NHS
Imperial College Healthcare
NHS Trust

Annual report
2018/19

Contents

Welcome 3

Performance report 5

- Overview 6
- About the Trust 9
- Trust in numbers 12
- Performance analysis corporate objectives 14
- Sustainability report 26
- Performance against five domains of quality 28
- Research discoveries 37

Accountability report 39

- Corporate governance report 40
- Statement of the chief executive officer's responsibilities as the accountable officer of the Trust 45
- Statement of directors' responsibilities in respect of the accounts 45
- Annual governance statement 48
- Care Quality Commission Regulatory Framework 50
- Chief executive's review of effectiveness 55
- Remuneration and staff report 57
- Remuneration report 57
- Staff report 62
- Trade Union facility time publication requirements report 64
- Chief financial officer's review 68
- Independent auditor's report to the directors 71
- Financial statements 74
- Statements of accounts 75
- Notes of the accounts 79

Appendices 108

- Glossary of terms 109

Alternative formats

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Welcome

Paula Vennells CBE
Chair

I'm delighted to introduce the annual report for Imperial College Healthcare NHS Trust for 2018/19 – the first to be published during my tenure as chair. I took up my new role in April 2019 and the achievements and challenges set out in these pages illustrate perfectly why I feel such pride and enthusiasm for the task ahead as we embrace the best in patient care.

Imperial College Healthcare incorporates five hospitals and a growing portfolio of community-based and digital services. We offer one of the broadest ranges of acute and specialist care in the country to over one million patients a year. Working closely with partners across the healthcare system, we draw patients from across the UK and from around the world, as well as being privileged to serve those who live locally in some of north west London's most diverse boroughs.

Like the rest of the NHS and all developed healthcare systems, we are grappling with how best to respond sustainably to growing needs. At the same time, we are excited and inspired by the expanding possibilities of 21st century healthcare, which has the potential to improve patient care and outcomes – beyond what we can imagine today. Our partnerships are central to this. We work closely with Imperial College London: its excellence in clinical research, engineering and technology is translated to real patient benefits in our hospitals and, increasingly, in their daily lives. Together, we continue to deliver the best in medical education as a renowned teaching Trust. We also have important and deepening relationships with a range of other key stakeholders, including Imperial Health Charity, our strategic lay forum and neighbouring trusts and GPs.

Patients tell us that the individual care they receive from our clinicians is kind, compassionate and expert. But, at a system level, patients are sometimes too patient with us. With our lay and healthcare partners, Imperial College Healthcare has a shared ambition for truly integrated healthcare. We want to make the experience for patients across our sector more understandable, more efficient, (in some cases, more bearable) and – at best – completely excellent. I have seen some amazing examples. Using data, digital technology and open and inclusive ways of working, multidisciplinary teams are putting the patient first every time. With such agile and collaborative engagement, and with like-minded partners, the Trust is improving and integrating healthcare for the people we serve and transforming the roles of many of those who work in and with the Trust.

I have been asked what has surprised me most since I started in my new role. The answer is that it's how well our staff cope with the constraints they face in delivering the outstanding care they provide.

> Patients tell us that the individual care they receive from our clinicians is kind, compassionate and expert.

The Trust has the biggest backlog maintenance liability of all NHS trust estates, reflecting the fact that a quarter of our buildings are over 70 years old and some well over 100 years. We must plan for major redevelopment. This work is now urgent and we are newly focused on determining our future plans. We will work with our patients and partners to determine, in the context of all the wonderful work and aspiration I described earlier, what is the right answer for the next 20-50 years.

In parallel, we face cost challenges and investment opportunities across estates, technology and the environment – today. We will address some of the very poor working conditions that exist and we will continue to invest in responding to our staff's needs, listening, engaging and developing. If we are to remain an employer of choice for up to 12,000 people in a global city, we have to provide the opportunities and support to attract the best staff at all levels, with much more attention to diversity and inclusion.

We are an inspiring and forward-looking organisation: Imperial College Healthcare is part of one of the UK's six academic health science centres and hosts one of 20 National Institute of Health Research biomedical research centres. As such, we have a particular responsibility to find better ways to identify and share new learning and innovation. Strong foundations are being built to ensure the Trust is well placed to continue this clinical leadership as well as respond to the challenges we face.

In 2018/19, while providing high quality care for more patients, more quickly, the Trust delivered significant efficiencies and achieved its financial plan. We posted a small surplus with the additional central funding we were able to access as a result of achieving the plan and we continued to reduce our underlying deficit. However, our financial outlook remains challenging and our executive team will be driving further efficiencies. Sustainable patient care and great future ambitions are only achievable when costs are reduced and financial targets are hit. Good care and good cost management are mutually dependent and I have seen serious benefits emerge where multidisciplinary teams have embraced the ways of working, as I described earlier. I've been inspired by one of my first tasks in the Trust – to judge the chair's category in our annual Make a Difference awards. My thanks to all those who presented this year – you set the standard!

Though less visible than operational and financial improvements, last year colleagues across the Trust worked collaboratively to plot a clearer route for change and transformation. Creating a common sense of purpose around a vision and understanding how our shared values – how we will behave with one another and how we will support our patients and partners – is essential. Further progress was made with the development of our data and digital capability and capacity too; this is an area of expertise that will reap future rewards for us. I am passionate about its potential!

For all of this, I am grateful for the leadership of my predecessor, Sir Richard Sykes, and our deputy chair, Sir Gerry Acher, who held the reigns between appointments; my thanks to my non-executive and executive board colleagues and to Professor Julian Redhead, who served as interim chief executive for the first quarter of the year. Most importantly, I am grateful to recognise all Imperial College Healthcare NHS Trust colleagues for their care and commitment to our patients. My final thanks are to our excellent chief executive, Professor Tim Orchard, who took up his new role last June. Tim is challenging our thinking and stretching our aspirations as well as modelling the culture of support and honest challenge he will lead. I look forward to supporting Tim and his team and ensuring the Trust continues to build strong relationships with our partners and stakeholders, to give us the best chance of achieving our vision of 'better health, for life'.

Paula Vennells CBE
Chair

Performance report

Overview

Professor Tim Orchard
Chief executive

There is always so much happening across our hospitals that it's often tricky, when the time comes, to summarise our year. We have a relentless focus on the here and now – ensuring we provide safe, high-quality care 24 hours a day, seven days a week – at the same time as developing strategic responses to the seismic changes happening in health needs, public expectations and advances in clinical knowledge.

This year, though, has felt like something of a watershed for Imperial College Healthcare. There have even been some big birthdays to illustrate the point. We marked 200 years of Charing Cross Hospital in October while the NHS turned 70 in July. Both were opportunities for reflection on a legacy of achievement and significant challenge ahead as well as recognition for our staff, volunteers, patients and partners. Our #ImperialPeople social media campaign – launched to coincide with the celebrations and offering snapshots of the huge variety of individuals who make up the Trust – continues to generate enormous pride in who we are and what we do.

Establishing our future direction and priorities

The year produced some important milestones in terms of future direction and priorities. NHS England published the *NHS Long Term Plan*, setting out a clear and coherent direction of travel for the whole of the NHS; one that promotes collaboration over competition, continues the shift to more accessible services, puts health centre stage, champions the role of digital and research and recognises the need to do much more to develop and support staff.

The Trust is well placed to respond to the plan as we completed our own major piece of work setting out the foundations of a new organisational strategy, making stronger connections between our day-to-day work and priorities and the delivery of our vision, 'better health, for life'. In addition, we developed our first behaviours framework, shaped by staff and partners, setting out what we should be able to expect from each other and what our patients should be able to expect from all of us.

There is much more work to do, including expanding engagement with our patients and communities to create more detailed plans for progressing strategy and implementation, but there is already greater clarity and direction for everyone. Importantly, we have also made a tangible connection between what we do and how we do it. There is much evidence that organisations achieve the most when their people are united by a shared vision and set of values, creating a culture that makes doing the right thing the best option.

Creating a better organisational culture

The importance of our organisational culture was a recurring theme throughout the year and some of the most significant developments relate to our people. In August, we published the independent review of the disciplinary processes that led to our dismissal of a staff member, Amin Abdullah, who later took his own life. It became clear that we had let Amin down and, while we can never put that right, the review led us to overhaul our disciplinary processes. I am very grateful to Amin's partner for ensuring the review took place and for his support in ensuring we make the most of the lessons learnt.

We have also begun to respond to a clear message from our people – through our staff survey and elsewhere – that we need to do more about fairness and equality. We have launched a programme to implement the NHS workforce race equality standard and another set of actions to promote and support diversity more widely, including the development of a number of increasingly influential staff networks. This connects with our vision and values work; in the coming year, we will look particularly to embed our new behaviours framework by expanding leadership, management and personal development and prioritising staff wellbeing and support improvements.

Our staff told us that we need to do more to foster collaborative working too. Last year saw the launch of a new, mobile-accessible intranet that makes it much easier for staff to get the information they need and to keep up to date with news and opportunities. In the coming year, we will be making more use of the functionality it offers – combined with an investment in Office 365 – to make team-working and getting involved much easier for everyone. We will also make workplace and other changes to help staff develop and build better connections with colleagues and to create opportunities for sharing learning and ideas.

Turning around our operational performance and finances

Another turning point for us during the year has been our ability to make sustainable improvements in all aspects of our operational performance and finances. We have cared for more patients and treated them more quickly, with much better delivery against the A&E four-hour access standard, a reduction in the number of patients waiting over 52 weeks to zero and maintenance of one of the best performances nationally for cancer care and diagnostic waiting times.

We did this through a focused effort on developments across our urgent and emergency and planned care pathways. This helps patients avoid unnecessary hospital admissions, making sure they get the specialist care they need as quickly as possible and working with community and social care partners to help more patients return home or closer to home as soon as they are medically fit. We were also successful in securing additional central funding to create over 50 extra inpatient beds and prioritised our own capital for the refurbishment of our A&E departments.

We met our financial plan for 2018/19, delivering a deficit of £20m. This included delivering efficiencies of £44m. Meeting our financial plan – as well as our expected improvement in A&E performance – has given us access to additional central funding of just over £48m, meaning we posted a surplus of £28m million. Our savings also enabled us to reduce our underlying financial deficit by £2m, less than planned but still an important contribution to our longer term sustainability.

The coming year brings another set of operational and financial challenges. Our financial plan for 2019/20 – to deliver a £16m deficit before additional, central funding – requires another £53m in efficiencies. With growing financial challenge across the whole north west London sector, there will be less opportunity for income growth and so we will need to be absolutely on top of spending control and delivery of savings. Likewise, our space and financial constraints mean further improvements in operational performance will need to be generated by new ways of working rather than additional capacity.

Improving quality and safety

Our continued focus on building our improvement capability, following our initial investment to create an organisational 'QI' (quality improvement) methodology and central resource in 2015/16, is of increasing importance.

We now have over 1,000 staff across the Trust who have completed improvement courses and 176 trained improvement coaches. The first year of our flow coaching academy – providing improvement support through an approach established by Sheffield Teaching Hospitals NHS Foundation Trust – produced some remarkable results in the care pathways involved.

Our improvement methodology is being applied systematically to safety more generally and we have seen sustained improvements in falls reduction, hand hygiene and infection control, medicines management and in identifying and treating sepsis. We continue to have high reporting of incidents and low harm as well as one of the lowest mortality ratios of all acute trusts in the country.

Unfortunately, however, we had seven 'never events' during the year. These are safety incidents that simply should not happen if we follow safety guidance fully. Although they did not result in any clinical harm and our investigations indicate that there are no real connections between them, we need to do more to prevent them in the future. We've put in place a range of practical measures to make further safety improvements, including rolling out simulation training across all theatres and intensive engagement with staff to promote key safety guidance and procedures and to encourage everyone to always speak up if they have any concerns or questions.

Despite the pressure on our estates budget due to the scale of the backlog maintenance we have to undertake on our aging buildings, we were able to progress a number of improvements that required capital funding. Major projects include the expansion and refurbishment of the children's intensive care unit at St Mary's, supported by both Imperial Charity and COSMIC and due to be completed in the coming year; the expansion of our thrombectomy service, the new 'gold standard' for stroke care at Charing Cross; and the piloting of a completely new 'wayfinding' system for patients and visitors, also supported by Imperial Health Charity.

Transforming through digital

We are one of 17 NHS acute global digital exemplars and we continued to roll out our programme of digital developments made possible by our electronic patient administration system, in place across all of our hospitals. In 2018/19 this included, the introduction of the Streams app, allowing clinicians to access test results and observations on mobile devices at the bedside; the roll out of Fetalink to improve monitoring of clinical indicators for babies' health in our maternity services; and the expansion of the Care Information Exchange, the secure patient portal we developed with the support of Imperial Health Charity and now supporting many patient pathways across north west London.

> "We now have over 1,000 staff across the Trust who have completed improvement courses and 176 trained improvement coaches."

> Our Trust has not always had a reputation for collaboration but we are now part of a growing number of flourishing partnerships with a range of stakeholders and neighbouring trusts.

Advancing knowledge and practice

Research and innovation remain central to our identity as an organisation, attracting staff and patients who want to be at the leading edge of clinical knowledge and practice. Through our partnership with Imperial College London, we've been part of some amazing breakthroughs during the year, including the development of new sensor technology able to diagnose reproductive health problems in real-time and using artificial intelligence to improve stroke and dementia diagnosis in brain scans.

We've also seen great service innovation, such as the development of the RAPID pathway to help reduce the diagnostic time for prostate cancer from six weeks to one or two.

Building stronger relationships

One of the developments in 2018/19 helping to create the sense of a watershed year has been the step change in the nature of many of our external relationships. Our Trust has not always had a reputation for collaboration but we are now part of a growing number of flourishing partnerships with a range of stakeholders and neighbouring trusts.

The need to focus on health as much as healthcare, to put the patient at the centre of their care and to make the very best use of all of our collective resources, is helping to drive new programmes like Connecting Care for Adults – bringing together our specialists with local GPs to improve care for patients with long-term conditions – as well as to highlight the achievements of services that have been quietly pioneering more joined up care for some time, such as Connecting Care for Children, selected as an exemplar in the *NHS Long Term Plan*, and the Hammersmith and Fulham Integrated Care Partnership.

The publication of the plan, together with the conclusion in March of the Shaping a Healthier Future service reconfiguration programme for north west London, brings further opportunities for expanding and strengthening partnerships across health and social care over the coming year.

We are working particularly closely with our nearest neighbour, Chelsea and Westminster NHS Foundation Trust. The year saw the beginning of a major programme to share our electronic patient administration system with their hospitals to support joined up care as well as the development of a proposal, also including Imperial College London, to improve heart and lung services for children and adults in north west London.

Our patient and public involvement activities are becoming ever more integral to how we work, including through the expansion of our lay partner programme to 19 roles across a range of major projects and services. Very sadly, the year was also marked by the death of the chair of our strategic lay forum, Michael Morton. To recognise his huge contribution to the Trust, we have established a new annual award for patient and public involvement and we will announce the first winner this coming summer.

Looking to the future

Though I have worked as a clinician at the Trust for many years, 2018/19 has been my first as chief executive. I'm extremely grateful to all of our 12,000 staff for their commitment, expertise and hard work that has enabled us to make real progress over the past 12 months, in the face of some very significant challenges.

I am committed, as is the whole of the executive team, to doing all we can to create the right conditions and support to enable our staff to continue that improvement together with our patients, communities and partners. For the coming year, that means a real focus on implementing our vision, values and behaviours work as well as getting clarity on how we can resolve some long-standing strategic issues, with the need for a major redevelopment of our aging estate right at the top of that list.

I hope that the outcome of our recent CQC inspections will recognise our improvement journey and I look forward to leading our organisation on the journey to follow.

Tim Orchard
Chief executive

About the Trust

Imperial College Healthcare NHS Trust provides acute and specialist healthcare for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with over 12,000 staff.

Our five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing clinical practice nationally and worldwide. We also have a growing number of community services and provide private healthcare in dedicated facilities on all of our sites, including at the Lindo Wing at St Mary's Hospital.

With our partners, Imperial College London, The Royal Marsden NHS Foundation Trust and Royal Brompton & Harefield NHS Foundation Trust, we form Imperial College Academic Health Science Centre. This is one of six academic health science centres in the UK, working to ensure the rapid translation of research for better patient care and excellence in education.

Our mission and strategic goals

In March 2019, we adopted a new strategy setting a clear and cohesive direction for our organisation, rooted in our existing core values – kind, expert, collaborative and aspirational.

Our mission is to be a key partner in our local health system and to drive health and healthcare innovation, delivering outstanding care, education and research with local, national and worldwide impact.

We have three overarching strategic goals that, together, will enable us to achieve our vision of 'better health, for life':

- to help create a high quality integrated care system with the population of north west London
- to develop a sustainable portfolio of outstanding services
- to build learning, improvement and innovation into everything we do.

Our values

Our new strategy and overarching goals are underpinned by our Trust values:

Kind – we are considerate and thoughtful, so you feel respected and included.

Expert – we draw on our diverse skills, knowledge and experience, so we provide the best possible care.

Collaborative – we actively seek others' views and ideas, so we achieve more together.

Aspirational – we are receptive and responsive to new thinking, so we never stop learning, discovering and improving.

Our hospitals

We provide care from five hospitals on four sites:

Charing Cross Hospital: providing a range of acute and specialist services including cancer care and a 24/7 accident and emergency department. It also hosts the hyper-acute stroke unit for the region and is a growing hub for integrated care in partnership with local GPs and community providers.

Hammersmith Hospital: a specialist hospital renowned for its strong research connections. It offers a range of services, including renal, haematology, cancer and cardiology care, and provides the regional specialist heart attack centre. As well as being a major base for Imperial College London, the site also hosts the clinical sciences centre of the Medical Research Council.

Queen Charlotte's & Chelsea Hospital: a maternity, women's and neonatal care hospital, also with strong research links. It has a midwife-led birth centre as well as specialist services for complicated pregnancies, fetal and neonatal care.

St Mary's Hospital: the major acute hospital for north west London as well as a maternity centre with consultant and midwife-led services. The hospital provides care across a wide range of specialties and runs one of four major trauma centres in London in addition to its 24/7 A&E department.

Western Eye Hospital: a specialist eye hospital with a 24/7 A&E department.

Increasingly, we provide our services in community facilities and in partnership with GPs and community, mental health and social care organisations.

Imperial Private Healthcare

Imperial Private Healthcare is our private care division, offering a range of services across all of our sites. This includes the Lindo Wing at St Mary's Hospital, the Thames View at Charing Cross Hospital and the Robert and Lisa Sainsbury Wing at Hammersmith Hospital. The income from our private care is invested back into supporting all of our services.

Research, education and innovation

As well as being part of Imperial College Academic Health Science Centre, the Trust, with Imperial College London, hosts one of 20 National Institute for Health Research (NIHR) biomedical research centres (BRCs). This designation is given to the most outstanding NHS and university research partnerships in the country, leaders in scientific translation, and early adopters of new insights in technologies, techniques and treatments for improving health.

The NIHR Imperial BRC currently supports over 600 active research projects across 12 different disease areas. The Trust is also part of the NIHR Health

Informatics Collaborative (NIHR HIC) together with Oxford University Hospitals, Cambridge University Hospitals, University College London Hospitals and Guy's and St Thomas' NHS foundation trusts.

This collaboration brings together clinical, scientific and informatics expertise to enable NHS clinical data to be catalogued and shared to enable new insights into care and treatment through research.

As one of the NHS's global digital exemplars, we are proud to be leading the way in using advances in digital technology to make tangible improvements to the care of our patients.

We are a major provider of education and training for doctors, nurses, midwives and allied health professionals including therapists, pharmacists, radiographers and healthcare scientists. In 2018/19, some 900 Imperial College London medical undergraduates trained with us. We had over 520 student nurses and midwives in training in the year, many of whom gained their first job or qualification with us.

Our charities

We work closely with Imperial Health Charity which helps our hospitals do more through grants, arts, volunteering and fundraising. In 2018/19, the charity invested £1.68m in a wide range of initiatives for the benefit of patients and staff.

The charity's grants programme helped fund major redevelopments, research and medical equipment. This support enabled major renovations to the children's intensive care unit at St Mary's Hospital, and the start of an important wayfinding project across our hospitals. Dementia patients at Charing Cross Hospital benefitted from a specially designed new garden opened to mark the hospital's 200th anniversary.

Imperial Health Charity also manages volunteering across all five hospitals, adding value to the work of staff and helping to improve the hospital experience for patients. In the last year, the volunteer community has grown significantly with a range of dynamic new roles. The charity also launched its first ever youth volunteering programme, giving 16-25 year-olds the opportunity to support their local hospital.

In addition, the charity has continued to develop its art collection and arts engagement programme, providing creative workshops and activities for patients and offering benefits to Trust staff through the Staff Arts Club.

During 2018/19, the Trust also received generous support from COSMIC (Children of St Mary's Intensive Care), which also helped to raise funds for the children's intensive care unit at St Mary's Hospital, the Winnicott Foundation, which raises funds to improve care for premature and sick babies at St Mary's Hospital, and each of the Friends of St Mary's, Charing Cross, and Hammersmith hospitals.

Our lay partners

We are committed to increasing and improving the involvement of patients and the public in every aspect of our work. An important element of our involvement approach is our community of lay partners – with experience or interest in the Trust who form part of our project and programme governance. The Trust currently has 42 lay partner roles supporting services and projects. Read more on page 18.

