4,174	4,003	4,155	4,003
Other taxes payable	3,438	3,275	3,422	3,275
PDC dividend payable	67	-	67	-
Accrued interest on loans*	-	7	-	7
Other payables	6,295	5,728	6,201	5,728
NHS charitable funds: trade and other payables	-	-	-	-
Total current trade and other payables	**62,213**	**63,328**	**62,703**	**63,328**
Non-current				
Trade payables	1,935	2,133	1,935	2,133
Finance lease payables	-	-	45,168	-
Total non-current trade and other payables	**1,935**	**2,133**	**47,103**	**2,133**
Of which payables from NHS and DHSC group bodies:				
Current	17,176	16,113	17,176	16,113

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 21. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 20 Other liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Deferred income: contract liabilities	13,745	10,754	13,745	10,754
Total other current liabilities	**13,745**	**10,754**	**13,745**	**10,754**

Note 21 Borrowings

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Loans from DHSC	725	719	725	719
Total current borrowings	**725**	**719**	**725**	**719**
Non-current				
Loans from DHSC	3,956	4,674	3,956	4,674
Total non-current borrowings	**3,956**	**4,674**	**3,956**	**4,674**

In 2015-16 the Trust obtained an unsecured borrowing facility of £6.8M from the Department of Health. This was used to invest in/support the IT capital programme. The loan is for a period of ten years ending on 18 August 2025. Capital of 5.25% is repayable in six month tranches on the principal outstanding. The first capital repayment was on the 18 August 2016; the last tranche is scheduled for 18 August 2025. Interest is payable at 1.25%.

Note 21.1 Reconciliation of liabilities arising from financing activities

Group	Loans from DHSC	Total	Trust
	£000	£000	£000
Carrying value at 1 April 2018	**5,393**	**5,393**	**5,393**
Cash movements:		-	-
Financing cash flows – payments and receipts of principal	(719)	(719)	(719)
Financing cash flows – payments of interest	(64)	(64)	(64)
Non-cash movements:		-	-
Impact of implementing IFRS 9 on 1 April 2018	7	7	7
Application of effective interest rate	64	64	64
Carrying value at 31 March 2019	**4,681**	**4,681**	**4,681**

Note 22 Finance leases

Note 22.1 Central and North West London NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Gross lease liabilities	**-**	**-**	**45,168**	**-**
of which liabilities are due:				
- not later than one year;	-	-	2,258	
- later than one year and not later than five years;	-	-	9,034	
- later than five years.	-	-	33,876	
Finance charges allocated to future periods	-	-		
Net lease liabilities	**-**	**-**	**45,168**	**-**

The Trust has a Finance Lease with its subsiidiary, Quality Trusted Solutions. The lease term is 20 years.

Note 23 Provisions for liabilities and charges analysis (Group)

Group	Pensions: injury benefits*	Redundancy	Total	Trust
	£000	£000	£000	£000
At 1 April 2018	**1,645**	**1,121**	**2,767**	**2,767**
Arising during the year	-	44	44	44
Utilised during the year	(120)	(906)	(1,026)	(1,026)
Reversed unused	-	(215)	(215)	(215)
At 31 March 2019	**1,526**	**44**	**1,570**	**1,570**
Expected timing of cash flows:				
- not later than one year;	183	44	227	227
- later than one year and not later than five years;	510	-	510	510
- later than five years.	833	0	833	833
Total	**1,526**	**44**	**1,570**	**1,570**

* In 2018-19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

Note 24 Clinical negligence liabilities

At 31 March 2019, £9,563k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Central and North West London NHS Foundation Trust (31 March 2018: £2,100k).

Note 25 Contingent assets and liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities				
Redundancy	-	-	-	-
Other	(81)	(69)	(81)	(69)
Gross value of contingent liabilities	**(81)**	**(69)**	**(81)**	**(69)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(81)**	**(69)**	**(81)**	**(69)**

Note 26 Contractual capital commitments

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	129	461	129	461
Intangible assets	38	83	38	83
Total	**167**	**544**	**167**	**544**

Note 27 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	47,192	**47,192**
Other investments / financial assets	-	**-**
Cash and cash equivalents	19,453	**19,453**
Consolidated NHS Charitable fund financial assets	-	**-**
Total at 31 March 2019	**66,645**	**66,645**

Group	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
Trade and other receivables excluding non financial assets	48,937	**48,937**
Other investments / financial assets	-	**-**
Cash and cash equivalents	16,405	**16,405**
Consolidated NHS Charitable fund financial assets	-	**-**
Total at 31 March 2018	**65,343**	**65,343**