Our commissioners

Almost half of our care is commissioned by north west London local Clinical Commissioning Groups (CCGs), about 40 per cent is specialist services commissioned by NHS England and the remaining 10 per cent or so is commissioned by other commissioners including CCGs beyond our local area.

The eight CCGs in north west London cover:

- Brent
- Central London
- Ealing
- Hammersmith & Fulham
- Harrow
- Hillingdon
- Hounslow
- West London

During 2018/19, the north west London CCGs came together under a single leadership structure. They formed a joint committee which has its own decision-making powers over certain health issues in north west London.

North west London health and care partnership

Over 30 NHS, local authority and voluntary sector partners, including our Trust, are working together to improve health and care across north west London. The first five-year sustainability and transformation plan, one of 44 such plans across England, was published in October 2016. Its five delivery areas are:

- improving health and wellbeing
- better care for people with long-term conditions
- better care for older people
- improving mental health services
- safe, high quality and sustainable hospital services

Since 2012, the NHS in north west London has also been working on a programme to re-shape and improve services under the banner of 'shaping a healthier future'. With the publication of the *NHS Long Term Plan* in January 2019, followed by a Government announcement in March, the north west London health and care partnership agreed to draw the Shaping a Healthier Future programme to a conclusion. As part of our response to the *NHS Long Term Plan*, we will bring our on-going efforts to improve health and care together in a new programme called the NHS north west London long term plan.

Our regulators

As an NHS provider, the Trust works with a number of different regulators. The two main regulators are NHS Improvement and the Care Quality Commission (CQC).

NHS Improvement is responsible for overseeing both NHS trusts and foundation trusts. During 2018/19, NHS Improvement and NHS England developed closer working arrangements creating a joint senior leadership team – the NHS Executive Group – including a new London regional director.

More information about NHS Improvement's oversight of the Trust, including the segmentation (regulatory rating) for the Trust, extant enforcement actions and the Trust's voluntary undertakings is detailed in the Annual Governance Statement on page 46.

The CQC is the independent regulator of health and adult social care in England. The Trust is currently rated overall as 'requires improvement'; made up of 'good' for the domains of caring and effective, and 'requires improvement' for the domains of safe, responsive and well-led. This rating follows a comprehensive inspection of Trust services in 2014. Since then a number of core services inspections have taken place as well as our first well-led inspection which was in December 2017. Our inspection reports show that we are on an improvement trajectory.

We had further core services inspections of critical care, children and young people, maternity, and neonatal services in February 2019, followed by a second well-led inspection in April 2019. We expect to receive the inspection reports and any changes to our ratings later in Summer 2019.

The Trust was compliant with the requirements of its CQC registration and was not subject to any enforcement action during 2018/19. For more information see p50.

More information about the CQC's oversight of the Trust, including inspections carried out during 2018/19, is detailed in the Annual Governance Statement on page 46.

Trust in numbers 2018/19*

Our services

1,225,000

Patient contacts
(including inpatients, outpatients and day cases)

312,000

Emergency attendees
(including A&E and AEC)

10,000

Babies born

40,000

Operations
(including day and inpatients)

97%

Inpatients who would recommend us to their friends and family

Our staff

12,000

Number of staff

2,700

Doctors

4,800

Nurses and midwives

770

Allied health professionals

1,200

Scientists and technicians

130

Pharmacists

900

Medical students

520

Nurses in education, pre-registration

Our finances

£28m

Surplus

£1,213bn

Turnover

£44m

Efficiencies

£55m

Capital investments including buildings, infrastructure and IT

*All rounded

Performance analysis

Introduction

We regularly review information and feedback about the quality and performance of our services and activities at all levels across the organisation. This helps us ensure we are on track to meet our targets and objectives and to deliver our strategic plans, as well as to help us spot and address problems as soon as they arise.

We also contribute to a range of national monitoring programmes, which allows our performance to be benchmarked against that of similar NHS trusts.

Every month, our executive management team reviews a comprehensive set of quality and performance indicators – our 'scorecard'.

A scorecard with a core set of indicators is also reviewed by the Trust board at its public meetings. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies.

On our website, we publish an easy-to-understand monthly performance summary taken from the scorecard as well as the full scorecard that goes to each public board meeting.

Assessing performance against our operational objectives

Assessing progress against our objectives is an important aspect of performance analysis. As we set out in last year's annual report, five operational objectives underpinned our 2017-2019 business plan:

- to improve the way we run our hospitals
- to develop more person-centred approaches to care
- to make our care safer
- to make the Trust a great place to work
- to build sustainability.

Many of our major Trust initiatives in 2018/19 were intended to support more than one of our operational objectives. However, in this report we have set them out under the primary objective to which they most relate.

Assessing performance against the five domains of quality

Our Trust scorecard looks at how we perform against the five domains of quality used by the CQC to assess the quality of NHS organisations across England. These are: safe, effective, caring, responsive and well-led.

These domains also form the framework for our quality strategy and for our annual quality account, which reports on our annual targets for improving quality.

The following report also summarises our annual performance under each of the quality domains, see pages 28 to 35. A more detailed assessment can be found in our 2018/19 quality account, which is available to download from our website.

Objective: to improve the way we run our hospitals

Redeveloping St Mary's children's intensive care

We have completed the first phase of a major redevelopment of children's intensive care at St Mary's Hospital. The £10m refurbishment and expansion project reached its half-way point in 2018/19. The unit currently looks after 400 critically ill children a year, including those needing emergency care and children who have long-term health conditions. When finished, its capacity will increase from eight beds to 15 beds, which means we will be able to treat 200 more critically ill children a year. To create a bright and welcoming environment, the new unit features inspiring artwork generously donated by modernist artists Josef and Anni Albers. Funding for the redevelopment came from Imperial Health Charity and COSMIC charity, as well as our own capital budget.

Keeping care flowing

Over the last two years, one of our main programmes of work has been expanding our physical capacity and improving 'flow'– ensuring patients get the care they need as quickly as possible as they move through our pathways. Despite growing demand for our services in 2018/19 – including a 4.3 per cent rise in emergency attendances – we improved our performance against the national standard to assess and treat or admit at least 95 per cent of A&E patients within four hours – a key indicator for 'flow'. We achieved the standard for 88.7 per cent of patients during the winter (Oct-Mar) of 2018/19 compared to 84.9 per cent the previous winter.

A range of developments helped us to achieve that improvement, including:

- refurbishing Charing Cross A&E and opening a new fracture clinic, majors' area, reception and urgent care centre
- creating 54 additional inpatient beds
- implementing real-time bed management on Cerner, our patient administration system
- rolling out the national red to green (R2G) initiative, which helps teams identify and tackle delays in care
- completing 37 dedicated projects using improvement methodology designed to support change at a local level.

We are continuing to progress new developments and improvement projects across all stages of our care pathways.

Imperial Flow Coaching Academy

Flow coaching is a best practice approach to improving clinical pathways developed by Sheffield Teaching Hospitals and supported by the Health Foundation. In 2018/19, 18 members of our staff completed the Imperial Flow Coaching year-long training course to become coaches. The coaches use their skills at weekly 'big rooms' – a collaborative, open space for members of staff involved in a particular clinical pathway to develop, test and embed improvements to reduce unwarranted variation. In this year's big rooms we have focused on the following pathways: antenatal; young people; improving care for lower urinary tract symptom patients; mental health crisis care in the emergency department; enhanced recovery; paediatric acute abdominal pain; acute respiratory; and elective vascular. Positive outcomes from these pathways include: reduction in length of stay; reduction in the number of cancelled operations and 'did not attends' in clinics; more collaborative working with partners such as GPs and the police; and increasing quality improvement capability within service teams.

A further 18 coaches have been identified to enable improvements along nine new care pathways in 2019/20. These include:

- emergency medicine in the acute medical unit (Charing Cross Hospital)
- rapid assessment and treatment in the emergency department (St Mary's Hospital)
- gynaecology emergency room (St Mary's Hospital)
- anaemia (Charing Cross Hospital)
- breast surgery (Charing Cross Hospital)
- retinal conditions (Western Eye Hospital)
- end of life care (Trust-wide)
- smoking cessation (Trust-wide)
- genomics (Trust-wide)

Quality improvement

As of March 2019, 150 staff members have completed our award-winning training to become quality improvement coaches and are now leading teams to make improvements at project, pathway and unit level. By 2022 our ambition is to have 600 coaches trained, in line with NHS Improvement guidance, which recommends that five per cent of staff within an organisation should be trained as coaches to support a successful improvement and learning ethos. Projects supported by the quality improvement programme include the new sepsis alert, which has seen a sustained reduction in mortality for all patients with a diagnosis of sepsis from 18 per cent to 14 per cent. For 2019/20, we have mapped our quality improvement objectives to the CQC's evidence requirements of a mature quality improvement approach – 12 criteria that demonstrate good or outstanding application of quality improvement.

Waiting list improvements

In 2018/19, we have continued to focus on improving the management of our patient waiting lists, as well as tackling the underlying issue of capacity challenges.

In 2018/19, we did not meet the national standard of 92 per cent of patients treated within 18 weeks of referral, reporting an average of 84.07 per cent across the year. We reported 573 patients waiting over 52 weeks in 2018/19, which is 1,281 fewer than the 1,854 patients reported in 2017/18. There were no patients waiting over 52 weeks in March 2019.

In 2019/20, our waiting list improvement programme will focus on:

- people: developing training programmes and introducing a new learning management system
- systems: implementing data validation, correction and visualisation tools to support efficient and proactive tracking of pathways
- processes: developing and embedding the necessary frameworks to meet waiting list standards and improve waiting times for patients.

Transforming how pharmacy works

This year we began the process of transforming how pharmacists and pharmacy staff work so they spend less time in the dispensary, and more time working directly with patients and other clinical teams. This change is happening at our Trust, but also across the NHS as a whole.

Having pharmacists as part of the multidisciplinary team – working with colleagues on the wards and clinics and with partners delivering services in the community – means more joined up care for patients and easier access to expert advice for colleagues. Pharmacists are now spending more time working in clinical areas, such as on wards for elderly patients, in the A&E, and in intensive care and vascular surgery.

By 2020, our aim is for 80 per cent of all pharmacists' time to be spent outside the dispensary and in clinical areas. We've made some progress this year, increasing this percentage of time from 44 per cent in 2017/18 to 55 per cent in 2018/19.

e-Referrals

In 2018/19 we successfully moved all first consultant-led outpatient appointments to the new online NHS e-Referrals system ahead of the national deadline of 1 October 2018. To deliver this project, we ensured all clinical and administrative staff were trained to manage referrals on the new system, and that reporting was in place to effectively monitor the referrals received and appointments booked via this method.

Real-time test results via mobile devices

Our clinicians can now access their patients' latest test results from their mobile devices via a secure app called Streams. With real-time, mobile access to test results, clinicians are able make faster decisions

without having to leave their patients to log into a computer. The time saved allows clinicians to have a greater focus on direct patient care. The general surgery team at St Mary's Hospital were the first to begin using the Streams app which is being rolled out across the Trust. The app is one example of how the Trust, as a NHS global digital exemplar, is using advances in digital technology to provide better care.

North West London Major Trauma Network

We have seen significant improvements for trauma patients and their families thanks to trauma centre networks across the country. Between 2017 and 2018, 595 more lives were saved nationally through trauma networks than would have been expected; five per cent of which were in north west London.

The North West London (NWL) Major Trauma Network – which comprises a major trauma centre (MTC) at St Mary's Hospital and six other major trauma units – sees more than 3,000 patients a year and around half of these are admitted to St Mary's. The network reaches from Westminster to just beyond the M25 and covers a daily average population of 3.9 million residents, tourists and commuters.

Objective: to develop more person-centred approaches to care

Transforming renal outpatient care with the virtual clinic

People living with chronic kidney disease (CKD) in north west London receive the majority of their care in the community from their GPs. However, a significant number have progressive disease, or experience changes in their kidney function, that requires specialist care from a hospital clinician. As part of an on-going programme to improve care for people with CKD in north west London, our renal service has been piloting a 'virtual clinic' with small numbers of patients who are now referred for an appointment at one of the many renal clinics run by Trust staff across the patch. The renal team receives 120 referrals a week and many of these patients are better suited to receiving their care from their GP instead of having to travel to a busy outpatient clinic. By enabling some patients to receive expert care via their GP, the virtual clinic also allows clinicians to dedicate more time to patients with complex needs who do need a face-to-face appointment.

Integrating care

As a major provider for health and social care across north west London, we have an opportunity to make care for our patients more joined up, especially for those with multiple and complex needs spanning the health and social care sectors. For over a decade we have worked closely with community health and care providers and in 2018/19, we continued to strengthen relationships with partners and the community by developing more integrated care initiatives. These initiatives concentrate on providing care that meets the health and care needs of local people in the right place and at the right time, and has seen us adapt our models of care to focus on prevention, early intervention and easier access. Initiatives include:

- the Hammersmith and Fulham Integrated Care Partnership, a formal partnership between Hammersmith and Fulham GP Federation, Chelsea and Westminster Hospital NHS Foundation Trust, West London Mental Health NHS Trust, Central London Community Healthcare NHS Trust and Hammersmith and Fulham Clinical Commissioning Group. Together we have developed three clinical workstreams looking at integrated clinical pathways for children, adults and older adults as well as building a network of integrated care champions.
- Connecting care for children, paediatricians from the Trust working at scale with local GPs, primary care colleagues, mental health and social care partners, to continue to improve the health and wellbeing of children in the community, avoiding unnecessary A&E or outpatient attendances. This programme won a national award in 2019, and is now being adopted in many other areas of the country.
- Connecting care for adults, where specialist consultants from the Trust go out to GP practices across north west London, offering specialist education to primary care teams, building collaborative working relationships and reviewing patient case records together to agree plans to better manage chronic lung, kidney and heart conditions whilst promoting self-management among patients and their carers.
- frailty programme, working collaboratively across organisational boundaries with GPs and community-based services to take a holistic view of patients – supporting them to manage chronic disease in a way that prevents acute episodes and hospital admissions.

RAPID pathway for prostate cancer

In 2018, the urology team at Charing Cross Hospital, led by Professor Hashim Ahmed, introduced the RAPID pathway to help reduce the diagnostic time for prostate cancer from six weeks to one or two. The pathway aimed to limit the number of unnecessary biopsies by using new technology which can pinpoint cancers that are effectively harmless and those that need treatment.

The RAPID pathway pairs a detailed morning multi-parametric magnetic resonance imaging (mpMRI) scan with an afternoon biopsy using a FUSION machine, which overlays ultrasound images of the prostate with 3D MRI scans, creating a detailed 'map' that enables clinicians to identify areas of the prostate that are more likely to contain cancerous tissue and target them for biopsy.

Over 700 men have been seen in the RAPID pathway at Charing Cross Hospital since the pathway launched in February 2018 with one-third avoiding an unnecessary biopsy.

Genomics

Genomic medicine, also known as 'personalised medicine', is a way to customise treatment to your body's genetic makeup. By analysing information of individual patients, healthcare professionals are beginning to diagnose certain conditions more accurately and 'personalise' the treatment to match.

Over the last four years, as lead partner for the West London Genomics Medicine Centre, we have gathered DNA samples from more than 3,000 patients with cancer or inherited rare diseases as part of the national '100,000 genomes project'. This work has helped us better understand the role that alterations in gene sequences play in diseases, enabling new scientific discoveries and medical insights.

The Trust has already used gene sequencing to produce life changing impacts. Some patients with rare diseases have been provided with a diagnosis after years of uncertainty.

We are working towards building genomic medicine into our everyday clinical practice.

Supporting high intensity users of A&E

Our high intensity user service exists to support patients who present frequently at our emergency departments, i.e. more than six times in six months. This is a particularly vulnerable patient group, typically with long-term health conditions who are often experiencing wider challenges in their lives which can further compromise their wellbeing.

Since launching the service in 2017, we have worked with nearly 200 patients with remarkable results – including a reduction in A&E attendances and admissions. The service collaborates closely with the patient and specialist clinicians to devise a bespoke care plan which A&E staff must follow each time the patient attends, streamlining treatment and reducing the need for repeated diagnostic tests.

In addition, through home visits, the service seeks to understand what wider factors might be driving frequent attendance, such as mental health issues, housing challenges or financial problems. Working in partnership with other agencies, including a patient's GP, the team provides practical support – often called social prescribing – to resolve these challenges.

In the Trust's first cohort of 13 patients, A&E attendances reduced from more than 60 in a month in total before our intervention, to just 10 in total after eight months, and stayed fairly stable at that level from then on.

Putting families at the heart of neonatal care

Integrated family delivered neonatal care is a model, developed in 2017, to give parents a much greater role in looking after their premature baby. This approach has now been shown to reduce hospital stays for babies born at less than 30 weeks' gestation, by an average of two weeks. Parents are trained by the multidisciplinary teams at St Mary's and Queen Charlotte's & Chelsea hospitals to tube feed, change nappies and take basic observations, while skin to skin contact is encouraged from as early a stage as possible. We are the first Trust in the UK to implement this model in neonatal intensive care. As it encourages babies to suck feed earlier, breastfeeding rates on the unit are high, and development is faster.

Making our hospitals easier to navigate

Patients and visitors often struggle to find their way around our complex hospital sites. The routes through some of our hospital buildings are not intuitive, signage is not always easy to understand, and the terminology we use lacks consistency.

With the support of Imperial Health Charity, we are developing a new Trust-wide approach to wayfinding to enable patients and visitors to navigate our sites and services easily. The new approach was designed following extensive patient, public and staff engagement. The first phase of the project was implemented at St Mary's Hospital in March and included new signage, which has a coherent design and uses more public-focused terminology. We have also made improvements by reducing the number of posters and notices, redecorating, and installing better lighting to make it easier to see signage. To support patients with disabilities, we commissioned AccessAble to provide detailed information guides about how to navigate to each of our hospital departments – including whether there is step-free access, handrails and automatic doors. Over the next two years, we plan to roll out this approach to wayfinding across our other sites.

Care Information Exchange

In the last six months of 2018, the number of patients able to see their appointments, test results and letters on the Care Information Exchange – a secure way for our patients in north west London to access their medical records – grew from 5,000 to 25,000. Patients can now sign up for an account at our outpatient self-check-in kiosks. Any patient with an NHS number can register an account by providing an email address and mobile phone number. They will then receive an invitation to activate their account, which gives them direct access to the following information about their own treatment at our hospitals:

- blood test results
- radiology results
- appointment and clinic letters and discharge summaries

- dates of past and future appointments, emergency department attendances and ward stays.

Imperial Health Charity has funded the Care Information Exchange since 2015 and we are now leading work for it to become 'business as usual' across north west London.

Using artificial intelligence to analyse patient feedback

The Friends and Family Test is an opportunity for patients to tell us about their experiences of our services. Every month we receive around 20,000 comments and analysing the feedback can be challenging. During 2018/19, consultant surgeon Erik Mayer and clinical research fellow Mustafa Khanbhai created computer software that could take these comments, group them into themes and assess whether they were positive or negative. While it takes a member of staff around four days to analyse 6,000 comments, the software can do the same job in 15 minutes. The Western Eye Hospital was the first to start using this technology and staff have been able to quickly identify simple actions to improve patient experience based on analysis of the feedback from patients, their relatives and carers. The software provides a continuous stream of data so, as changes are made, staff can see quickly whether the change has had a positive impact on patients.

Patient and public involvement

Throughout 2018/19, we continued to make good progress on expanding and deepening patient and public involvement. Our involvement strategy is overseen by our strategic lay forum which consists of 12 lay partners alongside colleagues from the Trust, Imperial Health Charity and Imperial College London.

Established a robust strategic lay forum

The forum is now well recognised as the foundation of involvement within the Trust and a key part of our governance for helping to ensure our care becomes more person-centred.

Through their bi-monthly meetings, the forum helped shape many key projects such as: the introduction of the physicians associate role; the review of the medical school curriculum; the quality account and strategy; and revalidation of doctors. The strategic lay forum also played a key role in the development of our new organisational strategy.

In 2018/19, we strengthened the forum's governance by introducing the role of a lay deputy chair. We also agreed regular reporting to our executive committee, including an annual plan and report to the Trust board. The chair and deputy chair of the forum meet with the Trust's chief executive every six months.

New staff recognition award for involvement

To help embed involvement, the forum was instrumental in creating a new category for the annual staff recognition awards. The 'Michael Morton patient and public involvement' award was co-designed with the forum in March 2019 to celebrate improvements based on patient involvement. The award is named after the first chair of the forum who passed away in late 2018, and will be awarded for the first time in July 2019.

Developing a lay partner community

Throughout the year the Trust continued to collaborate with lay partners on key projects. Lay partners joined new projects to improve palliative care and children's services. They also took part in the facilities' tenders, a committee to review new invasive procedures, and the 'improving flow' programme.

The Trust will continue to have lay partners on all of our key projects. To date, the Trust has created 53 lay partner roles across a range of projects, and there are currently 42 lay partner roles on active projects. As of March 2019, we are creating an additional 19 roles across 12 projects.

This year the Trust started to create a lay partner community by having regular breakfast networking meetings where we share updates and feedback and take part in relevant training. In 2019/20, we plan to continue the events and support this community by providing digital tools to allow online collaboration.

Trust-wide patient groups focusing on specific areas

We have two established reference groups that concentrate on a particular theme or part of the healthcare journey: a digital group which focuses on how we embrace and use digital technologies, and a communications group which comments on written communications and patient information. Both continued to meet throughout 2018/19 and gave helpful insights and challenges to ensure patients are at the centre of our plans.

The digital group provided useful feedback on how we set up a mobile access for clinicians to electronic patient records and fed into the requirements for a supplier tender for the Care Information Exchange.

Patient communications reference group

The patient communications reference group provides vital support in developing the Trust's patient information, which comes in a variety of formats, including leaflets, letters and posters. Due to our diverse patient population, it's essential that our materials are user-friendly and jargon-free. This group is invaluable in helping us to improve the wording and flow of our communications as well as the 'look and feel'.

The group currently reviews at least two leaflets or posters each month and has worked with 11 different services across the organisation so far. The group has also been involved in helping to shape Trust-wide initiatives such as the nursing job title harmonisation poster and our adult inpatient leaflet. This group was also the driving force behind changing the term 'critical care' to 'intensive care'.

Measuring impact

While it's positive to have robust processes and established patient groups, we recognise more needs to be done to capture the impact of this collaboration. Our focus for 2019/20 is to look at metrics and ways of evaluating the input from lay partners, and the difference they make to decision-making.

Objective: to make our care safer

Safety streams

In 2016, we established nine safety streams focused on improving patient safety in recognised areas of clinical risk identified from our most frequently reported serious incidents. Below is a summary of the progress we have made for each of these streams in 2018/19:

Abnormal results: Recognition of and response to abnormal results is a key patient safety priority for our Trust. In 2018/19 we designed new reporting systems to monitor the endorsement of results. These will launch in May and are supported by a standard operating procedure, which outlines what abnormal ranges of results look like. Once this new procedure is implemented within our electronic patient records system, all 'normal' results will be automatically endorsed. Going forward, we will monitor the impact of this work through: an increase in endorsement of results and a reduction in incidents causing harm.

Falls: For patients, a fall can result in pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. The aim of the falls safety stream is to support patients to mobilise safely and to reduce the rate of inpatient falls with harm. This year we have piloted 90-day cycles of improvement on individual wards to address local risk factors – this has resulted in improvements, including a reduction in falls with harm on several of the wards.

Overall, we have seen a 22 per cent decrease in falls with moderate and above harm since 2016 when the safety stream started, and a 73 per cent reduction in serious incidents. Data from the latest national falls audit shows that we are below average both for the rate of falls in total and for the rate of falls resulting in moderate/severe harm.

Fetal monitoring: This safety stream aims to reduce the number of infants delivered with poor outcomes as a result of misinterpretation of the fetal heart rate – also known as 'CTG'. In 2018/19 we launched a central monitoring system called 'Fetalink'. This system provides remote monitoring of key clinical metrics, including the fetal heart rate, allowing rapid escalation of issues. The system is fully implemented and staff are trained through local induction and within the labour ward environment.

Other improvements include:

- weekly educational meetings (per site) with presentation and CTG interpretation, including case outcomes and learning points
- updated CTG learning package and clinical guidelines for staff in line with current NICE guidelines
- introduction of 'Fresh Eyes' – a 'buddy' system where a second midwife confirms the fetal heart rate pattern.

We have seen a reduction in the number of clinical incidents where misinterpretation of CTG was a contributing factor, with no incidents of this type since August 2018. There has also been a reduction in complaints and claims relating to CTG interpretation.

Hand hygiene: Our hands are the principle route by which cross-infection happens, and hand hygiene is the single most important factor in the control of infection. In May 2018, we introduced a new methodology for auditing the five moments of hand hygiene, which sets a realistic benchmark for us to evaluate progress and target improvement work. Overall compliance was 56 per cent. The results prompted a Trust-wide hand hygiene improvement programme and the identification of a small number of 'focus wards' which received intensive support in developing local improvement plans. When we audited again in November 2018, compliance increased to 61 per cent, with the focus wards being the most improved. The improvements are being supported by an upgrade of the hand hygiene dispensers and a new hand hygiene communications campaign. We are currently analysing the results of the third audit round and we expect to identify more wards for focused improvement support.

Patient ID: Ensuring patients are correctly identified every time care or treatment is given – including where samples are taken and processed – is central to the safe delivery of care. In 2018 we launched a new Trust policy, which incorporates national guidance and learning from incident investigations.

Through a review of incidents, we identified a risk around 'wrong blood in tubes' (WBIT); this is where blood taken from a patient is mislabelled as having come from a different patient. Targeted improvement work has resulted in a 33 per cent reduction in WBIT incidents this year.

Care of mental health patients within A&E:

We continue to have significant delays for mental health patients in our A&E departments. This year, we had 68 patients who waited in A&E over 12 hours before being admitted. The majority of these were patients waiting for a mental health bed to become available. We are working closely with Central North West London NHS Foundation Trust to improve the patient pathway and reduce delays.

We established a safety stream in November 2018 to drive improvements internally and so far we have improved documentation and reduced transport

delays. We have established a multi-stakeholder steering group to address the root causes of this problem and have begun to progress our action plan.

To help ensure the safety of these patients, our mental health waiting suites in our A&E departments have been refurbished so we have separate, quiet spaces for patients with mental health issues waiting to be seen. We have also developed an educational video for staff.

Responding to deteriorating patients: Failure to detect, respond and escalate the care of an acutely unwell patient may result in further avoidable clinical deterioration, impairment or in extreme cases, death. This safety stream's primary focus is to enable clinical staff to identify those patients at risk and prevent clinical deterioration through accurate and robust observation; using data to identify patients at risk at safety briefings, and to encourage effective escalation conversations between clinical staff.

This year we implemented NEWS2 – the latest version of the National Early Warning Score – which, following an assessment enables staff to calculate a standardised score so they can respond more effectively to acute illness. We have also rolled out an electronic alert within our patient records system to improve the management of sepsis resulting in reduced patient morbidity and mortality.

Overall, we have seen a 64 per cent reduction in incidents resulting in moderate or above harm in 2018/19 compared to 2016/17 when this safety stream began.

Safer medicines: Medicines are the most common intervention in healthcare and can be associated with risk and harm. Within this safety stream we have focused on improving compliance with medicines management best practice, concentrating specifically on storage security and disposal. This year, we have reported two serious incidents related to medications, compared to four last year.

Safer surgery: This safety stream was established to create a culture of safety in our theatres and areas where we carry out invasive procedures to reduce avoidable harm and improve performance and outcomes. Throughout 2018/19, we have piloted a simulation and coaching programme for interventional procedure areas to support teams to focus on improving how they carry out safety checks, as well as looking at teamwork and behaviours to support a safe and efficient working culture. Given our increased number of 'never events' (we reported seven never events, six of which were related to invasive procedures in 2018/19) we agreed to speed up the roll-out of the programme. The five specialties which had never events had completed their first training sessions by 15 May. From June 2019, the programme will be rolled out to all areas which undertake invasive procedures.

Never events

Over the course of 2018/19 we reported seven never events. Never events are defined as serious, largely preventable incidents that should not occur if the available preventative measures have been implemented. Six of the seven incidents we had related to invasive procedures. All of the incidents have been investigated and action plans are in place locally. We also implemented a Trust-wide action plan. This included the medical director visiting theatres, talking to staff on the frontline about how to make improvements and encouraging staff to support each other to work safely; the roll-out of a tailored coaching and simulation training programme for all areas where we undertake invasive procedures, starting with the specialties where we've had never events; actions to improve, monitor and provide assurance around compliance with key safety checks, including the five steps to safer surgery, and a review of all Trust policies and processes related to invasive procedures. At our request, Dr Fowler, the national director of patient safety visited us to discuss our plans. He was supportive of the actions and approach we are taking.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures reported to our Trust board. Through this process, 93 per cent of deaths which occurred at the Trust between April 2018 and March 2019 have been reviewed so far. Of these, 14 per cent have gone forward for structured judgment review (SJR). This is a validated methodology and involves trained clinicians reviewing medical records in a critical manner to comment on phases of care and determine whether the death may have been due to problems with the care the patient received. We have identified avoidable factors in eleven out of the 1,702 deaths which occurred this year.

The SJR process includes presentation to the monthly Mortality Review Group where we identify learning opportunities and themes and share these across the Trust. Where the review identifies avoidable factors in a death, we also complete a serious incident investigation.

In late 2018, we identified some improvements to the process which will support us in the lead up to the implementation of the nationally mandated role of a medical examiner (ME). As a result, we are in the process of forming a comprehensive patient affairs and bereavement service, which will provide holistic care and respond efficiently and compassionately to the bereaved.

Improving intensive and high dependency care

We improved care for our most seriously ill patients at St Mary's Hospital in 2018 by bringing together our high dependency and intensive care beds onto a single floor, and creating an additional five major trauma beds giving us 19 beds in total. This has allowed us to concentrate specialist skills for patients with the highest needs on one floor.

We also expanded our clinical team with over 50 additional staff including doctors, nurses, healthcare assistants, pharmacists and therapists as well as investing £800,000 in additional equipment and ward refurbishments.

The St Mary's changes follow a similar initiative at Charing Cross Hospital last year which brought together intensive and high dependency beds. A review of intensive and high dependency care at Hammersmith Hospital is underway.

Improving our care for stroke patients

Considered the 'gold standard' in treating severe strokes where a major blood vessel is blocked, we have offered a thrombectomy service at our hyper acute stroke unit (HASU) at Charing Cross Hospital since 2013. In summer 2018, we were pleased to become one of the first trusts in the UK to offer this ground-breaking treatment seven days a week.

Thrombectomy is a minimally invasive technique which physically removes the clot blocking blood supply to a patient's brain by inserting a special device under x-ray guidance into the blood vessel. When a major brain artery is blocked, which happens in around 10 per cent of strokes, it's been shown to significantly reduce the risk of long-term brain injury, disability and loss of independence.

With the extended hours, the procedure can now be offered to the vast majority of patients who would benefit from it and our aim is to offer a full, 24-hour service as soon as possible.

The roll-out of thrombectomy builds on the successful formation of the HASU in 2010, one of eight stroke treatment hubs in London which now sees around 1800 patients a year.

£1.9m award for state-of-the-art surgical and imaging theatre

In 2018/19, we were awarded funding to create a new 'endovascular hybrid' theatre at St Mary's Hospital, allowing patients with complex blood vessel problems to be treated with the most up-to-date procedures.

The hybrid theatre will allow surgery and very high quality imaging to be undertaken as a combined procedure in the same operating theatre. This means a team of vascular surgeons and interventional radiologists can work together to carry out endovascular procedures, treating problems with blood vessels without open surgery. Minimally invasive procedures, such as this, reduce physical trauma to the patient, are less painful and enable a faster physical recovery time, which reduces length of hospital stay.

Objective: to make the Trust a great place to work

Creating a better culture

In November 2018, we launched the leading change though vision, values and behaviours programme to help transform the culture of our organisation. The programme built on work undertaken in 2015/16 when we defined our four organisational values – to be kind, collaborative, aspirational and expert, alongside our organisational vision – 'better health, for life'.

The 2018 programme was informed by evidence that a shared and compelling vision, plus a commitment to meaningful values and behaviours, will help us be a great place to work and enable us to do the best for our patients and local communities.

More than 2,000 staff took part in activities designed to explore themes around our vision, values and behaviours; their views and insights fed into work to develop our organisational strategy and to co-design our 2019/20 priorities. This feedback also helped inform a 'behaviours framework', setting out clear examples of the behaviours that demonstrate when we are living our values, and those that show when we are not.

In 2019/20 and beyond, we will embed this approach in how we work through a range of initiatives; for example, our personal development review process will change to take greater account of how people achieve their objectives by living the Trust values.

Staff-led networks

A number of self-organising staff networks have been established over the last year – connecting people, hosting events and giving a voice to different staff groups.

The Trust launched a women's network with funding from the NHS London Leadership Academy. This self-organising group connects women from all areas of the organisation, at all levels, to discuss the particular demands on women and how we can improve support. The network held five events and partnered with the communications team to mark International Women's Day by sharing stories of Imperial women.

The LGBTQ+ network launched in 2018 organising a formal Trust presence at London's 2018 Pride parade and flying rainbow flags at our hospitals for the first time. The group is planning a series of events for 2019/20 and will work with Trust leaders to mark Pride again this year.

The black, Asian and minority ethnic (BAME) nursing and midwifery group was established in 2018 focussing on a range of issues, including supporting the education, training and leadership development of BAME nurses and midwives, and sharing opportunities to become more involved.

Great Place to Work week

Great Place to Work week took place from 24-28 September 2018. The week focused on our offer to our staff, and how staff can take advantage of the opportunities and benefits available to them.

The packed agenda for the week included a health and wellbeing marketplace at each of our sites. We also offered our staff: career clinics, learning and development taster sessions and team health sessions, alongside activities like healthy cooking demonstrations, health checks and complimentary massages.

More than 1,000 staff visited our marketplace throughout the week, and plenty more attended our events and took part in staff competitions.

Staff wellbeing

The mental and physical wellbeing of our staff is a Trust priority, and over the past year we put a number of initiatives in place to improve wellbeing.

CONTACT, the staff counselling, stress management and conflict resolution service, offered teams one-hour health sessions at Great Place to Work Week (see above) to discuss how to address challenges and improve self-care both on an individual and team level. A total of 15 teams (168 staff members) engaged with this during the week and, following positive feedback, the sessions were rolled out again in February 2019, with a further nine teams (110 staff members) signing up.

Throughout the year we held a total of 29 Schwartz Rounds – staff-only group discussions that offer a space to share and reflect on the personal, emotional and social aspects of our work in healthcare. The total attendance for these sessions was around 1,200, with an average attendance of 41 staff members for each session. The most popular themes from the year ranged from going above and beyond for our patients, to resilience and the impact of how our staff are treated by patients and fellow colleagues.

Recognising that some of our staff struggle to fit in physical activity around their working day, in May 2018 our fitness team rolled out a 'workplace wheels' initiative that allows departments to have access to a stationary exercise bike on their ward, which they can conveniently use during breaks. This initiative has encouraged better movement and increased fitness among those who have used it.

The fitness team also introduced active weight loss sessions in April 2018. This six week programme gives staff tailored advice to help them achieve their fitness and weight loss goals. As well as weight loss, participants recorded an increase in energy levels, reduction in fatigue and improved productivity.

Nursing associates, physician associates and apprenticeships

As pressures on the NHS continue to increase, supporting and developing our workforce is a top priority. We have introduced a number of new roles to allow staff to develop and to support existing staff.

The nursing associate is a new support role that sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. In 2018/19, ten trainee nursing associates were working and learning at the Trust as part of a national pilot programme, and a further 10 trainees are part of our apprenticeship programme.

Physician associates are professionals with a general medical education who work under a doctor's supervision as part of a multidisciplinary team. In November 2018, we welcomed our first three physician associates to the Trust, working in paediatric surgery, urology and neurology.

Our apprenticeship programme offers people the chance to earn and learn in the workplace and has continued to grow. Our new entrant programme supports people from local communities to progress into full-time employment or make a career change. During 2018/19, nine people transitioned into substantial posts.

The apprenticeship programme also offers development opportunities to our workforce, creating new career pathways and extending skills and experience. During 2018/19, 114 staff were enrolled on various programmes. This is 1.09 per cent of our workforce against a target of 2.3 per cent. We plan to reach this target in 2019/20 by focusing on extending the new entrant programme and offering a wider range of business and management programmes.

Celebrating a landmark birthday at Charing Cross Hospital

In 2018/19 we marked the 200th anniversary of Charing Cross Hospital, which was founded by Dr Benjamin Golding in October 1818.

A range of events took place throughout the month to mark this special occasion, including an exclusive performance for staff of the award-winning 'Check Up: NHS at 70' show by comedian Mark Thomas which was based on members of Trust staff. We also held a reflections and celebrations event for staff to share their stories and memories of the hospital, and a hospital open day with entertainment, information stands, education talks, recruitment opportunities and service tours for patients and the public.

There were more lasting tributes, too. Patients at Charing Cross Hospital now benefit from a new, specially designed garden which was opened to mark the anniversary. Funded by Imperial Health Charity, the garden was created for patients with dementia, as well as those recovering from a stroke or suffering from another neurological condition.

A history zone – displaying key historical artefacts and images of key moments in the hospital's history remains in the main hospital foyer and on the ground floor near the chapel.

Celebrating the NHS's 70th birthday

The 5 July 2018 marked 70 years since the NHS was created. The Trust, along with Imperial Health Charity, organised a number of celebrations to mark the occasion. We took the opportunity to celebrate our hospitals' rich histories and the people who make our Trust what it is.

Imperial Health Charity led the Big7Tea, a nationwide campaign which encouraged NHS staff, volunteers and the public to host tea parties and raise money for the UK's NHS charities. Wards and departments at our Trust hosted over 50 tea parties, bringing staff and patients together to celebrate the special anniversary. The Charity also teamed up with leading artists to create a series of limited edition NHS70 prints, and worked with the Trust to curate the 'Hospitals That Make History' exhibition, which highlighted some of the landmark moments at our hospitals from the last 70 years.

We started the 'Imperial People' campaign on our social media channels in January 2018. The campaign's aim was to celebrate the many diverse personalities that make up our Trust by sharing short quotes and photos from individuals around our hospitals.

In a special NHS70 edition of the Trust magazine and on our website blog, staff past and present reflected on their careers at our hospitals and on what the next 70 years holds for the NHS. Notable people who took part included Dr William Frankland, who worked with Alexander Fleming and invented the pollen count, Professor the Lord Ara Darzi, and Professor Averil Mansfield, the UK's first female professor of surgery.

On the day itself, ITV presented a special NHS70 edition of This Morning at Queen Charlotte's & Chelsea and Hammersmith hospitals, where presenters Holly Willoughby and Philip Schofield met some of our staff as well as patients.

Improving our disciplinary procedures

This year we carried out a root and branch review of how we manage disciplinary processes. We have now expanded our training programme for managers, and have monthly executive oversight meetings to review active cases and ensure any delays are minimised and communication is timely. We are establishing an in-house investigation team to increase the independence of the disciplinary procedures we conduct.

This review of our processes came as a response to a report of the independent investigation into the disciplinary process that resulted in the dismissal of Amin Abdullah, a nurse who subsequently took his own life in February 2016. The Trust commissioned independent consultancy Verita to carry out the investigation, which was overseen by a stakeholder panel including representatives of the Trust and NHS Improvement, Mr Abdullah's partner and his partner's representative.

We accepted all the findings and recommendations of the investigation and following the report's publication put the following measures in place:

- a new checkpoint involving a senior staff member unrelated to the case to assess whether or not to move on to formal proceedings
- pastoral care for all staff in a formal disciplinary process
- ensuring staff undertake new training before taking up a role as an investigating officer or a chair of a disciplinary hearing
- additional review by a senior staff member unrelated to the case at the conclusion of the investigation
- a new outcome letter template and guidance for disciplinary procedures

Brexit

In the run up to the UK leaving the European Union, we have run a series of information sessions for staff who are EU citizens and wish to apply to the EU Settlement Scheme. This scheme allows EU citizens and their family members to continue to live, work and study in the UK, as well as continuing to access public services like healthcare, schools and benefits.

Between 4 and 21 December 2018 we were invited to take part in a Government pilot of EU Settlement Scheme in advance of its formal launch in 2019. We supported the relevant staff to apply for settled status during the pilot period, and have continued to communicate regularly on our preparations for Brexit – including our business continuity plans in the case of a no deal Brexit. Our assessment of Brexit is outlined in the accounting policies (note 1.2.2.3).

New intranet for Trust staff

In 2018/19 we launched a new intranet solution for our staff which can be used securely anywhere on any device – revolutionising the way we access information.

Some of the main features of the new platform include:

- a robust search function, where you can search for documents, events, news content and more
- a comprehensive directory of staff profiles and departments
- personalised engagement functionality: the ability to like, share and favourite content, and receive alerts when content is updated
- a mobile intranet giving clinical staff the ability to access clinical guidelines at the bedside from their phone on a fast, reliable and safe connection

Other aspects of the intranet that have improved the working lives of our staff include having 'trending' items on the home-page, top tasks and quick links to Trust-wide systems and applications – making it easier to navigate to key information and on-board new colleagues.

> Our cost improvements in 2018/19 made a significant contribution to achieving our financial plan.

For our communications team, page analytics have meant they can better tailor the content published to reflect items that are frequently viewed, or searched for.

In 2019/20, staff can look forward to the introduction of a new electronic forms solution to speed-up internal processes, 'team spaces' – protected areas where staff can collaborate with their colleagues remotely, based around a project, theme or grouping, reducing our reliance on emails and shared drives.

Objective: to build sustainability

Overseas patients

The Trust's overseas visitors' office ensures we're complying with Government guidance on the treatment and charging of patients who are not ordinarily resident in the UK, and secures payment from those patients who are liable for charges.

During 2018/19, the overseas visitor office worked with Trust staff to implement the changes detailed in the Department of Health's updated Overseas Visitors Charging Regulations of 2017. These changes meant the Trust is now legally obliged to recover in advance the estimated cost of a course of treatment from an overseas visitor, unless doing so would prevent or delay the provision of immediately necessary or urgent treatment. The Trust ran a three-month pilot across seven specialties to identify best practice before expanding to the whole Trust.