Note 27.1 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	4,681	4,681
Trade and other payables excluding non financial liabilities	54,306	54,306
Total at 31 March 2019	**58,986**	**58,986**

Group	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	5,393	5,393
Trade and other payables excluding non financial liabilities	50,514	50,514
Total at 31 March 2018	**55,906**	**55,906**

Note 27.2 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	55,030	55,906
In more than one year but not more than two years	3,956	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**58,986**	**55,906**

Note 28 Losses and special payments

	2018-19		2017-18	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	25	27	17	10
Bad debts and claims abandoned	198	454	42	190
Total losses	**223**	**482**	**59**	**200**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	2	1
Ex-gratia payments	12	4	22	13
Total special payments	**13**	**5**	**24**	**14**
Total losses and special payments	**236**	**486**	**83**	**214**

Note 29 Events after the reporting date

There were no events to report after the reporting period

Note 30 Related parties

NHS Foundation Trusts are public benefit corporations established under the National Health Service Act 2006 (relevant provisions of which replaced the provisions of the Health and Social Care (Community Health and Standards) Act 2003 relating to NHS Foundation Trusts). The Department of Health is regarded as a related party. During the period, the Trust had a significant number of material transactions with the Department of Health and with other entities for which the Department of Health is regarded as the parent department i.e. NHS England, NHS Trusts, Clinical Commissioning Groups, NHS agencies and Special Health Authorities.

The bodies with which the Trust had major transactions with include: NHS England, NHS Property Services, London Specialised Commissioning Hub, Brent CCG, Camden CCG, Harrow CCG, Hillingdon CCG, Central London (Westminster) CCG and NHS West London. In addition the Trust had a number of material transactions with other Government bodies including central and local government bodies.

(1) Professor Dorothy Griffiths is a Non Executive Director at CNWL. She is also acting as Dorothy Griffiths Associates, offering training and consultancy services to corporates, individuals and NHS trusts. She is a Trustee of the Feminist Review Trust and also a Chair of the Feminist Review Trust. Through Imperial College, she provides consultancy services on strategy, change management and team working, to NHS trusts. She is also a Trustee of Imperial College Student Union. The Trust works with Imperial College on research projects. During the year it has paid £558k (2017-18 £487k) to the College, mostly for the recharge of staff time working on research projects. Recharge of staff time is determined based on salary rates and so is considered to be under market conditions. At 31 March 2019 the Trust had an outstanding balance of £112K (31 March 2018 – £0k) payable to Imperial College.

(2) Helen Edwards is a Non Executive Director at CNWL as well as a Trustee of Lloyds Bank Foundation and on the Board of Peabody Trust as well as on the Board of Social Finance UK. She is also the Chair of Recovery Focus.

(3) Mr Andy Mattin Director of Operations and Nursing at CNWL has declared an interest in Buckinghamshire New University as a Visiting Professor. His wife works as Director of Quality and Integrated Governance and Executive Nurse for Haringey Clinical Commissioning Group. The Trust has incurred approximately £5.5k of expenditure with services from the University; with £2.8k balance outstanding at year end 31 March 2019. He also provides consultancy advice to the Healthcare division of Ernst and Young on nursing and mental health.

(4) CNWL Chief Executive Ms. Claire Murdoch is National Mental Health Director, and also a Director of Imperial Health Partnership. She is also a trustee of the Board of the Bloomsbury Network Charitable Incorporated Organisation (CIO)

(5) Mr David Walker is a Non Executive Director at CNWL. He is also a member of Ethics and Governance Council at UK Biobank. His son is employed in CNWL.

(6) Mr Hardev Virdee Chief Finance Officer is a Trustee of The Point of Care Foundation charity which focuses on supporting carers and those they care for. This is a voluntary role. He also has a voluntary role as a member of the Health Panel for CIPFA (Chartered Institute of Public Finance and Accountancy) as well as a council member. The role is to review, assess and influence national health policy from the accountancy body perspective. He is also a Director of Quality Trusted Solutions.

(7) Maria O'Brien is Deputy Chief Operating Officer and Board Director of Community Services. She has no interests to declare

(8) Grant Macdonald, Executive Director of Strategy and Workforce has no interests to declare

(9) Mr Tom Kibasi, a Non Executive Director is Director of the Institute for Public Policy Research, which is a registered charity.

(10) Dr Cornelius Kelly is the Medical Director at CNWL. He has no other interests to declare.