The overseas visitors' office worked with the communications team to ensure staff and patients were aware of these changes, and supported staff to refer patients to the overseas office when appropriate. For 2018/19, the forecasted outturn for overseas visitor billing is £7.3m, compared with £5.4m in 2017/18.

In 2019/20, the overseas visitors' team will continue to support clinicians to identify patients who may not qualify for NHS care free of charge, and recover costs from those patients, while finessing processes.

Imperial Private Healthcare

Imperial Private Healthcare is the private arm of the Trust, with all profits reinvested back into supporting and improving NHS services as well as our dedicated private facilities. The service has delivered strong growth throughout 2018/19, generating £52.2m in revenue, an increase of £1.5m or 3.0 per cent on the previous year. Last year saw Imperial Private Healthcare look after 17,500 patients, from all over London, the UK and overseas who either have private healthcare insurance, are embassy sponsored or self-pay for their treatment. Among our patients, we were delighted to care for the Duchess of Cambridge once more as she delivered her third child, Prince Louis of Cambridge, at The Lindo Wing.

As well as growing the business by offering an increased range of treatments from across the spectrum of Trust services this year, Imperial Private Healthcare has continued to invest in improving the experience of patients in its care. This has included the implementation of a new private patients' referrals hub to streamline the appointments process. The hub has led to a centralised booking process, and a specialist referrals team, who are all experts in customer service. The team now also offer a 24/7-based answering service to provide additional support for patients at peak times, which has led to a significant increase in referrals.

Cost improvements this year

The Trust delivered another challenging programme of cost improvements in 2018/19, worth £44.1m recurrently, increasing our efficiency and productivity while continuing to improve our care and caring for more patients.

We use a comprehensive quality impact assessment process for all our cost improvement programmes.

Our cost improvements in 2018/19 made a significant contribution to achieving our financial plan. We delivered a £28.2m surplus, taking into account central support including provider sustainability funding.

Important to building our financial sustainability, we have also reduced our underlying deficit by around £2.4m and are working on a plan to do the same in the coming year.

Going concern

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the entity's ability to continue as a going concern. Financial statements should be prepared on a going concern basis unless there is an intention to cease activities or there is no realistic alternative but to do so. Current guidance is that Department of Health and Social Care bodies should prepare their financial statements on a going concern basis unless informed by the Department of Health and Social Care of the intention for dissolution without transfer or service or function to another entity.

Management has identified a material uncertainty about the financial viability of the Trust in certain circumstances should it not receive additional centrally agreed funding. Further details are given in note 1.1.2 of the financial statements which form part of this report.

Payslips go paperless

In January 2019, we stopped producing and distributing paper payslips. Staff can now view their own payslips, employment information and total reward statement – as well as update their personal information – using a new internal platform called ESR self-service.

The benefits of going paperless are:

- staff can access their payslip 48 hours before payday
- staff can access their payslip 24/7 on a home PC or through the My ESR app
- staff can download their payslips as a PDF should they wish to have a hard copy
- it's environmentally friendlier to provide this information digitally, and saves on costs.

Joint electronic patient record system with Chelsea and Westminster Hospital NHS Trust

This year we began sharing our Cerner electronic patient record system with Chelsea and Westminster Hospital NHS Trust – breaking the tradition of NHS trusts having separate systems for managing patient information. Sharing systems brings benefits for both patients and staff and a cost saving for the NHS. Staff have only one system to learn now, and patients who are treated at both trusts know their clinicians have all the information they need to deliver care, irrespective of where their care is received.

Sustainability report

Our vision of better health, for life is intrinsically linked to developing a truly sustainable approach to healthcare. With this as a guiding principle, we are formulating a sustainability programme to help us work towards three key aims:

- long-term financial sustainability
- minimising our impact and even having a positive impact on the environment
- supporting wellbeing to enable a healthy, happy, productive workforce and community.

Over the last year we been working on producing a sustainable development management plan (SDMP). This sets out the actions we need to take to deliver our vision, and support each of our Trust's three strategic goals (see pX).

The following sections highlight the progress we have made in 2018/19 and our plans for the coming year.

Our environmental impact

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also transport Trust staff, patients and goods, and purchase a large range of medical and other equipment and services. All of these activities generate carbon dioxide (CO_2) emissions, which are linked to climate change, and can be collectively summarised as our carbon footprint.

Since our baseline year of 2015-16 we have reduced our absolute carbon footprint by 6,760 tonnes CO_2e[1] (13.3 per cent).

Resources		2015/16	2016/17	2017/18	2018/19
Gas	Use (MWh)	86,702	86,716	84,814	92,297
	tCO2e	18,190	18,148	17,725	19,568
Coal	Use (MWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (MWh)	53,444	54,757	57,534	56,988
	tCO2e	31,669	28,898	27,109	24,221
Green Electricity	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Total Energy tCO_2e		50769	47256	45181	44009
Total Energy Spend		£9,012,756	£8,940,086	£9,242,247	£9,927,889

Our other key environmental impacts in delivering our services include:

- waste: we produced approximately 4,846.49 tonnes of waste in 2018/19 and recycled around 3288.48 tonnes of our non-healthcare waste.
- travel: our staff travel is around 61,487 business miles each year, which includes staff travelling with the hopper bus – which connects our sites – and by taxi over the Christmas period when public transport was not available.
- gas and energy: our spend on utilities in 2018/19 increased significantly. This is due in part to a prolonged spell of cold weather last year, which caused a spike in the cost of electricity and gas. Secondly, in 2017/18, we were invoiced by our gas supplier based on estimated readings, which were lower than the amount of gas we consumed. In 2018/19, we were invoiced based on the actual amount of gas we consumed. Some of the gas consumed in 2017/18 was included in our charges for 2018/2019.

Reducing our energy usage

The Trust has made great progress with its combined heating and power (CHP) installation at the Hammersmith Hospital site. We will now be able to connect to UK Power networks – the local distribution network operator – allowing the Trust to use the electricity produced by the CHP on the Hammersmith site. This means we will reduce our reliance on the National Grid for our electricity requirements and also benefit financially from self-generated electricity and lower carbon emissions.

This project is in addition to 34 energy efficiency projects that we have already implemented since 2009/10. The cumulative investment of £10.4m in these initiatives has delivered a savings of £2.7m and has helped us reduce our carbon emissions by 19,135 tonnes per annum. The lifetime savings over a 15-year period from 2011 to 2025 are estimated to be £39,571,069. In 2016/17, we installed a heat recovery system at Hammersmith Hospital and evaluation of this project this year showed we have delivered 120 per cent of the projected savings.

In 2018/19 we implemented a lift upgrade programme across some of the lifts on all of our sites, which put in place new energy-efficient lifts as well as an intelligent 'traffic management system' whereby users will be approached by the nearest lift and reach their destination via the optimised route.

In 2018/19 we were awarded a certificate of excellence by the Sustainable Development Unit, with HFMA and NHS Improvement, for our sustainability reporting in last year's annual report. Out of 432 organisations across England, 55 Trusts and 42 CCGs (around 22 per cent) were selected for this recognition. We were also short listed for Energy Live Personality Awards and EMA Energy Management Awards in the 'Energy Manager of the Year' category.

1 CO2e is the standard unit for measuring carbon footprints. It reflects the impact of all six greenhouse gases that cause global warming including carbon dioxide and methane. This is important as some of the gases have a greater warming effect than carbon dioxide.

In 2018/19 we made significant headway with regard to procurement and management of energy system upgrades through the Energy Performance Contract (EPC) programme. The EPC programme will support us to meet our medium to long-term heat and power strategy, as well as holistically identify and implement commercially viable energy efficiency options on all sites. In addition to benefiting from external financing, cutting backlog maintenance, achieving guaranteed energy savings and protecting capital budgets, the use of an OJEU-compliant procurement framework could also reduce utilities costs and risks while allowing the Trust unlimited access to advisers and a standard suite of contracts. Following two comprehensive site visits by the service providers, we have now received detailed proposals from them. The next step is to appoint a strategic energy partner to put together an Investment Grade Proposal (IGP). This IGP will lay out firm figures for investments and guaranteed savings for the term of the agreement.

Sustainable transport

Our Trust sites are well placed for staff to travel in to work by public transport. We also provide a discount to staff using electric cars. We are also looking at providing electric charging points for visitors.

Waste

4,846.49*
tonnes of waste

3288.48*
tonnes of our non-healthcare waste recycled

Staff travel

61,487*
business miles each year

This includes staff travelling with the hopper bus – which connects our sites – and by taxi over the Christmas period when public transport was not available.

Gas and energy

Our spend on utilities in 2018/19 increased **significantly.**

This is due in part to a prolonged spell of cold weather last year, which caused a spike in the cost of electricity and gas.

Secondly, in 2017/18, we were invoiced by our gas supplier based on estimated readings, which were lower than the amount of gas we consumed. In 2018/19, we were invoiced based on the actual amount of gas we consumed. Some of the gas consumed in 2017/18 was included in our charges for 2018/2019.

*Approximately

Performance against the domains of quality

We measure quality against the five domains used by the Care Quality Commission (CQC). These domains are known as: safe, effective, caring, responsive and well-led. The domains are designed to ensure we focus on the issues that matter to people, and make improvements which are aligned to the CQC's regulatory requirements.

For 2018/19, we reported on an additional quality domain known as: 'use resources sustainably'. This domain was defined by the National Quality Board (NQB) and is monitored by NHS Improvement (NHSI). It is also included in CQC inspection reports to ensure NHS trusts deliver value for money for patients, communities and taxpayers.

We report progress against each quality domain on a bi-monthly basis at our Trust board meeting. Every domain has a number of different work-streams attached to it, alongside a driver diagram – an improvement tool which helps us to capture each change programme in one diagram, as well as providing us with a measurement framework for monitoring progress.

Last year, we identified 13 priority quality improvement areas based on insight from: a listening campaign we conducted with more than 1,000 staff and members of the public; CQC inspections; and quality domain driver diagrams. Highlights from these programmes are included below. For full details see our quality account, which is published on our website.

Below are some of the areas where we have made improvements we are proud of, alongside areas where we have not performed as well as we wanted to:

Safe

Goal: People are protected from abuse and avoidable harm

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm.

Safe quality highlights and challenges

One of our improvement priorities for 2018/19 was reducing avoidable harm. Compared to 2017/18, we have had fewer incidents which cause the most harm to patients, reporting 11 severe and extreme harm incidents compared to 27 last year, and continue to be below the national average compared to other acute trusts.

We introduced nine safety work-streams to address the risks identified from our most frequently reported serious incidents. Some of the improvements we have made include:

- a 30 per cent reduction in cardiac arrests that happen outside of the intensive care unit
- a reduction in the number of deaths as a result of sepsis from 18 per cent to 14 per cent
- achieving our target of ensuring at least 50 per cent of patients who are newly diagnosed with sepsis receive antibiotics within one hour – averaging 70 per cent per month since we started reporting on this target in November 2018
- a 64 per cent reduction in incidents causing the most harm in the category of 'failure to respond to the deteriorating patient' since 2016/17
- 22 per cent reduction in falls with moderate and above harm since 2016/17
- a 33 per cent reduction in incidents related to wrong blood in tubes – this is where blood taken from a patient is mislabelled as having come from a different patient
- a reduction in serious incidents related to medications from 4 to 2
- a reduction in the number of clinical incidents where misinterpretation of cardiotocography (CTG) was a contributing factor, with no incidents of this type since August 2018.

Incident reporting rate

An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety to learn from them and deliver improved care. A high reporting rate reflects a positive reporting culture. Since we started our incident reporting improvement programme we have seen an increase in the numbers of incidents reported by 746 from 16,166 in 2016/17 compared to 16,912 in 2018/19, while maintaining low levels of harm. Our incident reporting rate per 1,000 bed days has however reduced and is below the top quartile when compared nationally, this is due to a number of issues with our published bed day data for quarter three which is used to calculate our reporting rate for the last six months of 2018/19. The quarter four bed occupancy data is expected to reduce, bringing our reporting rate up.

Never events

We reported seven never events, compared to one last year. Never events are defined as serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented. Six of the seven were related to invasive procedures. All of the incidents have been investigated and local action plans are in place. We have also developed a Trust-wide action plan, including a simulation and coaching programme for staff who work in areas where invasive procedures happen.

Safe staffing levels

In 2018/19 we maintained safe staffing levels despite our vacancy rates remaining higher than our targets. Where shifts were not filled, we made sure any risk to patient care was minimised by:

- using our workforce flexibly across floors and clinical areas
- specialist staff working clinically during the shift to support their ward-based colleagues
- the nurse or midwife in charge of the area working clinically and taking on a case load.

One of our improvement priorities for 2018/19 was to increase permanent nurse staffing levels and we've seen some progress in this area, including an increase in the number of student nurses who train with us deciding to take up employment afterwards. We've also seen an increase in the internal vs external hire ratio. In addition, we have met the targets we set for ourselves in terms of recruiting international nursing and midwifery staff, and recruiting nursing associates and graduate nurse apprentices.

VTE risk

The risk of hospital acquired venous thromboembolism (VTE) – blood clots which form in a vein – can be reduced by assessing patients on admission. Although we met our VTE assessment target for the first three quarters this year, between December 2018 and March 2019 we were below the target of 95 per cent, reporting our lowest compliance in March at 93.42 per cent. We are working with the areas that we have identified as below target to support staff to complete the assessment, including creating a network of VTE 'champions'. We are also addressing technical issues with the electronic system that prompts staff to undertake the assessment.

Infection prevention and control

Despite seeing a reduction in the number of cases of Clostridium difficile compared to last year, overall we have seen an increase in avoidable infections (cases of MRSA BSI and Clostridium difficile related to lapses in care) in 2018/19, reporting 14 compared to 10 last year.

In 2017/18, we were one of only 59 trusts who achieved a 10 per cent or greater reduction in Escherichia Coli bloodstream infections. Unfortunately, in 2018/19 we did not achieve our target of a further 10 per cent reduction, reporting 83 cases of E. coli BSI, which is more than last year.

We reported seven Carbapenemase-producing Enterobacteriaceae bloodstream infection cases (CPE BSI), one more than last year. The seven cases this year all occurred in patients with advanced malignant disease or complex urological or hepatic conditions; review of these cases has confirmed that no specific preventive action could have been taken.

Our on-going work-streams to improve infection prevention and control include the hand hygiene safety stream, focused on improving hand hygiene compliance across the Trust, anti-microbial stewardship (ensuring the appropriate use of antibiotics) and improving our cleaning processes.

This year we did not meet our target for flu vaccinations: In 2017/18, we were the most improved trust for vaccination take-up rates, with 60.5 per cent of our frontline healthcare workers vaccinated against flu. In 2018/19, our vaccination rate was similar to last year's at 60.2 per cent, and did not meet the national target of 70 per cent. Overall, take-up of the vaccination across London has been low this year, due to a milder climate and limited national news. We will review our flu plan and identify improvements to support us to meet our target next year.

We are pleased to have met our maternity standards for puerperal sepsis (postpartum infections) this year, as well as our targets around the ratio of births to midwifery staff.

Duty of candour

We have improved how we are enacting the duty of candour and being open with our patients when things go wrong, with patients receiving a verbal and written explanation and apology for all appropriate incidents in over 90 per cent of cases, which is an improvement on last year, though below our target of 100 per cent. We will continue to work to make improvements.

Safeguarding

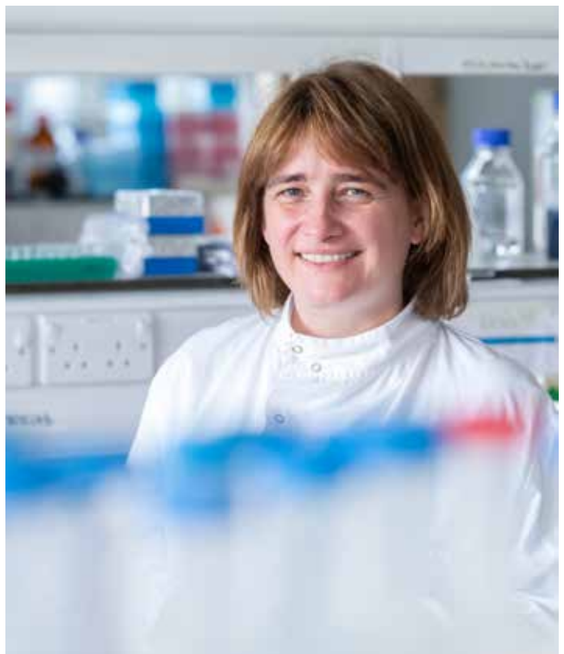
We are committed to the protection and safeguarding of all our patients, including children and young people. We provide staff with different levels of safeguarding training, depending on their role. We have seen an improvement in compliance with training at all levels for both safeguarding children and adults, achieving 90 per cent compliance by the end of 2018/19.

Health and safety

We have achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 75 per cent of clinical wards, clinical departments and corporate departments. While we are pleased to have met both of these targets in 2018/19, we did not meet our target to reduce the number of reportable serious accidents, occupational diseases and specified dangerous occurrences in the workplace (known as RIDDOR incidents), reporting 55 compared to 51 last year. The majority of these are slips, trips and falls and 'dangerous occurrences' (mainly involving sharps injuries). Plans are in place to support a reduction in these types of incidents including the launch of a new online workplace inspection module to support staff in identifying areas of risk.

Estates and facilities

We have met most of the targets we set ourselves for estates and facilities improvement. We have one of the poorest NHS estates in the country, with a £1.3bn backlog maintenance liability. We are working hard to improve this estate, and to make sure we minimise potential disruption and inconvenience for our patients and staff, as we complete these works. To monitor our progress in this area, we included five targets in our quality account metrics for 2018/19, three of which we have met, and have made significant improvements in performance with our planned maintenance targets for medical devices. Read our latest quality account on our Trust website.



Effective

Goal: people's care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

The goal and targets in our 'Effective' domain are designed to drive improvements, support good practice in our services, and ensure the outcomes for our patients are as good as they can be using best available evidence to continuously improve care and treatment.

Effective quality highlights and challenges

Mortality rates

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur at the Trust: As part of our drive to deliver good outcomes for our patients, we closely monitor our mortality rates using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator). Both of these have remained low, with our Trust having the lowest HSMR across the last year of data when compared to peer trusts in England, and the fourth lowest SHMI.

Clinical audits

We participated in 27 out of the 32 relevant national clinical audits, which were published in 2018/19 and action plans have been implemented where required. Clinical audit is a key improvement tool through which we can monitor and improve the quality of care that we provide. By taking part in national clinical audit programmes, we are able to benchmark our performance and measure improvements on a year-by-year basis.

Our aim is for all national clinical audit reports to be formally reviewed by the clinical lead within 90 days. We have improved over the last year, with 32 out of 33 reviews completed by the end of March 2019, 19 of which were done within the timeframe. Of these, two audits have been assessed as significant risk/little assurance and have action plans in place.

Recruiting to clinical trials

From quarter two this year we met our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days. We are committed to encouraging innovation in everything we do and part of this involves carrying out pioneering research into diagnostic methods and treatments. We are pleased we are now meeting this target and giving patients the opportunity to participate in research in a timely way.

Caring

Goal: staff involve and treat people with compassion, kindness, dignity and respect.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals we ensure we listen to our patients, their families and carers, and respond to their feedback.

Caring quality highlights and challenges

Patient experience and feedback

We have exceeded our target for the percentage of inpatients who would recommend us to their friends and family, with an average of 97.42 per cent, and improved our overall performance in the national inpatient survey: out of 62 questions, we scored about the same as average in 60, better than average in one and worse than average in one. This is an improvement on the previous year when we scored worse than average in five questions and better than average in none. For patients reporting a positive experience, interaction with staff continues to be the most significant factor. This relationship between staff and patient experience is well recognised; our patients report this as having the most positive impact on their experience. We are continuing to build upon this relationship by actively encouraging staff to understand and act upon patient feedback. We have also introduced patient support volunteers at St Mary's and Hammersmith hospitals, which have proved very popular with both patients and staff. Based on themes emerging from patient feedback, we have developed a number of actions to improve in two key areas: reducing noise at night and improving the quality of food and protected meal times for our inpatients.

We have improved the percentage of outpatients who would recommend our Trust from 91.06 per cent to 92.98 per cent. As our outpatient improvement programme progresses, we are confident we will carry on seeing improvements in outpatient experience.

We met our target for the percentage of our accident and emergency (A&E) patients who would recommend us and, with an average score of 94.26 per cent, were significantly above the national average of 86.8 per cent.

We also significantly improved the percentage of patients using patient transport who would recommend our Trust from 82 per cent last year to over 91 per cent this year: patient transport has been a key issue for those who are not able to travel to appointments independently and we expect our new non-emergency patient transport contract will deliver further improvements for our patients.

The percentage of patients who would recommend our maternity services dropped slightly this year from 93.83 per cent to 93.81 per cent. Some of the changes we've made to improve patient experience in this area include: volunteer support with managing queues and informing women about waiting times; 'quality rounds' delivered by a lead nurse who talks to all the women on the ward to discuss any issues they've identified; and new equipment, including chairs, fans, ear plugs and ear masks.

We slightly improved on our national cancer patient experience survey results from last year (8.7/10 for overall care compared to 8.5/10 last year). The number of questions which scored in the lowest range decreased from 23 last year to 17 this year. We also scored above or within the expected range for 35 questions, compared to 29 last year. These improvements reflect our on-going work around the role of the clinical nurse specialist, consolidating our navigator service and strengthening links with primary care.

Mixed sex accommodation

The national standard for mixed sex accommodation (MSA) breaches is none for level one patients (patients requiring ward-based care). In 2018/19, we reported 554 MSA breaches. All of these were the result of patients whose condition had improved and were awaiting discharge from critical care units to ward areas. We are working on reducing the number of delayed discharges from critical care as part of our on-going work to increase capacity and improve flow across our sites, which in turn will support reductions in MSA breaches.

Responsive

Goal: services are organised so that they meet people's needs.

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment, which can cause harm to our patients.

Responsive quality highlights and challenges

Cancer standards

We met five out of the nine cancer standards and met all except for the 62-day screening standard and 62-day upgrade standard in quarter four (data to February 2019). An action plan has been agreed, supported by the CCG and screening commissioners from NHS England. Performance is expected to recover in the new financial year. These improvements we have seen to our cancer waiting times overall are the result of actions taken, including improvements in patient pathways for prostate cancer and lung nodule surveillance, establishment of a Tyrosine Kinase Inhibitor (TKI) clinic and straight to test access for GPs to a number of services.

Four-hour A&E standard

Like many NHS trusts, we continue to struggle to meet the 95 per cent standard for A&E patients to be treated and discharged or admitted within four hours, although we have seen an improvement compared to last year. In March 2019 our A&E four-hour access performance was significantly better (5.2 per cent) compared to March 2018, despite having 4.3 per cent more attendances. Overall, we achieved an average of 88.11 per cent across 2018/19, compared to 87.11 per cent last year. We also saw a reduction in delayed beds, an increase in patients discharged before noon. We still have issues with capacity and increased lengths of stay. In 2018 we identified a 100 bed shortfall. Since then we have invested in 50 additional beds while delivering another 35 through efficiencies in A&E and patient flow. Pressures on A&E are complex and include pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery. Work continues through our 'Keeping care flowing collaborative' to improve the care journey and flow of patients attending our hospitals.

18-week referral to treatment standard

We did not meet the standard of 92 per cent of patients treated within 18 weeks of referral in 2018/19, although we have improved since last year reporting an average of 84.12 per cent in 2018/19 compared to 83.34 per cent in 2017/18. Improvement trajectories were agreed with our commissioners and NHSI and a number of work-streams are in place to drive improvement.

We have seen a significant reduction in the number of patients waiting over 52 weeks for treatment, with 573 reported in 2018/19 compared to 1,854 in 2017/18 and none in March 2019. The programme remains patient-focused with a clinical harm process established to monitor the impact waiting for treatment is having on our patients to ensure that avoidable harm has not/is not occurring as a result of delays in treatment. There were no cases of confirmed clinical harm for patients waiting over 52 weeks for treatment in 2018/19; four have been confirmed since the process began in August 2016.

Critical care admissions standard

We did not meet the national standard for critical care of admitting 100 per cent of critically unwell patients within four hours, achieving an average of 92.74 per cent. Delays to admission can be harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care. Improvements we are making include: identifying potential patients for step down earlier and improving 'turn around' times for each bed.

Theatres

One of the key areas we have identified to help increase our productivity is more efficient and effective scheduling of theatre lists – both the volume of patients booked and ensuring we are booking the right, properly prepared patients onto the right theatre lists and in the right order. This work has started to improve oversight of elective theatre activity, session utilisation and the ability of scheduling staff to plan and build theatre lists properly, with overall performance against this target at 79.43 per cent.

We are pleased to have slightly reduced our percentage of operations cancelled for non-clinical reasons (at 0.89 per cent we are below our target and below national average), despite operational pressures. However, we have seen an increase in the percentage of patients whose cancelled operations were not rebooked within 28 days. We have a number of work-streams in place to improve our understanding and monitoring of cancellations and to reduce the root causes wherever possible.

Outpatients' targets

We have seen improvements with our outpatient targets. Around one million people come to the Trust's hospitals as outpatients every year, with a five per cent increase in attendances since 2017/18. We have been running a major programme to improve the quality of their experience. As a result, we are seeing improvements in performance in some key areas, with our average waiting time for the first appointment reducing by one week, a reduction in the average percentage of patients who do not attend their appointments from 11.68 per cent in 2017/18 to 10.69 per cent in 2018/19, and a reduction in the percentage of clinics we cancel with less than six weeks' notice from 8.01 per cent in 2017/18 to 7.93 per cent in 2018/19. We have also maintained the percentage of outpatient appointments made within five working days of receipt of referral at over 10 per cent.

PLACE

We have improved our PLACE (patient-led assessment of the care environment) scores in five out of six categories (cleanliness; food and hydration; privacy, dignity and wellbeing; condition, appearance and maintenance; and disability).

Complaints

We have exceeded our target of responding to complaints within an average of 40 days, with an average of 30 days: the process for complaints handling is fully embedded and effective, with a strong commitment to resolving concerns as promptly and effectively as possible and with better access to complaints investigators. We have also seen a further reduction in the number of complainants taking their complaint onto the Parliamentary & Health Service Ombudsman (PHSO). Overall, the volume of formal complaints has remained at a similar level to last year, with values and behaviours of staff, care, clinical treatment and appointments continuing to be the main themes.

Patient transport

We have maintained similar pick-up and drop-off times for patients using our non-emergency patient transport service to last year (93.51 per cent and 99.29 per cent respectively): we expect that our new non-emergency patient transport contract, which begins in June 2019, will help drive further improvements for our patients over the coming year.

Well-led

Goal: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around people's individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation and to help us deliver our annual targets.

Well-led quality highlights and challenges

Staff engagement and retention

We did not increase the percentage of staff who would recommend our Trust as a place to work and as a place for treatment. We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice, Our Trust' which ran between May and June 2018. The percentage of staff who would recommend us as a place for treatment remained the same as last year (86 per cent); however, we were disappointed that the percentage of staff who would recommend us as a place to work decreased slightly (70 per cent in 2018 compared to 72 per cent in 2017). These results were mirrored in the national staff survey. We have developed local action plans in response to the results, which have been facilitated by workshops, toolkits and team-based listening exercises. We have also identified Trust-wide areas for improvement, including improving the visibility of senior leadership and improving our response to poor performance and behaviours.

We also looked at what we could do further to address leadership behaviours and the cultural issues raised by the survey results. Using a framework developed by NHS Improvement to guide local action on developing NHS staff, more than 2,000 staff took part in activities designed to explore themes around our vision, values and behaviours. Their views and insights have fed into work to develop our organisational strategy. One of the first practical outputs is an updated 'behavioural framework', co-designed with staff, setting out clear examples of the behaviours that demonstrate when we are living our values, and those that show when we aren't. This will support conversations with colleagues about when behaviours are helpful and when they are challenging. The roll-out and embedding of our values and behavioural framework is a key priority in 2019.

Other examples of our work to improve staff engagement include:

- further development of our leadership development programme, including the introduction of a programme for medical consultants called 'Frontier'
- development of an equality and diversity programme with sets of actions covering the main protected characteristics groups, including ethnicity, gender and disability.

We have met our voluntary turnover rate and staff retention targets: a key aspect of reducing the voluntary turnover rate (the number of staff who choose to leave and work elsewhere) is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. We are pleased to have met our target again this year (at 11.51 per cent we are just below our 12 per cent target), and to have exceeded our 80 per cent staff retention rate target at 85.46 per cent.

Our sickness absence rate remains low, but is slightly above our target at 3.07 per cent: low sickness absence is an indicator of effective leadership and good people management. Over the past year we have seen a small but steady increase in the levels of recorded absence. Working in healthcare can be stressful and emotional at times. We are continuing our focus on supporting the health and wellbeing of our staff along with supportive management interventions for those who are absent due to sickness.

Junior doctor wellbeing and engagement

We did not improve our performance in the General Medical Council's national training survey (GMC NTS). We aim to provide the best learning environment for our doctors and the GMC NTS is one of the ways we monitor the quality of the teaching we provide. In 2016, our results saw a significant improvement and since then we have largely maintained our performance overall. However, in 2018 our results deteriorated, with an increase in red flags (negative outliers) and a decrease in green flags (positive outliers). We are working to resolve on-going concerns about junior doctor wellbeing and engagement, and the facilities available to them, as well as working closely with specialties where there are particular concerns. As a result of improvements made, the GMC advised us in March 2019 that they have removed Intensive Care Medicine at Charing Cross Hospital from Enhanced Monitoring.

Appraisal and performance development review

We have increased the percentage of staff who have had a performance development review (PDR): Our appraisal scheme for staff is aimed at driving a new performance culture across the Trust. Although, we are below target, we have improved on last year's result at 89.6 per cent compared to 88.5 per cent in 2017/18.

The percentage of doctors who have completed their appraisal has increased steadily throughout the year and is now at its highest (93.76 per cent) since we started measuring it, although it is still below our 95 per cent target. A number of actions are being taken to increase compliance including monthly professional development drop-in sessions across all Trust sites and regular reports for managers highlighting staff whose appraisals are overdue.

We exceeded our target for completion of consultant job plans: Job planning involves regular reviews of how consultants use their time looking at, for example, the time they devote to clinical practice, education and research. The aim of job planning is to ensure consultants' time is used efficiently and effectively. We review our consultants' job plans each year, with the aim of ensuring at least 95 per cent of our consultants have a completed, approved job plan in place: 99.5 per cent had a job plan in place at the end of the job planning round in July 2018.

Core skills training

We have achieved our target of 90 per cent of staff being compliant with core skills training, one of our quality improvement priorities for 2018/19: Our core skills training programme ensures the safety and wellbeing of all our staff and patients. This is the result of a full review of the core skills' requirements, ensuring all staff are doing the right training based on their role.

Using resources sustainably

Goal: we use resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture

We have included this standard to ensure that we are delivering value for money for our patients, communities and taxpayers.

Using resources quality highlights and challenges

This year we have seen a number of improvements in key areas such as: efficient use of theatres, reductions in cancelled operations, and investment in additional beds. Through our flow-coaching academy, we have also worked on unwarranted variation in care. This is when variation in care occurs by chance and is characterised by patients not receiving high quality care.

We have trained 24 flow coaches so far within the Trust who are leading on delivering demonstrable improvements in specific patient pathways. More information can be found on page 24.

Speciality review programme

Throughout 2018/19 all 37 of our specialties participated in our specialty review programme, which looked at the financial, operational and clinical sustainability of each speciality. The outputs of the workshops we ran for each specialty will inform specialty-specific strategies, due to be launched in 2019/20.

We have also been improving how we use management information to optimise workforce productivity, and how we use technology to improve operational productivity and patient safety. We continue to work to improve our estate, which is a major driver of our deficit.

Financial position

Since identifying a serious underlying deficit in 2015/16 we have set and delivered stretching financial targets.

We have reduced annual agency spend by 40 per cent (£20.89m) since 2015/16; this has been facilitated through robust control, recruitment and expanded bank provision. In 2018, fewer agency cap breaches have also been seen.

Recently we have been delivering our cost improvement programmes (CIP) above national targets: A CIP is the identification of schemes to increase efficiency or reduce expenditure. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in permanent cost savings, but also improved patient care, satisfaction and safety. We delivered a £43m CIP in 2017/18 and £44m in 2018/19.

For more detailed information on our financial position, please see section three.

Research discoveries

In partnership with Imperial College London and two other NHS hospital trusts, we form one of six academic health science centres in the UK working to translate research rapidly into better patient care and excellence in education. We host one of 20 National Institute for Health Research (NIHR) biomedical research centres (BRCs) in partnership with Imperial College London. This designation is given to the most outstanding NHS and university research partnerships in the country – leaders in scientific translation and early adopters of new insights in technology, techniques and treatments for improving health. Here is an overview of just some of our research highlights from this year:

Artificial intelligence can predict survival of ovarian cancer patients

A trial, which took place at Hammersmith Hospital, has used artificial intelligence software to predict the prognosis of patients with ovarian cancer, and identify which treatment would be the most effective for them. Ovarian cancer is the sixth most common cancer in women. There are 6,000 new cases a year in the UK, but the long-term survival rate is just 35-40 per cent as the disease is often diagnosed at a late stage once symptoms become noticeable. The machine-learning technology was developed at Imperial College London and the University of Melbourne. Researchers used a mathematical software tool called TEXLab to identify the aggressiveness of tumours in the CT scans and tissue samples from 364 women with ovarian cancer between 2004 and 2015. Clinicians hope the technology can be used to stratify ovarian cancer patients into groups based on the subtle differences in the texture of their cancer on CT scans, rather than the usual ways of classifying patients based on the type of cancer they have, or how advanced it is. The new technology also gives clinicians a more detailed, accurate picture of how patients are likely to respond to different treatments, which could enable them to make more targeted treatment decisions.

New hepatitis C cases down by almost 70 per cent in HIV positive men in London

In a recent study, researchers found that new cases of hepatitis C among HIV positive men in London had fallen by nearly 70 per cent in recent years. The analysis of data from three clinics in London found 256 men were diagnosed between 2013 and 2018. New infections peaked at 17 for every 1000 people studied in 2015 and fell to six by 2018. The researchers analysed data of 6,000 HIV positive men at risk of acute hepatitis C at St Mary's Hospital, the Royal Free Hospital and the Mortimer Market Centre from July 2013-June 2018. The team found that following regular screening and treatment, cases of newly acquired acute hepatitis C had fallen sharply and in 2018 were the lowest recorded in London since 2008 for HIV positive men. The study network is now being expanded to other centres with the ambition of collecting data nationally.

Breath test could diagnose pancreatic cancer at an earlier stage

A breath test that can detect pancreatic cancer has been developed by researchers at Imperial College London, who analysed the breath samples of 132 patients at St Mary's Hospital between March and December 2016. They found the test can correctly identify cancer from benign conditions in 81 per cent of patients who had the disease. To take the test, patients breathe into a device and their exhaled breath is analysed in a laboratory. The test looks for volatile chemical compounds (VOCs) that are unique to patients with pancreatic cancer and have a distinctive smell. Researchers were able to identify and quantify the number of VOCs in breath samples by using a mass spectrometer. Unlike other methods such as endoscopies, the test is non-invasive. Scientists believe the test could be used to diagnose pancreatic cancer at an earlier stage and screen patients who are most at risk of developing the disease.

Artificial intelligence improves stroke and dementia diagnosis in brain scans

Small vessel disease (SVD) is a very common neurological disease in older people that reduces blood flow to the deep white matter connections of the brain, damaging and eventually killing the brain cells. It causes stroke and dementia as well as mood disturbance. At the moment, doctors diagnose SVD by looking for changes to white matter in the brain during MRI or CT scans. However, this relies on a doctor gauging from the scan how far the disease has spread. In CT scans it is often difficult to decide where the edges of the SVD are, making it difficult to estimate the severity of the disease. Researchers have created new machine learning software that can detect SVD in CT scans more accurately than current methods. The software, created by scientists at Imperial College London and the University of Edinburgh, has been able to identify and measure the severity of small vessel disease. In a study across 70 hospitals, including Charing Cross Hospital, 1082 CT scans of stroke patients were analysed between 2000 and 2014. The software identified and measured a marker of SVD, and then gave a score indicating how severe the disease was ranging from mild to severe. Researchers say this technology could help clinicians to administer the best treatment to patients more quickly in emergency settings and predict a person's likelihood of developing dementia.

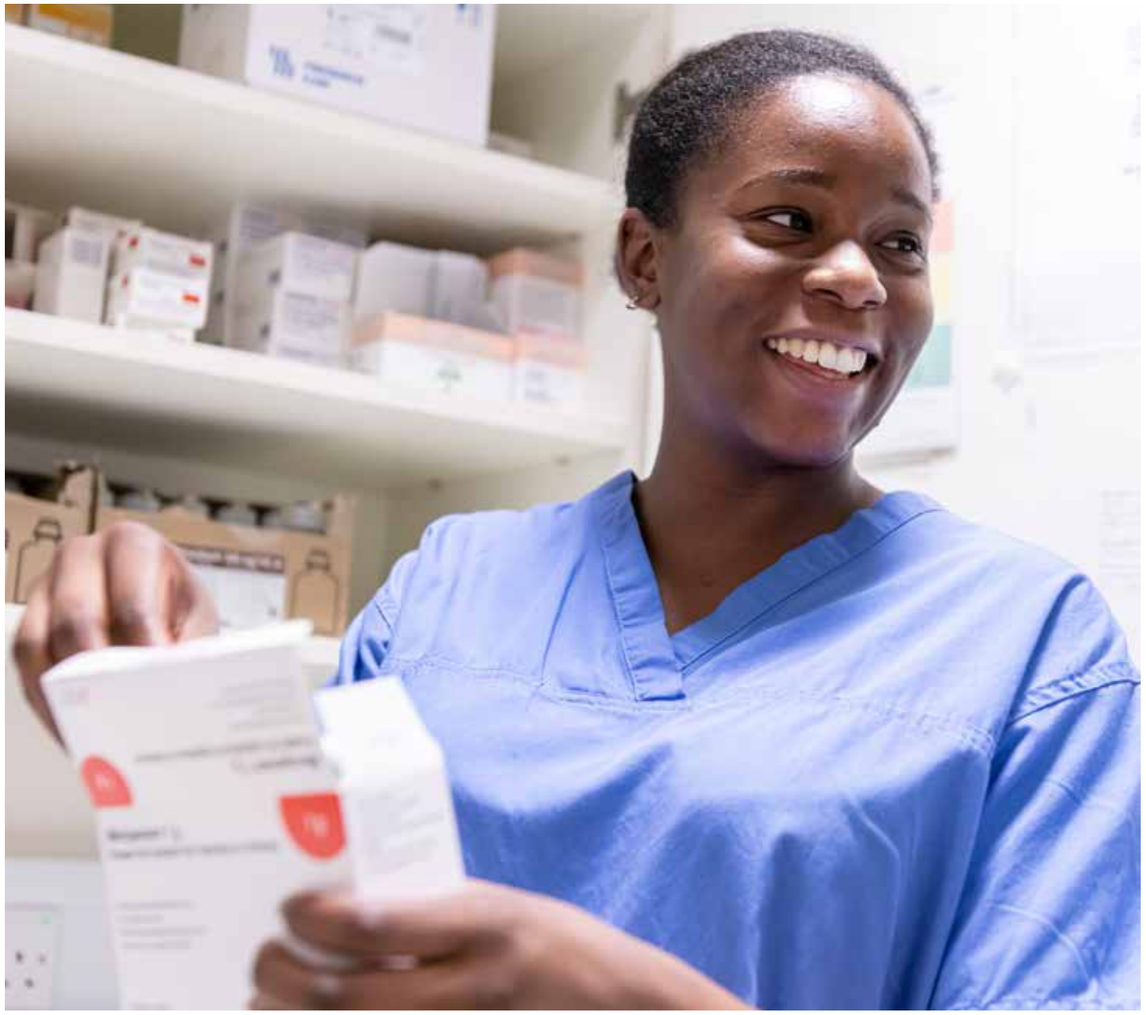
Apps that help users 'tune in' to hearing aids

Researchers have developed a collection of apps and video games that aims to improve the lives of people

who are impacted by hearing loss and wear hearing aids. Currently the majority of hearing aid users only use them to amplify sounds and do not take full advantage of the range of features that can allow them to hear better. The 3D Tune-In toolkit and apps has a range of functions, including improving the experience of listening to music through a hearing aid. The app is web-based and provides a database of pieces of music that can be tuned and adjusted to sound optimal for the user's level of hearing loss. The app also displays the lyrics of the song being played as well as visual representations of the different instruments present in the music, allowing the listener to position each individual sound source in different locations around their heads. The 3D Tune-In toolkit and apps were designed and developed by researchers at Imperial College London, the University of Malaga, Nottingham University De Montfort University, gaming developers and a large European hearing aid manufacturer. They also worked in collaboration with the hearing communities and patients at the Trust and with other institutions across the UK, Spain and Italy.

New sensor technology can diagnose reproductive health problems in real-time

A third of women in England suffer from severe reproductive health problems such as infertility and early menopause. Doctors usually diagnose these conditions by carrying out a blood test to measure the amount of luteinizing hormone (LH) in the sample, but current tests cannot easily measure the rise and fall of LH levels which is vital for normal fertility. Researchers have developed new robotic sensor technology that has the capability to diagnose women's reproductive health problems in real-time. The technology, which was trialled with women at Hammersmith Hospital, was developed by researchers at Imperial College London and The University of Hong Kong and can be used to measure hormones that affect fertility, sexual development and menstruation more quickly and cheaply than current methods.



Accountability report

Accountability report

NHS bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health and Social Care. The accountability report takes account of the Department of Health and Social Care's guidance for NHS trusts in the manual for accounts, as follows:

- The corporate governance report explains how the composition and organisation of the Trust's governance structures, developed in line with good governance standards, support the Trust's objectives, and provide assurance that the Trust's risks are appropriately identified and managed.
- The remuneration and staff report sets out the Trust's remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce.
- The Trust's external auditor also provides a report of its audit of the annual accounts, remuneration and staff report and annual report.