(11) Mr John Vaughan, Director of Strategic Planning and Community Services is a Director of CNWL Holdings

(12) Ms Robyn Doran, Chief Operating Officer at CNWL is a Board Member of Listening Place.

Both John Vaughan and Robyn Doran have worked (unpaid) with the Care Quality Commission (CQC). The trust paid £332k annual fee to the CQC in the year.

(13) Mr David Roberts, Non Executive Director at CNWL has no other interests to declare.

(14) Mr Michael Nutt, a Non Executive Director at CNWL is also a Non Executive Director at Fiddler Lake

Resort in Quebec, Canada. He is a Council Member of Your Health CIC in Kingston-Upon-Thames and a Trustee of The Point of Care Foundation in London. He is a Director of Quality Trusted Solutions.

(15) Dr Reva Gudi, a Non Executive Director at CNWL is a GP and Senior Partner at the Pine Medical Centre in Hayes, Hillingdon. A shareholder and a part of Clover Health Ltd and Hillingdon Primary Care Confederation (HPCC) Ltd. Both which are GP led provider organisations. 2 GP partners at Pine Medical Centre, one a Director of Clover Health Ltd Board and one a Director on HPCC Ltd Board. Her husband is a consultant fertility specialist at the Homerton Hospital NHS FT, Hackney, and Director at Fertility Plus Ltd, a private fertility service provider.

(16) Ian Mansfield, a Non Executive Director at CNWL is a chair of Richmond CVS, and infrastructure body supporting the third sector in Richmond upon Thames borough. His wife is Primary PGCE programme lead at Brunel University London. His daughter is doing Masters in Mental Health Social Work through Think Ahead, based at Camden and Islington.

(17) The Central and North West London NHS Foundation Trust Charitable Fund (Registered Charity No. 1082989) is affiliated with the Trust.

In the year to 31 March 2019 the Trust made a charge to the Charity for support and governance costs of £155k (2018: £157k).

Note 31 Fair value and financial risks

Fair Value of financial assets and liabilities

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.

Financial risks are listed below:

Liquidity risk

The Trust's net operating costs are incurred under one- to three-year contracts with local Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government generated from its contracts. All fixed assets have been purchased without the need for commercial borrowing. Central and North West London NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

The majority of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest. Central and North West London NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

The Trust operates primarily within the NHS and Social Care market and receives the majority of its income from other NHS organisations and Local Authorities.

Bad debt provisions are calculated based on the Trust's bad debt provision policy which prescribes rates of provision on the type of debtor, age of the outstanding debt and knowledge of specific balances.

Note 32 Pension schemes on statement of financial position

The Trust has no on-Statement of Financial Position pension schemes.

Note 33 Third party assets

Note 33.1 Patient's monies

The Trust held £1,110k cash at bank and in hand at 31 March 2019 (31 March 2018 – £1,441k) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

Note 34.1 Critical accounting estimates and judgement

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the financial statements in the current or next financial year are detailed below:

1. Determination of useful lives for property, plant and equipment – estimated useful lives for Trust's assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired.

2. Capital expenditure on leasehold assets with short leases – less than 10 years, and those without a formal lease agreement in place, is excluded for valuation services.

The rationale for this methodology is in accordance with paragraph 7.1.14 of the FREeM, states that Trust may adopt a depreciated historical costs basis as a proxy for the current value in existing use or a fair value in respect of assets which have short useful lives or low values (or both). For depreciated historical cost to be considered as a proxy for current value in existing use or fair value, the useful life must be a realistic reflection of the life of the asset and the depreciation method used must provide a realistic reflection of the consumption of that asset. Where such a basis is not used, assets should be carried at fair value or current value in existing use and NHS foundation trusts should value them using the most appropriate valuation methodology available.

Where the remaining lease was less than 10 years, the Trust has decided to value these at historical cost depreciated over the remaining life of the lease.

For those assets without a formal lease, the Trust has opted to maintain the historical cost of its capital expenditure. This will be depreciated over the life of the property; the asset life will be an estimate provided by the Trust's Estates department.

3. Income is deferred to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project.

4. Accruals are based on estimates and judgements of historical trends and anticipated outcomes. At the end of each accounting period, management review items that are outstanding and estimate the amount to be accrued in the closing financial statements of the foundation trust. Any variation between the estimate and the actual is recorded under the relevant heading within the accounts in the subsequent financial period.

5. Provisions for pension and legal liabilities are based on the information provided from NHS Pension Agency, NHS Litigation Agency and the Trust's own sources. Pension provision is based on the life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

6. The debtors and intangible assets are shown at fair values and any provisions for impairments in values provided for when it is judged that these are required for adjustment to the fair values.