Corporate governance report

Directors' report

The Trust board and its committees

The Trust board is accountable, through the chair, to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board at 31 March 2019 consisted of the chair, six non-executive directors, chief executive, medical director, director of nursing, and chief financial officer, as outlined below.

The membership of the Trust board is balanced and appropriate; biographies for each of the Trust's board directors are available on the website at: https://www.imperial.nhs.uk/about-us/who-we-are/our-board.

The Trust board has the capability and experience necessary to deliver the Trust's business plan, and the governance structure the Trust has in place is appropriate to assure the Trust board of this delivery.

The members of the Trust board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector. All directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability, and both the selection process (led by NHS Improvement), the induction of new non-executive directors and ongoing board seminar programme, ensure that the non-executive directors have appropriate skills and level of understanding to undertake their role.

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

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

The Trust board, and each of the committees, undertake an annual self-assessment of performance and effectiveness, using a questionnaire developed for this purpose. The results of these self-assessments are presented to each committee, and to the Trust board, and the findings used to inform the development plans for each committee.

During the year, there have been a number of changes to board members:

- Following his appointment as chief executive, Professor Tim Orchard stepped down as interim medical director on 7 June 2018 and replaced Professor Julian Redhead as interim chief executive from 7 June 2018, who then resumed his substantive role as medical director from 7 June 2018.
- Sir Richard Sykes stepped down as chair from 31 December 2018, upon completion of his term of office. Sir Gerald Acher acted as interim chair from 1 January to 31 March 2019.
- Sarika Patel stepped down as non-executive director from 31 December 2018, upon completion of her term of office. This role remained vacant from 1 January to 31 March 2019.

Dr William Oldfield stepped down as interim medical director from 7 June 2018.

The Trust board as of 31 March 2019 was as follows:

Sir Gerald Acher	Interim chair
Professor Andrew Bush	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Victoria Russell	Non-executive director
Nick Ross	Designate non-executive director
Professor Tim Orchard	Chief executive
Professor Julian Redhead	Medical director
Professor Janice Sigsworth	Director of nursing
Richard Alexander	Chief financial officer

There were two vacant non-executive positions and one vacant executive position on the board as at 31 March 2019.

Subsequent to the year-end date, the Trust has appointed Paula Vennells CBE as Trust chair, from 1 April 2019.

Attendance at Trust board meetings: 1 April 2018 – 31 March 2019

The Trust board met six times in regular session and two extraordinary meetings held in the reporting period. Five board seminars were held during the reporting period. Attendance at the Trust board and attendance at the board committees is described below:

Member*	Attendance (actual/possible)
Non-executive directors*	
Sir Richard Sykes, chair (to 31 December 2018)	5/6
Sir Gerald Acher, interim chairman (1 January to 31 March 2019)	2/2
Sir Gerald Acher, Non-executive director (to 31 December 2018)	6/6
Professor Andrew Bush	6/8
Dr Andreas Raffel	8/8
Victoria Russell	6/8
Executive directors	
Professor Julian Redhead, as interim chief executive (from 4 December 2017 to 6 June 2018)	2/2
Professor Julian Redhead, as medical director (resumed from 7 June 2018)	6/6
Professor Tim Orchard, interim medical director (from 4 December 2017 to 6 June 2018)	2/2
Professor Tim Orchard, chief executive (from 7 June 2018)	6/6
Richard Alexander, chief financial officer	8/8
Dr William Oldfield, interim medical director (from 4 December 2017 to 6 June 2018)	1/2
Professor Janice Sigsworth, director of nursing	8/8

* Changes to the board membership are outlined above

The board has six committees which meet regularly; five are chaired by a non-executive director, and one by the chief executive (which is a committee acting across a number of partners). A number of board responsibilities are delegated either to these committees or individual directors. The Trust board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide a report to the Trust board showing how they are fulfilling their duties as required by the Trust board, and highlighting any key issues and achievements.

Audit, risk and governance committee

The audit, risk and governance committee has both mandatory and non-mandatory roles. As the audit committee, it provides the Trust board with independent and objective assurance that an adequate system of internal control is in place and working effectively. It is also responsible for providing assurance on the Trust's annual report and accounts, and also the work of the internal and external auditors and local counter fraud providers and any actions arising from that work, and, as the auditor panel, for the appointment of external auditors. It also has a governance role in relation to financial reporting.

In its broader, non-mandatory role, the committee oversees and seeks assurance that risk management and corporate governance arrangements are in place and working effectively, and undertakes reviews of areas of activity which may expose the Trust to particular risk and seeks assurance that appropriate management action is being taken. In such matters, it is cognisant of the work of other committees. The terms of reference of the audit, risk and governance committee are available upon request.

The committee met five times in regular session during the reporting period, and also held one meeting to review the annual accounts and related issues only.

Member	Attendance (actual/possible)
Sir Gerald Acher, non-executive director (chair)	6/6
Professor Andrew Bush, non-executive director	0/6
Sarika Patel, non-executive director (to 31 December 2018)	2/2
Dr Andreas Raffel, non-executive director	6/6
Professor Julian Redhead, as interim Chief executive (from 4 December 2017 until 6 June 2018)	2/2
Professor Julian Redhead, as medical director (resumed 7 June 2018)	3/4
Professor Tim Orchard, interim medical director (from 4 December 2017 to 6 June 2018)	1/2
Professor Tim Orchard, chief executive (from 7 June 2018)	3/4
Richard Alexander, chief financial officer	6/6
Professor Janice Sigsworth, director of nursing	5/6

Deloitte LLP acted as the Trust's external auditors in 2018/19, having been appointed in April 2017 for an initial three year period. Pricewaterhouse Coopers LLP (PwC) continued as the Trust's internal auditors, having been appointed for an initial period of three years from April 2018.

During 2018/19, the committee has remained observant of the key financial, operational and strategic risks facing the Trust through review of the board assurance framework (to gain on-going assurance of risk and internal control processes), the corporate risk register and through internal sources of validation and triangulation with the quality committee.

The committee has reviewed and approved the annual internal and external audit plans, and has reviewed and evaluated internal audit reports on key systems of internal audit control, including finance, governance, risk management, estates, human resources and data quality.

The corporate risk register is also reviewed regularly, and during 2018/19, the committee agreed a refreshed formal risk appetite framework and statement to support improved decision making and prioritising across the Trust. The committee has undertaken a number of in-depth reviews where specific risks were identified. These included cyber security, data quality and estates and facilities.

The committee received regular reports on losses and compensation payments, the waiver of tendering process and competitive quotations, and any allegation of suspected fraud notified to the Trust. Other key items of discussion included overseas patients, North West London Pathology governance arrangements, as well as periodic reports on raising concerns, compliance with the Trust's duty of candour policy and data quality framework.

Quality committee

The quality committee is responsible for seeking and securing assurance that the Trust's services are delivering, to patients, carers and commissioners, the high levels of quality performance expected of them by the Trust board. It also seeks and provides assurance in relation to patient and staff experience, and health and safety; performance is monitored in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the CQC, and ensures that there is a clear compliance framework against these.

The committee met six times in regular session during the reporting period:

Member	Attendance (actual/possible)
Professor Andrew Bush, non-executive director (chair)	5/6
Sir Gerald Acher, deputy chair	5/6
Victoria Russell, non-executive director (committee member from August 2018, attendee from May to August)	3/6
Professor Tim Orchard, Chief executive (from 7 June 2018)	4/5
Professor Tim Orchard, interim medical director (to 6 June 2018)	1/1
Professor Janice Sigsworth, director of nursing	6/6
Professor Julian Redhead, interim Chief executive (to 6 June 2018)	0/1
Professor Julian Redhead, medical director (resumed from 7 June 2018)	4/5
Dr William Oldfield, interim medical director (to 6 June 2018)	1/1

Regular discussions included review of divisional quality risks, the Trust's comprehensive quality report, the infection prevention and control report, serious incident monitoring report, claims and complaint data, and health and safety report. The committee also received regular reports on actions and processes relating to CQC compliance, including the results of the Trust self-assessment process which seeks to support continual improvement.

The committee undertook a number of in-depth reviews in areas of potential quality concern, including the number of never events declared during the year. Close attention was also paid to the progress in improving the staff influenza immunisation rates.

The committee receives and considers a range of assurances regarding quality of services, including findings from national cancer patient experience survey, ward accreditation programme, and patient-led assessments of the care environment (PLACE), as well as various patient and staff survey results, including friends and family test, General Medical Council national training survey, adult inpatients and NHS staff survey.

The committee initiated a deep dive into hospital initiated cancellations and monitored them throughout the year, in response to concerns about the high level of cancellations and the impact this has on patient experience.

The committee has also reviewed the findings, recommendations and the Trust's response to national inquiries such as the Kirkup review and the Gosport independent panel report.

Finance and investment committee

The committee is responsible for receiving assurance that the Trust achieves financial performance targets set by the Trust board and also for ensuring the Trust's investment decisions support achievement of its strategic objectives.

The committee met six times in regular session during the reporting period:

Member	Attendance (actual/possible)
Dr Andreas Raffel, non-executive director (chair)	4/6
Sir Richard Sykes, chair (to 31 December 2018)	1/1
Peter Goldsbrough, non-executive director	4/6
Victoria Russell, non-executive director	1/1
Professor Julian Redhead, as interim Chief executive (to 6 June 2018)	1/1
Professor Tim Orchard, Chief executive (from 7 June 2018)	5/5
Richard Alexander, chief financial officer	6/6

The committee regularly considered reports in relation to the Trust's performance against agreed corporate and divisional budgets, cost improvement plans and the capital programme. The committee reviewed and agreed the financial recovery plan ahead of submission to NHS Improvement.

The committee received assurance on the development of the transformation plan, which focuses on larger-scale and longer-term change programmes to deliver our strategic goals, including financial sustainability. It also considered progress reports on the specialty review programme, recognising this to be a key part of clinical transformation and sustainability.

The committee also undertook regular review of a number of key areas of activity, including an annual financial review of the redevelopment programme, an annual review of the performance and strategy of Imperial Private Healthcare and a regular review of the financial position of North West London Pathology (NWLP).

The committee considered summaries of business cases approved by the executive during the year, and reviewed and commended for Trust board approval business cases for major investment, including the non-emergency patient transport tender.

Redevelopment committee

The committee oversees the redevelopment transformation programme, including performance reviews and financial issues, and reviews investment requirements and risks associated with the overall redevelopment transformation programme.

The committee met 10 times in the reporting period:

Member	Attendance (actual/possible)
Sir Richard Sykes, chair (chair until July 2018 then member until 31 December 2018)	6/8
Dr Andreas Raffel, non-executive director	6/10
Peter Goldsbrough, non-executive director	7/10
Victoria Russell, non-executive director (committee chair from July 2018, member before then)	8/10
Professor Julian Redhead, interim Chief executive (to 6 June 2018)	2/2
Professor Julian Redhead, medical director (resumed from 7 June 2018)	6/8
Professor Tim Orchard, Chief executive (from 7 June 2018)	8/8
Dr William Oldfield, interim medical director (to 6 June 2018)	2/2
Richard Alexander, chief financial officer	8/10

Discussions during the year included the redevelopment programme and strategy across all Trust sites, and received regular updates on the review of NHS property and estates and the strategy for London. The committee received updates on the redevelopment programme financial position and regular updates from Imperial Healthcare Charity.

The committee considered the Paddington Square development and monitored the impact on the Trust, and discussed other risks arising from other 'neighbourly matters'.

Remuneration and appointments committee

On behalf of the Trust board, the committee is responsible for decisions concerning the appointment, remuneration and terms of service of executive directors and other very senior appointments.

Member	Attendance (actual/possible)
Sarika Patel, non-executive director (chair until 31 December 2018)	4/4
Sir Richard Sykes, chair (to 31 December 2018)	4/4
Peter Goldsbrough, non-executive director (chair from January 2019, member before then)	3/5
Sir Gerald Acher, interim trust chair (from 1 January to 31 March 2019)	1/1
Professor Julian Redhead, interim Chief executive (to 6 June 2018)	1/1
Professor Tim Orchard, chief executive officer (from 7 June 2018)	4/4
David Wells, director of people and development (to 13 July 2018)	2/2
Kevin Croft, director of people and development (from 14 August 2018)	3/3

The committee met five times during the reporting period, where discussions included the appointment of senior executive team members, including Tim Orchard as the new chief executive, review of executive performance and executive succession planning, national executive pay review, and the policy for executive directors taking on non-executive director appointments or similar external roles. The committee has also considered the impact of changes to the NHS pension lifetime allowances, and updates on the workforce-related equality standards (WRES) and staff survey findings.

Hammersmith & Fulham integrated care partnership board

In January 2018 five formal partners in Hammersmith and Fulham signed a partnership agreement to work towards an integrated care model, which included setting up a 'committees in common' governance mechanism. This means that each partner remains an independent organisation, accountable to its own board, but oversees key aspects of the partnership's work through delegation to the committee, which is a formal Trust board committee.

The committee met nine times during the reporting period and held two board seminars. The Trust has been represented at each meeting by either the chief executive or divisional director, or their designated deputy.

Member	Attendance (actual/possible)
Professor Tim Orchard, divisional director and interim medical director (to 6 June 2018)	1/1
Professor Julian Redhead, interim Chief executive (to 6 June 2018)	0/1
Dr Frances Bowen, divisional director (from 1 July 2018)	3/7

The committee has agreed and monitored the implementation of the alliance agreement with Hammersmith and Fulham Clinical Commissioning Group to support the delivery of an integrated care approach for some services for the population of the borough, particularly in relation to services for children, adults with long term conditions and frail, older people.

Directors' interests

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust board directors which may conflict with their management responsibilities. This register is updated on the change of any directors' interests, and is reported formally twice yearly to the Trust board; the register is available to the public on the Trust website at www.imperial.nhs.uk. The Trust board considers that all its non-executive directors are independent in character and judgement. Where potential conflicts of interest are identified in relation to matters to be discussed by committees or Trust board, these are recorded and the individual excluded from the discussion.

In addition, the Trust seeks annual declarations from all staff graded band 8a and above. Returns for 1562 staff, approaching 83 per cent, had been returned at the end of March 2019. The Trust publishes on its website a list of those staff considered to hold clear decision-making roles; of these 150 staff, 87 per cent had declared at the end of March 2019.

The directors have been responsible for preparing this annual report and the associated financial accounts and also the quality account and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance and strategy.

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the chief executive should be the accountable officer of the Trust. The relevant responsibilities of accountable officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Tim Orchard
Chief executive

24 May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Trust board

Tim Orchard
Chief executive

28 May 2019

Richard Alexander
Chief financial officer

28 May 2019

Annual governance statement

Scope of responsibility

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

The structure for the Trust's annual governance statement for 2018/19 follows the format required by NHS Improvement.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Imperial College Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Imperial College Healthcare NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

The following have been identified as the significant risks facing the Trust as it enters 2019/20, further detail on each is provided later in the report:

- ability to meet control total and deliver financial recovery plan
- reliability of Trust estates critical equipment to support Trust operations.

The risk and control framework

The Trust has a systematised framework for ensuring effective reporting and escalation mechanisms, not only from the divisional management and divisional quality groups, but also from the specialist committees (for example the health and safety committee and infection prevention and control committee); the framework for this is outlined top right of the opposite page.

The risk management policy describes the approach that the Trust takes to identifying, managing and mitigating risk. Each (clinical) directorate and (clinical and corporate) division maintains a risk register containing clinical and non-clinical risks. The divisional boards ensure that operational staff identify and mitigate risk appropriately; each risk is scored using a standardised matrix across the Trust which includes likelihood and potential impact. If risks cannot be satisfactorily resolved or managed at a local level, they are considered for escalation and inclusion on to the divisional registers, with risks on these registers in turn reviewed for escalation onto the corporate risk register where they have a significant impact on the whole organisation, impact on the achievement of corporate objectives, or fall outside the relevant risk appetite.

Corporate committees provide internal assurance to the Trust board that the mitigations are effective and the risks are adequately controlled and monitored. Clinical audits, the internal audit programme and external reviews and inspections of the organisation are all sources used to provide assurance that these processes are effective and risk management is fully embedded.

Risks are identified from various sources including proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, whistleblowing, stakeholder/partnership feedback and internal and external assurance from stakeholders such as the CQC and NHS Improvement.

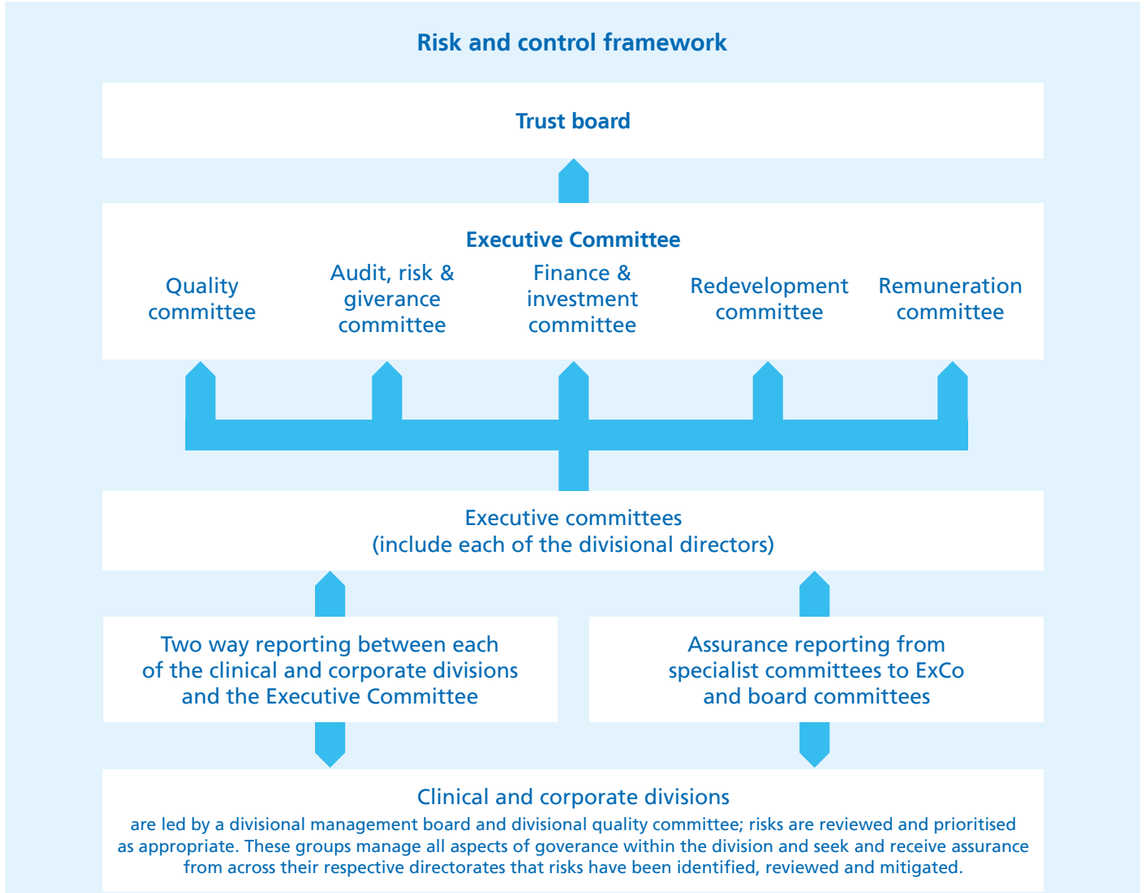
Risk management is embedded within the organisation through the corporate, divisional and directorate structures and the reporting and feedback mechanisms are in place as outlined overleaft:

The executive committee meets on a weekly basis to review the adequacy of, and progress against, action plans and to consider acceptance or further resolution. If additional resources are required to reduce the risk to an acceptable level this is considered, prioritising those risks where there is a higher likelihood or consequence.

The board assurance framework provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the robustness of internal controls to reduce or manage the risks to an acceptable level.

Capacity to handle risk

While executive directors are full-time employees who manage the daily running of the Trust, the entire Trust board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The Trust board is also accountable for upholding high standards of governance and probity. The chair and non-executives in particular provide strategic guidance and support.



The Trust board approved framework, consists of the:

- risk management policy, which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk within the Trust
- risk registers, which document risks at each level of the Trust, alongside actions to control, mitigate or resolve each risk
- board assurance framework, with its focus on assurance
- risk appetite statement and operational implementation framework.

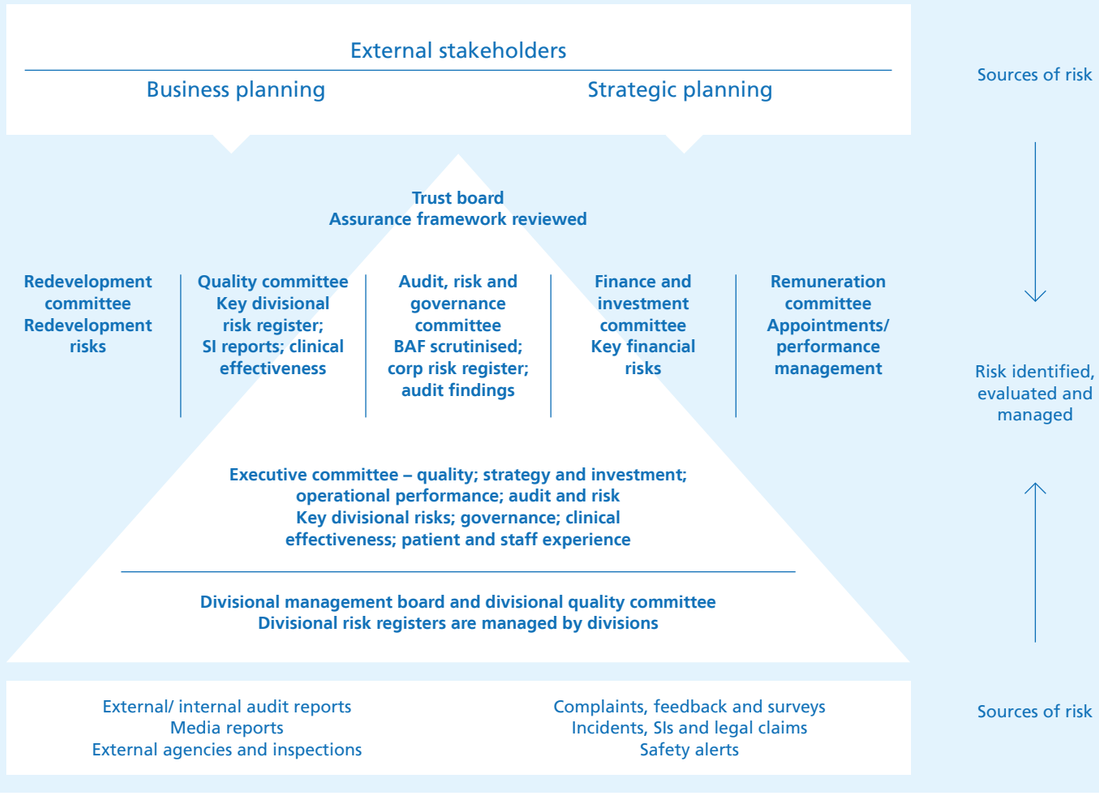
Together, these support the development of an organisational approach to risk management whereby effective risk management is an integral part of providing healthcare and day-to-day decision-making.

The board assurance framework provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.

The Trust has a risk appetite framework in place, interlinking with the existing risk registers and board assurance framework, forming an illustration of the Trust's current risk exposure, by taking into account: the length of time a risk has existed on the register, the score it has held for that period, and the target risk score.

The risk appetite statement has been refreshed during 2018/19, and amended to reflect the Trust's commitment to continual improvement in data quality. The Trust board approved the statement on page 49 in March 2019.

Risk identification reporting framework



It is recognised that the Trust is currently operating within a challenging financial and operational environment and is not comprehensively achieving national standards and targets. Rather than through choice, it is considered that a higher level of risk appetite is inherent in the scale of challenge faced in these areas. The Trust is cognisant of the need to actively manage the financial and operational risks whilst ensuring that patient safety is not compromised. In view of this:

- *The Trust will not take any unnecessary risk that has a direct impact on patient safety; however, it will be open in accepting risks that emerge while developing intra and inter-provider pathways which do not impact on any individual patient negatively.*
- *The Trust will minimise any risk posed to patients or staff as a result of staff competence, conduct, health and behaviour.*
- *Recognising the challenging recruitment environment, the Trust will be open to taking opportunistic risk in improving staff recruitment and retention.*
- *The Trust will tolerate a higher reputational risk associated with ensuring the implementation of its redevelopment plan. This will ensure sustainable mitigation to the estates risk.*
- *Recognising the challenging operational and financial environment, the Trust will be cautious when responding to any risk that could compromise data quality, which also carries performance and reputational risks. The Trust will commit to continual improvement in data quality.*
- *In view of this, the Trust is open to the risks associated with the implementation of emerging technology; however, it will minimise exposure to cyber risk.*
- *The Trust has a significant appetite to exploit opportunistic risks where positive gains can be anticipated, particularly in relation to promoting and delivering excellent research and education.*

The audit, risk and governance committee oversees and monitors the performance of the risk management system, informed by internal auditors undertaking reviews and providing assurance to the committee on the systems of control operating within the Trust.

An internal audit of risk management was carried out by PwC between June and July 2018, with the scope to assess the design and operating effectiveness of risk management controls in place at divisional level and the consistency of processes across divisions. Overall, the report was classified as 'Low risk'. Three 'minor' findings were identified, with regard to monitoring, reporting and assurance processes relating to risk.

In response to the audit findings and recommendations, further changes have been made to the Trust's risk management framework to strengthen the Trust's approach to risk management, including:

- The executive finance committee now functions as the Trust executive risk committee and reviews the corporate risk register monthly.
- Key divisional risks are now presented to the committee every month and are submitted directly from the (corporate and clinical) divisions.
- In order to support this, Datix functionality has been developed that allows the divisions to select, manage and download their key risks directly from Datix.
- The audit, risk and governance (ARG) committee also receives a summary of themes from the key divisional risks based on discussion at the executive finance committee.
- This information is included in a joint paper including the corporate risk register and board assurance framework. This supports the ARG in determining the effectiveness of the relevant risk controls.
- The divisions are provided with quarterly risk management reports, which reflect overall risk management figures in the divisions, also with regard to number of risks overdue for review, details of actions overdue for review and number of risks that have been on the risk register for longer than two years.
- At executive level, divisional performance with regard to timely review of the risk registers has been included as a regular item in the risk management report since July 2018.

In addition to the above, improvements have been made to the presentation of risks, to provide the executive and the Trust board with a more robust and agile presentation of the Trust's risk profile, to include the life cycle of a risk over a twelve month period. In-depth analysis of those risks where the score has not reduced over the previous 12 months is undertaken twice a year and presented to the executive committee and the Trust board.

In addition to the above changes, the Trust continues to develop the capacity of staff to manage risk through its leadership development programme and via the launch of a bespoke risk management e-learning module in September 2018 to enable staff to strengthen their knowledge of risk management and put this into practice in their day to day work. Completion of training is a compulsory requirement in order to get access to the risk register system.

Care Quality Commission regulatory framework

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The Trust was compliant with the requirements of its CQC registration and was not subject to any enforcement action during 2018/19.

The Trust has not participated in any special reviews or investigations by the CQC during the year. However, all trusts are captured in CQC patient surveys, of which two were published during 2018/19: adult inpatients and maternity. The Trust's performance in the maternity survey, carried out during 2018, was the same as or better than the results of the previous survey. For the adult inpatient survey, carried out during 2017, the Trust's performance was generally better than the results of the previous survey.

During 2018/19 four of the Trust's core services were inspected: critical care at St Mary's, Charing Cross and Hammersmith hospitals; services for children and young people at St Mary's and Hammersmith hospitals; maternity at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital; and neonatal services at Queen Charlotte's & Chelsea Hospital (the neonatal intensive care unit). The Trust also had its annual CQC inspection of the well-led domain at Trust level. Inspection reports from all inspections carried out during 2018/19 are expected to be published by the CQC in July 2019, at which time the CQC will update the overall ratings for each of the Trust's sites where inspections have taken place, and the Trust's overall rating. Additionally, the Trust had its first *Use of Resources* assessment by NHS Improvement in February 2019, the rating from which will be used by the CQC to inform the overall quality rating for an overall combined well-led rating for the Trust.

Performance management and oversight

The Trust has an integrated quality and performance framework providing oversight of over 70 core indicators across all domains of performance, at each of the four levels of the organisation (board, division, directorate and where relevant ward/clinic).

The integrated report is reviewed monthly at the executive committee, bi-monthly at quality committee, and at each Trust board meeting, where detailed reviews are undertaken of areas where potential issues are identified. A suite of metrics, aligned to the five CQC domains of quality, have been agreed as the indicators of progress towards achieving the quality strategy. These metrics have been developed on a divisional and site basis as well as at Trust level, covering patient safety, patient experience and clinical effectiveness, highlighting current quality and safety issues and action being taken.

NHS Improvement's single overview framework (SOF) remains NHS Improvement's focus in overseeing both NHS trusts and foundation trusts, and identifying the support they need to deliver high quality, sustainable healthcare services; its stated aim is to help providers attain and maintain CQC ratings of 'good' or 'outstanding'. The framework is reflected in the integrated performance framework and other performance monitoring processes.

The SOF's mechanism of categorising trusts is to review their performance against a number of metrics across five themes (quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability), as below:

1. Providers with maximum autonomy, and no potential support needs have been identified
2. Providers are offered targeted support, where there are concerns in relation to one or more of the themes
3. Providers are receiving mandated support for significant concerns
4. Providers are in special measures.

Throughout 2018/19, the Trust has been placed, by NHS Improvement, in segment three of four segments, relating predominantly to financial position and performance on constitutional standards.

As part of enhanced oversight by NHS Improvement, the Trust agreed on a series of undertakings with its regulator in November 2017. The delivery of the undertakings forms a key element of regulatory requirement, and NHS Improvement requires a robust monitoring mechanism to be in place to review progress, and ultimately delivery, of each element. Much of the undertaking reflects existing commitments monitored as part of the Trust's overall performance, but to ensure all items are addressed, bi-monthly summary monitoring reports are also provided to the Trust board.

These undertakings have been revised by NHS Improvement during 2018/19, to reflect the progress made by the Trust in achieving the undertakings and the Trust's improved operational and financial performance.

Review of economy, efficiency and effective use of resources

The Trust has a range of processes to ensure resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of monthly finance and performance reports to the finance and investment committee, executive committee and to the Trust board. The Trust has an agreed risk-based annual audit programme with the Trust's internal auditors. These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focused, in part, on reviewing operational arrangements for securing best value and optimum use of resources in respect of the services we provide. The head of internal audit's opinion provides assurance regarding the robustness of the system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Our external auditors are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if, in their opinion, the Trust has not. The external auditor's opinion is qualified "except for" in relation to two matters, the first of these is in relation to the undertakings agreed with NHS Improvement as described on page 50, the second element is in relation to financial sustainability. More information regarding financial sustainability is included in the key risks section of this statement.

With respect to the NHS Improvement enforcement actions and related undertakings, the Trust has taken significant further actions to progress towards removal of the undertakings. Such actions include the development of a financial recovery plan, the creation of additional inpatient beds and refurbishment of our A&E departments, and improvements in the 'flow' of care across our urgent and emergency and planned care pathways through the Trust's care journey and capacity collaborative strategy.

These actions resulted in the following achievements by 31 March 2019:

- Agreement with NHS Improvement regarding the closure of the undertaking in relation to the financial recovery plan in November 2018
- Year on year improvement in performance against the A&E waiting time standards to achieve 88.4 per cent for the month of March 2019 compared with 83.2 per cent in March 2018, and performance for 2018/19 of 88.2 per cent, a 1 per cent increase compared with 2017/18
- Reduction in the number of patients waiting in excess of 52 weeks for treatment to zero at the end of March 2019, and achievement of the trajectory for the PTL size.

To ensure that any cost improvement schemes, a key part of the Trust's focus on economy, efficiency and effectiveness, do not impact adversely on the quality of patient care, a Trust board approved quality impact process is used to review schemes. Schemes approved by the responsible director are then reviewed and risk assessed by the medical director and director of nursing prior to sign off; schemes rated as high risk require mitigations and controls in place before approval is granted. Post-implementation reviews occur to ensure that low risk scoring schemes did not have a higher quality impact than expected and that the controls enacted for high risk scoring schemes were effective. If a serious quality impact begins to materialise during implementation, schemes are stopped. A quarterly summary is provided to the executive quality committee, the board quality committee and the Trust board, and shared with our commissioners; this also includes information on schemes that were not approved for progression.

Key risks

There have been no significant lapses in the system of internal control during the past year. The Trust continues to manage its key risks, as described. The two most significant risks relate to financial sustainability and our estates and redevelopment.

Financial sustainability

Since its posting of an underlying deficit of £53.6m in 2015/16, the Trust has steadily improved its financial position. The Trust has delivered against its control totals for the last three years, including for its 2018/19 outturn position.

In November 2018, the Trust board agreed a four year financial recovery plan which set a path to improve the underlying position by approximately £5m per year. This was before new tariff arrangements were announced for 2019/20.

The recovery plan described how the Trust is considered to have a structural deficit of £35m, primarily relating to the condition of its estate. This figure is based on work undertaken by PwC on 2015/16 data. Since then, the Trust's estate has deteriorated further, as evidenced by the range and seriousness of estates incidents impacting operations across its sites.

The assumptions in the recovery plan do not reflect the 2019/20 planning guidelines and tariff changes, therefore the recovery plan may need to be revised. However, the actions outlined to improve the Trust's long term financial position remain valid and are informing 2019/20 planning. The final 2019/20 plan represents a full 'bottom-up' consolidation of divisional plans and budgets. These have been bridged from 2018/19 outturn, adding 2019/20 cost pressures and deducting efficiencies, with divisional targets set to ensure that the Trust meets its control total.

There are three primary challenges to the Trust's ability to deliver its 2019/20 plan: the need to make operational efficiencies, sustain an acceptable level of cash, and maintain the estate.

Efficiencies

It is recognised that further work is required to fully identify efficiencies, both for 2019/20 and to keep the Trust on a path to financial sustainability. In September 2018, the Trust appointed a transformation

director who is driving forward the Trust's transformation programme, closely linked to cost improvement programme (CIP) delivery.

To inform the approaches to efficiencies outlined above, the Trust uses a number of NHS-wide tools to identify opportunities, plan, and deliver improvements, including benchmarking data from Model Hospital, NHS National Benchmarking Network and GIRFT (Get it right first time).

Cash

The Trust expects that business-as-usual activities will be carried out without extending its working capital facility. This is largely because the Trust benefitted from a number of cash improvements which also benefitted its A&E position over the course of the year, including receipt of all expected provider sustainability funding (PSF) and continued improvement in its in-year cash management.

Whilst, with the planned approach, cash is within a manageable range, consideration must also be given to the Trust's ability to withstand unforeseen events.

Given the ageing of the estate, the need to make continued efficiencies and the challenge posed by potential liabilities previously reported in the accounts, the Trust recognises that an unplanned event that materialises, a cash requirement would not be readily absorbed within the day-to-day working capital assumptions.

Estates and redevelopment

The Trust's capital plan for 2019/20 is once again extremely challenging due to the level of backlog maintenance, ICT infrastructure, and medical equipment replacements required to mitigate Trust level risks. This is in addition to divisional capital projects which are essential for the quality and safety of our services.

The Trust has the largest backlog maintenance liabilities of all NHS or foundation trusts, principally due to the age of its estates. ERIC data published in 2016 showed the Trust had nearly 25 per cent of all NHS risk adjusted backlog maintenance costs, with a fully built up backlog liability of £1.3bn. The Trust is part way through a board-approved plan to spend a minimum of £131m over eight years on the highest priority backlog items. The amount in the 2019/20 plan is consistent with this.

The CQC stated in a recent report that, "in some areas, the premises and equipment were unsuitable" and urgent action is needed to improve the on-site facilities. This is reflected in the safety projects in our plan, geared towards improving clinical areas, wards and theatres. The Trust has numerous instances where equipment is now obsolete which means there is prolonged downtime if the equipment fails. Medical equipment in the 2019/20 plan represents the most urgent replacements.

The Trust follows a comprehensive approach to capital planning, collating all potential capital projects and prioritising based on factors including risk, timing, and underlying drivers. This is fully peer reviewed and challenged before being approved by the executive.

The core, depreciation, element of the Trust's capital resource limit (CRL) is not sufficient to cover essential capital schemes in 2019/20. Therefore, the Trust is in the process of applying for an emergency capital loan of £15m. This will pay for essential projects to support the safe running of services and compliance with CQC and NICE guidance. It will include ward refurbishments and schemes for emergency care and theatres.

While the capital programme is primarily focused on essential quality and safety-related projects, prioritisation of capital projects is also informed by the specialty review programme and the Trust's strategy, especially the clinical strategic implementation plan in development.

Given the limitations of capital in the short to medium term, the Trust is exploring non-capital options in some areas. For example, the Trust has commenced a significant strategic imaging asset project, engaging with suppliers, NHSI, and sector partners to develop alternative options to purchasing outright for the replacement and management of imaging assets.

In addition to the immediate challenges of maintaining our infrastructure and estate, it is widely accepted that in the longer term the Trust needs to fully redevelop its sites. A redevelopment programme is on-going. In 2017/18, planning permission and a strategic outline case were approved for phase one, a new outpatient and ophthalmology building on the St Mary's site. The outline business case is currently on hold due to funding challenges. The approach to the much larger phase two redevelopment is still under review. Our 2019/20 financial plan includes a relatively small amount of capital and revenue spend to support progression of the redevelopment programme.

While the Trust's plan for 2019/20 demonstrates generation of sufficient cash flow to meet planned expenditure, there is a dependency upon delivering the challenging control total set in order to receive central MRET and PSF of £27m.

The poor condition of the estate, while addressed in part by an eight-year essential backlog maintenance programme, gives cause for material concern in that relatively small estate failures can cause significant delays to service provision and significant loss of income. There can also be very significant costs to rectify such estate failings.

Data security and protection

The Trust has a published data protection framework designed to deliver compliance with the General Data Protection Regulations (GDPR) and the NHS digital data security and protection toolkit. The Information governance and cyber security committee (IGCS) is responsible for oversight of Trust cyber security and data protection policies and monitoring the mitigation plans identified in the information and communications technology (ICT) risk register and ICT risks listed in the corporate risk register.

The chief information officer (CIO) acts as the senior information risk owner (SIRO), a role designed to take ownership of the Trust's information risk policy and as advocate for information risk on the Trust board, with overall accountability for data protection and cyber security. The chief clinical information officer (CCIO), as Caldicott Guardian, is the appointed senior clinician with ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key advisory role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information. The data protection officer is a role assigned in compliance with, and duties outlined in GDPR. In summary these are:

- to inform and advise the organisation and its employees about their obligations to comply with the GDPR and other data protection laws
- to monitor compliance with the GDPR and other data protection laws, including managing internal data protection activities
- advise on data protection impact assessments; train staff and conduct internal audits; and to be the first point of contact for the ICO and for individuals (patients/staff) whose data is processed.

In 2018/19 the General Data Protection Regulation and Data Protection Act 2018 were also enacted as law replacing the Data Protection Act 1998.

The data security and protection toolkit is an online self-assessment tool that enables organisations to measure and publish performance against the National Data Guardian's ten data security standards. It consists of 32 mandatory assertions and requires 100 mandatory evidence items, mandatory standards are either "met" or "not met".

This included the requirement for 95 per cent staff to complete annual mandatory data security and protection training. The Trust exceeded this target with 96.3 per cent of staff holding a compliant annual mandatory data security and protection training record.

The Trust submitted an independently audited data security protocol toolkit return to the Department of Health and Social Care and met all the mandatory standards.

Notification to the ICO: Article 33 GDPR

In compliance with GDPR the Trust reports personal data breaches to the Information Commissioner's Office (ICO). The table below reports the number of breaches reported during 2018/19.

Table of reportable information security incidents and department and social care

Grade of incident	Number
Incident reported to the ICO and Department of Health	3
Trust level incident	48
Total *	**51**

*Late Reporting: there are instances where incidents may have previously occurred and were not reported to the Data Protection Officer. This final total figure may increase should there be any such cases of late or previously unreported data protection breaches

Other disclosures

Modern Slavery Act – 2018/19 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

Pensions and remuneration

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.

Details of directors' remuneration and further information on the wider workforce are set out in the remuneration and staff report as are exit packages and severance payments, and the Trust off-payroll engagement disclosures (which are in accordance with HMRC requirements). The Trust's external auditor and details of their remuneration and fees are set out in the accounts.

Cost allocation and charges for information

The Trust complies with HM Treasury's guidance on setting charges for information required.

Equality disclosures

The Trust is committed to the promotion of equality of opportunity for all its employees. Our equal opportunities policy is to provide employment

equality to all, irrespective of race, gender, disability, age, sexual orientation or religion. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The gender pay gap report (published on the Trust website) demonstrates areas where the Trust will seek improvement in perceived or real gender inequality. Progress will be reported through the annual workforce equality data report, produced annually to provide information on how different groups of staff are affected by recruitment and human resources procedures and policies. This is available on our website:

www.imperial.nhs.uk/equalityanddiversity/workforcedata/index.htm

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with, and objectives forming part of the Trust's equality delivery scheme are reported to the Trust board.

Better payment for suppliers

The Trust supports the Prompt Payment Code which applies the following principle to payment practices: pay suppliers on time; give clear guidance to suppliers; and encourage good practice. The Trust's performance is summarised in the notes to the annual accounts.

Emergency preparedness

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005. The Trust participates in the annual emergency preparedness, resilience and response (EPRR) assurance process carried out by NHS England. The Trust continues to be rated as having 'substantial' assurance, and an action plan is in place to address the last amber rated area.

Principles for remedy

The Trust handles all complaints in line with the Principle of Good Administration and aims to resolve complaints in line with the Principles for Remedy.

Workforce safeguards framework

In October 2018, the *Developing Workforce Safeguards Framework* was launched. Building on existing National Quality Board (NQB) guidance, the framework provides a set of recommendations on workforce safeguards to strengthen the delivery of safe, high quality care across all staff groups and includes new recommendations for governance processes and formal reporting from ward to board.