CNWL developed an ambitious ICT Strategy several years ago recognising that achieving the Trust's strategic goals were dependent upon the successful delivery of a number of important changes /enablers, one of the most important of which was better ICT. The Trust recognised that the infrastructure provision, developed piecemeal due to the growth of the Trust through acquisition, was not fit for purpose as it does not meet the Trust's future needs as there were significant reliability, security and operational risks inherent in the provision and unable to support the many of its clinical services plans for future development.

The ICT Strategy clearly identified the need for the provision of resilient, reliable and secure ICT infrastructure services to form the foundation for the rest of the ambitious and innovative strategic programme of work that will ultimately enable the deliver:

- efficiencies across the NHS as reflected in CNWL's internal cost improvement plans. Better ICT infrastructure is seen as a key enabler to greater efficiency across the Trust's services, for example efficiency improvements that the Trust expects to make from the Strategic Clinical Systems;
- drive towards greater integration of services both within CNWL and with other providers in the health and social care community. Integration leads to requirements such as interoperability and the ability to share electronic patient records which in turn can lead to better service quality and further efficiencies across health and social care;
- changes required to support the national ICT strategy;
- ICT infrastructure to provide a firm base to support delivery of the Trust's strategic objectives such as growth and improved engagement;
- address weaknesses in the current ICT infrastructure

such as the limited ability to support remote working, limited support for end-user devices and slow response from core ICT infrastructure – this need is essential to enable transformation of clinical service delivery;

- opportunity to improve ICT user experience through improvements such as greater use mobile working and unified communications (direct messaging, presentation sharing in meetings, video conferencing etc.).

The delivery of the IT Strategy's was underpinning by several work streams; key were the upgrading of the Trust's Strategic IT Infrastructure and Strategic Clinical Systems. The successful delivery of these two strategic programmes were the cornerstone to achieving the objectives set out in the IT Strategy.

The delivery of these programmes not only required significant investment but spanned several years to complete. IT Strategic Infrastructure programme was in development over 4-years and operational across 95% of the Trust in January 2018. The Clinical Systems Programme too has been in development for 4-years and is expected to be fully functional by Q3 of the next financial year (2018-19).

The cost of developing these IT Projects has been reflected in the Trust's financial statements under 'Assets In the Course of Construction' for the past few years. The Strategic Infrastructure Programme, from an accounting point of view, was brought in to use at the end of January 2018 and as such recognised as an intangible asset.

In line with the NHS Foundation Trust Annual Report Manual (ARM) the Trust is required to follow the accounting requirements as set out in the Department of Health Group Accounting Manual (GAM). Intangible assets are initially recognised in the balance sheet at cost. Following the initial recognition of an intangible asset, accounting rules require the Trust to assess a subsequent measurement; whether there is any indication that an asset may be impaired. For subsequent measurement GAM sets out possible options for valuation; and Depreciated Replacement cost was applied as the most appropriate form of measurement for valuation.

The Trust engaged Deloitte IT Valuation team to offer expert independent valuation advice to Trust Management for the IT Strategic Infrastructure Programme and to comment on the valuation at Replacement cost proposed by the Trust's IT and Finance Teams. Depreciated Replacement Cost Valuation by CNWL IT Management was £13.0m; Deloitte £15.7m. The differential relates to costs associated with the initial discovery phase.

The DRC Valuation of Trust's IT Management has been accepted as the DRC for the IT Platform resulting in an impairment of £14.123m.

Deloitte concluded the Useful Economic Lives (UEL) to be c 10 years, in line with discussions with Management, and in line with observations of concluded disclosed for similar assets.

In 2014, a Full Business Case was approved by the Trust to procure a single clinical system across the Trust. The capital cost estimated was c£14.0 million with a new system to be delivered within 2-years. The total (nominal) capital cost incurred is £21.7m. Uplifted for inflation over the years, the inflated capital cost is £22.5m. The Trust has been spending capital for the clinical systems re procurement and implementation since 2013-14. Since 2013-14, the capital costs have been recognised on the balance sheet as intangible assets in the course of construction (AICC). It is now agreed that the Clinical System, from an accounting point of view, will be brought in to use and as such recognised as an intangible asset and not AUC. It is now agreed that the Clinical System, from an accounting point of view, will be brought in to use and as such recognised as an intangible asset and not AUC.

Note 35 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £7k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a -£208k increase in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 36 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).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NHS Foundation Trust

Annual Report and Accounts 2018-19

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