The Trust has proactively worked to support delivery of the framework recommendations through the establishment of a multidisciplinary workforce safeguards steering group, reporting into the Trust's executive people committee. This group is now well established and is chaired by the director of people and organisation development. The membership is formed of clinical and corporate leads representing all of the Trust's staff groups and professions.

The clinical and corporate leads have completed a comprehensive self-assessment and gap analysis for their respective professions, against the 14 recommendations of the Workforce Safeguards Framework. This work has informed a set of specific actions which have been created and prioritised to move the Trust towards compliance with all aspects of the framework. This interpretation of the framework requirements, the Trust's approach, work to date and governance structure put in place to meet the requirements of the framework, has been fully endorsed by NHS England/improvement leads.

Chief executive's review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust board, the audit, risk and governance committee and quality committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In support of this:

- The head of internal audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal audits carried out (listed in appendix one) have provided assurance from substantial assurance to limited assurance; following the audit reports, management have accepted, and taken action to address, recommendations made. Management improvement plans for all audits given limited assurance are reviewed by the audit, risk and governance committee.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that each has taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.
- The Trust board reviews risks to the delivery of the Trust performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety and quality, and workforce.
- The board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed. Internal audit have rated the framework as providing substantial assurance.
- The audit, risk and governance committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed recorded and escalated as appropriate. The committee regularly receives reports on internal control and risk management matters from the internal and external auditors.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- During 2018/19, the CQC inspected four of the Trust's core services: Critical care at St Mary's, Charing Cross and Hammersmith hospitals; services for children and young people at St Mary's and Hammersmith hospitals, maternity at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital; and neonatal services at Queen Charlotte's & Chelsea Hospital (the NICU). The Trust also had an inspection of the well-led domain at Trust level. The report from this inspection is expected to be published in July 2019.
- NHS Improvement's *Single Oversight Framework* provides a structure for overseeing trusts 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). Trusts are then rated from one to four, according to these themes, with a four being those who need the most support. The Trust has been rated as a three within the framework, since its introduction in the autumn of 2016/17, reflecting the Trust's financial and operational challenges as outlined in the governance statement.
- The Trust has agreed revisions to the regulatory undertakings agreed with NHS Improvement in 2017, to reflect the progress being made by the Trust in addressing operational and financial sustainability challenges.
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; reports from external assessments; Deanery and Royal College assessments; accreditation of clinical services; and patient led assessments of the care environment.

I can confirm, having taken all appropriate steps to be aware of potential breaches or failures to comply, that arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant.

Conclusion

The Trust board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. The board is also committed to ensuring that serious incidents, as well as the incidence of non-compliance with standards and regulatory requirements, are escalated and subject to prompt and effective remedial action. This is to ensure that patients, service users and staff and stakeholders of Imperial College Healthcare NHS Trust can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

I consider that any significant issues are detailed in the body of the annual governance statement above, namely: ability to recruit and retain clinical staff, particularly in relation to ward-based nurses, midwives and radiographers; ability to achieve required performance targets in the emergency department and for elective surgery; risk of delayed treatment to patients awaiting planned procedures due to data quality problems which can also result in breach of contractual and regulatory requirement; ability to achieve and maintain financial stability; ability to secure broader health economy (sustainability and transformation partners) commitment to the Trust's clinical and financial transformation plans; and risk of failure of estates critical equipment and facilities that jeopardises Trust operations and increases clinical and safety risks. Action to address each of these areas is detailed in the relevant section of the corporate

Chief executive
24 May 2019

Remuneration report

Remuneration for the Trust's executive directors is determined by the Remuneration Committee of the board.

Remuneration consists mainly of salary, which is inclusive of high cost area supplement, and pension benefits in the form of contributions to the NHS pension fund.

Annual salary increases are ordinarily in line with increases for the wider NHS workforce but may be higher where there is a significant change to an individual's responsibilities.

In order to attract high quality candidates to senior posts and to support retention we:

- make decisions in the context of the current market
- take into account independently sourced benchmark data and analysis of pay within relevant NHS, private health and non-healthcare markets
- compare pay with other staff on nationally agreed Agenda for Change and medical consultant terms and conditions.

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post-holder and are performance-based. Salary levels (which typically take effect from 1 April) for executive directors in 2018/19 are set out in the staff report.

The Trust has taken advantage of flexibilities offered in the Agenda for Change to offer pay spot salaries to 28 senior managers who are not executive directors. These salaries are set by the relevant executive director with approval from the director of people and organisation development.

Subject to any future reform of national terms and conditions the Trust plans to increase the number of senior managers on spot salaries in order to better control cost, maintain a competitive position in recruiting for senior positions and to readily link salary increases to performance.

Non-executive directors are normally appointed on fixed-term contracts of between two and four years. Non-executive directors are not generally members of the pension scheme, and receive payments based on benchmarking data for similar posts elsewhere in the NHS.

The remuneration of all other members of staff is determined by national terms and conditions such as the Agenda for Change, new and medical consultant terms and conditions.

Pay multiples (subject to audit)

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the Trust and the median remuneration of all staff. The remuneration of the highest paid director in the financial year 2018/19 was £253,103 (£244,237 in 2017/18). This was 6.25 times (7.53 times in 2017/18) the median remuneration of the workforce, which was £40,481 (£32,429 in 2017/18). The change in the ratio from 7.53 (2017/18) to 6.25 this year is due to a combination of the effects of an increase in remuneration for the general workforce as part of the Agenda for Change pay agreements, increases in the numbers of staff employed and changes in the grade mix of staff employed to support increased activity.

In both 2017/18 and 2018/19 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £7,922 to £253,103 (£7,476 to £244,237 in 2017/18).

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

Remuneration tables

Salary and pension disclosure tables: information subject to audit

Remuneration report 2018/19

Salaries and allowances	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
	Salary (bands of £5,000)	Expense payments (taxable) (Total to nearest £00)	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total Remuneration (bands of £5,000)
Name and title	£000	£00	£000	£000	£000	£000
Non-executive director						
Sir Richard Sykes, chair[1]	15 – 20	0	0	0	0	15 – 20
Sir Gerald Acher, deputy chair	5 – 10	0	0	0	0	5 – 10
Prof Andrew Bush, non-executive director	5 – 10	0	0	0	0	5 – 10
Peter Goldsbrough, non-executive director	5 – 10	0	0	0	0	5 – 10
Sarika Patel, non-executive director[4]	0 – 5	0	0	0	0	0 – 5
Andreas Raffel, non-executive director	5 – 10	0	0	0	0	5 – 10
Victoria Russell, non-executive director	5 – 10	0	0	0	0	5 – 10
Nick Ross, designate non-executive director[3]	5 – 10	0	0	0	0	5 – 10
Executive director						
Prof Tim Orchard, chief executive[6]	250 – 255	0	0	0	25 – 27.5	275 – 280
Prof Julian Redhead, interim chief executive[5]	240 – 245	0	0	0	0	240 – 245
Richard Alexander, chief financial officer[2]	215 – 220	0	0	0	12.5 – 15	225 – 230
Dr William Oldfield, interim medical director[7]	65 – 70	0	0	0	15 -17.5	80 – 85
Prof Janice Sigsworth, director of nursing	175 – 180	0	0	0	22.5 – 25	200 – 205

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash equivalent transfer Value at 1 April 2018	Real increase in cash equivalent transfer value8	Cash equivalent transfer value at 31 March 2019	Employer's contribution to stakeholder pension
Name and title	£000	£000	£000	£000	£000	£000	£000	£000
Non-executive director								
Sir Richard Sykes, chair[1]	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Prof Andrew Bush, non-executive director	0	0	0	0	0	0	0	0
Peter Goldsbrough, non-executive director	0	0	0	0	0	0	0	0
Sarika Patel, non-executive director[4]	0	0	0	0	0	0	0	0
Andreas Raffel, non-executive director	0	0	0	0	0	0	0	0
Victoria Russell, non-executive director	0	0	0	0	0	0	0	0
Nick Ross, designate non-executive director[3]	0	0	0	0	0	0	0	0
Executive director								
Prof Tim Orchard, chief executive[6]	0 – 2.5	0 – 2.5	55 – 60	85 – 90	729	109	861	0
Prof Julian Redhead, interim chief executive[5]	0	0	0	0	0	0	0	0
Richard Alexander, chief financial officer[2]	0 – 2.5	0 – 2.5	25 – 30	85 – 90	581	14	655	0
Dr William Oldfield, interim medical director[7]	0 – 2.5	0 – 2.5	50 – 55	75 – 80	752	15	858	0
Prof Janice Sigsworth, director of nursing	0 – 2.5	0 – 2.5	85 – 90	260 – 265	1,760	182	1996	0

1 Sir Richard Sykes left the board on 31 December 2018.
2 Richard Alexander opted out of the pension scheme on 30 June 2018.
3 Nick Ross donated all his salary to the Imperial Health Charity.
4 Sarika Patel left the board on 31 December 2018.
5 Prof Julian Redhead was interim chief executive till 6 June 2018. The amount of £135k – £140k of his salary relates to payment for clinical role.
6 Prof Tim Orchard was made chief executive from 7 June 2018. The amount of £60k – £65k of his salary relates to payment for clinical role.
7 Dr William Oldfield left the Trust on 31 July 2018. The amount of £30k – £35k of his salary relates to payment for clinical role. Pension benefit calculations are based on pro-rata basis.
8 NHS Pensions are assessing the impact of the McCloud case in relation to changes in benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

There were no non-contractual payments made to individuals where the payment was more than 12 months' annual salary (exit packages).

Remuneration report 2017/18

Salaries and allowances	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
	Salary (bands of £5,000)	Expense payments (taxable) (Total to nearest £00)	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	Pension-related benefits (bands of £2,500)	Total Remuneration (bands of £5,000)
Name and title	£000	£00	£000	£000	£000	£000
Non-executive director						
Sir Richard Sykes, chair	20 – 25	0	0	0	0	20 – 25
Sir Gerald Acher, deputy chair	5 – 10	0	0	0	0	5 – 10
Dr Rodney Eastwood, non-executive director[1]	0 – 5	0	0	0	0	0 – 5
Prof Andrew Bush, non-executive director	5 – 10	0	0	0	0	5 – 10
Peter Goldsbrough, non-executive director	5 – 10	0	0	0	0	5 – 10
Sarika Patel, non-executive director	5 – 10	0	0	0	0	5 – 10
Andreas Raffel, non-executive director	5 – 10	0	0	0	0	5 – 10
Victoria Russell, non-executive director[2]	5 – 10	0	0	0	0	5 – 10
Nick Ross, designate non-executive director[3]	5 – 10	0	0	0	0	5 – 10
Executive director						
Tracey Batten, chief executive[6]	105 – 110	0	0	0	0	105 – 110
Ian Dalton, chief executive[5]	100 – 105	0	0	0	80 – 82.5	180 – 185
Prof Julian Redhead, interim chief executive[6]	240 – 245	0	0	0	0	240 – 245
Richard Alexander, chief financial officer	210 – 215	0	0	0	30 – 32.5	245 – 250
Prof Tim Orchard, interim medical director[7]	230 – 235	0	0	0	42.5 – 45	270 – 275
Dr William Oldfield, interim medical director[8]	205 – 210	0	0	0	152.5 -155	355 – 360
Prof Janice Sigsworth, director of nursing	175 – 180	0	0	0	25 – 27.5	200 – 205

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash equivalent transfer value at 1 April 2017	Real increase in cash equivalent transfer value 8	Cash equivalent transfer value at 31 March 2018	Employer's contribution to stakeholder pension
Name and title	£000	£000	£000	£000	£000	£000	£000	£000
Non-executive director								
Sir Richard Sykes, chair	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Dr Rodney Eastwood, non-executive director[1]	0	0	0	0	0	0	0	0
Prof Andrew Bush, non-executive director	0	0	0	0	0	0	0	0
Peter Goldsbrough, non-executive director	0	0	0	0	0	0	0	0
Sarika Patel, non-executive director	0	0	0	0	0	0	0	0
Andreas Raffel , non-executive director	0	0	0	0	0	0	0	0
Victoria Russell, non-executive director[2]	0	0	0	0	0	0	0	0
Nick Ross, designate non-executive director[3]	0	0	0	0	0	0	0	0
Executive director								
Tracey Batten, chief executive[4]	0	0	0	0	0	0	0	0
Ian Dalton, chief executive[5]	2.5 – 5	5 – 7.5	25 – 30	80 – 85	447	40	552	0
Prof Julian Redhead, interim chief executive[6]	0	0	0	0	0	0	0	0
Richard Alexander, chief financial officer	2.5 – 5	7.5 – 10	25 – 30	85 – 90	511	70	581	0
Prof Tim Orchard, interim medical director[7]	2.5 – 5	0 – 2.5	55 – 60	85 – 90	658	71	729	0
Dr William Oldfield, interim medical director[8]	7.5 – 10	7.5 – 10	50 – 55	75 – 80	696	56	752	0
Prof Janice Sigsworth, director of nursing[7]	0 – 2.5	5 – 7.5	80 – 85	250 – 255	1,673	88	1761	0

1 Dr Rodney Eastwood left the board on 30 June 2017.
2 Victoria Russell joined the board on 1 July 2017.
3 Nick Ross, designate non-executive director from 1 September 2016.
4 Dr Tracey Batten left the Trust on 30 July 2017.
5 Ian Dalton joined the Trust in July 2017 and left on 3 December 2017. Pension benefit calculations are based on a pro-rata basis and other employers will disclose accordingly.
6 Prof Julian Redhead was made Interim chief executive on 4 December 2017. The amount of £120k – £125k of his salary relates to payment for clinical role.
7 Prof Tim Orchard was made interim joint medical director on 4 December 2017. The amount of £135k – £140k of his salary relates to payment for clinical role.
8 Dr William Oldfield was made interim joint medical director on 4 December 2017. The amount of £90k – £95k of his salary relates to payment for clinical role.

There were no non-contractual payments made to individuals where the payment was more than 12 months annual salary (exit packages).

Staff report

The headcount data is at 31 March 2019 and is for clinical and corporate divisions and research and development (excluding hosted and contracted services).

Workforce composition by staff group

At the end of 2018/19 the Trust employed 12,179 staff. Approximately 68 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in table titled 'headcount by Trust staff group' below.

Headcount by Trust staff group	Headcount
Admin and clerical	1,889
Allied health professional (qualified)	727
Allied health professional (unqualified)	99
Doctor (career grade)	35
Doctor (consultant)	1,038
Doctor (training grade)	1,606
Nursing (qualified)	3,753
Nursing (unqualified)	1,050
Pharmacist	137
Physician associate	3
Scientific and technical (qualified)	813
Scientific and technical (unqualified)	336
Senior manager	693
Trust Total	**12,179**

Workforce composition by sex

Seventy-one per cent of our workforce is female and 29 per cent is male. The high proportion of female workers is typical of NHS organisations. The proportion of male employees increases in more senior roles. The gender tables below show that at the end of 2018/19 women accounted for 56 per cent of senior managers, 38 per cent of executive directors and 22 per cent of board directors. There are four directors who are defined both as executive team members and as board directors.

Gender – all	Headcount
Female	8,643
Male	3,536
Trust total	**12,179**

Gender – senior managers	Headcount
Female	381
Male	297
Trust total	**678**

Gender – board of directors	Headcount
Female	2
Male	7
Trust total	**9**

Gender – Executive team	Headcount
Female	6
Male	10
Trust total	**16**

Workforce composition by age and ethnicity

Age group	Headcount
16-19 years	9
20-29 years	2,432
30-39 years	3,746
40-49 years	2,963
50-59 years	2,219
60 years and over	810
Trust total	**12,179**

Ethnic origin	Headcount
White – British	3,186
White – Irish	397
White – Any other White background	1,572
Mixed – White and Black Caribbean	78
Mixed – White and Black African	76
Mixed – White and Asian	79
Mixed – Any other mixed background	**169**
Asian or Asian British – Indian	934
Asian or Asian British – Pakistani	208
Asian or Asian British – Bangladeshi	149
Asian or Asian British – Any other Asian background	1,122
Black or Black British – Caribbean	508
Black or Black British – African	1,176
Black or Black British – Any other Black background	443
Chinese	189
Any other ethnic group	709
Undefined	845
Not Stated	339
Trust	**12,179**

Average staff numbers (subject to audit)

Average staff numbers	Total	Permanently employed	Other	Total prior year	Prior year permanently employed	Prior year other
Medical and dental	2,085	2,081	4	2,083	2,075	8
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,632	2,513	119	2,556	2,413	143
Healthcare assistants and other support staff	1,631	1,602	29	1,698	1,644	54
Nursing, midwifery and health visiting staff	4,176	3,986	190	4,206	3,969	237
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	974	880	94	959	826	133
Social care staff	0	0	0	0	0	0
Healthcare science staff	651	651	0	628	628	0
Other	1	1	0	0	0	0
TOTAL	12,150	11,714	436	12,130	11,555	575
Staff engaged on capital projects (included above)	27	27	0	16	15	1

The analysis of staff costs is shown below:

	2018/19			2017/18		
	Total	Permanently employed	Other	Total prior year	Prior year permanently employed	Prior year other
Salaries and wages	479,072	84,040	563,112	452,264	78,060	530,324
Social security costs	54,261	3,143	57,404	51,233	2,417	53,650
Apprenticeship levy	2,392	174	2,566	2,254	140	2,394
Employer contributions to NHS BSA	56,675	1,015	57,690	53,722	832	54,554
Other pension costs	37	13	50	18	4	22
Termination benefits	38	-	38	333	0	333
Total employee benefits	**592,475**	**88,385**	**680,860**	**559,824**	**81,453**	**641,277**
Employee costs capitalised	1,786	230	2,016	946	335	1,281
Gross Employee Benefits ex. capitalised costs	**595,034**	**83,810**	**678,844**	**558,878**	**81,118**	**639,996**

Separate to the table above consultancy spend in 2018/19 was £2,093k (£291k in 2017/18).

Sickness absence

Low sickness absence is an indicator of effective leadership, good people management and staff wellbeing and as such this an important key performance indicator for the Trust. In 2018/19, the Trust achieved a sickness absence rate of 6.6 average sick days per full-time equivalent; comparing favourably to the average of 9.81 days reported nationally across the NHS.

Employment of staff with disabilities

The Trust is committed to attracting and developing staff with disabilities. The Trust's commitments are described in its equal opportunities policy and its policy on maintaining the employment of people with disabilities. The Trust is a 'two ticks' employer, guaranteeing an interview for any disabled person who meets the minimum criteria for a role. Information on the proportion of staff with declared disabilities is shown in the table on the right.

Further information on the employment of people with disabilities is available in our annual equality workforce information report which is published on the Trust website.

Staff with disabilities	Headcount
No	7,867
Not declared	221
Prefer not to answer	25
Unspecified	3,900
Yes	166
Trust total	**12,179**

Trade Union facility time publication requirements report: 2018/19 (unaudited)

The facility time data that organisations are required to collate and publish under the new regulations is shown below. We have included tables to illustrate the information required.

Trade Union facility time information required for publication

The below data refers to the relevant period which is 1 April 2018-31 March 2019.

a) TU representatives – the total number of employees who were TU representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	FTE employee number
81	80.2

b) Percentage of time spent on facility time – How many employees who were TU representatives' officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	54
1-50%	27
51%-99%	0
100%	0

c) Percentage of pay bill spent on facility time – The figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period.

First column	Figures
Provide the total cost of facility time	£37,692.35
Provide the total pay bill	£680,860,000 = total figure for 2018/2019 including apprenticeship levy (£2,566,000) £678,294,000 = total figure excluding apprenticeship levy
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.006%

d) Paid TU activities – As a percentage of total paid facility time hours, how many hours were spent by employees who were TU representatives during the relevant period on paid TU activities.

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	77%

Off-payroll arrangements

It is Trust policy that all substantive staff should be paid through the payroll wherever possible.

NHS bodies are required to disclose specific information about off-payroll engagements.

Off-payroll engagements longer than six months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	12
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	4
for 4 or more years at the time of reporting	5

New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31st March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (2018/19)	1
Total no. of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both on payroll and off-payroll engagements (2018/19)	23

Exit packages (subject to audit)

In 2018/19 the Trust approved severance payments to five staff.

Exit Packages

2018/19								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	7,720	0	0	1	7,720	0	0
£10,000-£25,000	2	29,926	1	16,500	3	46,426	0	0
£25,001-£50,000	0	0	1	35,500	1	35,000	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 – £150,000	0	0	0	0	0	0	0	0
Total	**3**	**37,646**	**2**	**51,500**	**5**	**89,146**	**0**	**0**

2017/18								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	9	53,138	12	43,696	21	96,834	0	0
£10,000-£25,000	3	57,570	1	16,843	4	74,413	0	0
£25,001-£50,000	5	170,640	0	0	5	170,640	0	0
£50,001-£100,000	1	52,067	0	0	1	52,067	0	0
£100,001 – £150,000	0	0	0	0	0	0	0	0
Total	**18**	**333,415**	**13**	**60,539**	**31**	**393,954**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages – other departures analysis

In 2018/19 the Trust approved severance payments to five staff.

Exit packages

	2018/19		2017/18	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	2	77	1	17
Exit payments following Employment Tribunals or court orders	1	35	12	44
Total	**3**	**112**	**13**	**61**

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Chief financial officer's report

Once again it is pleasing to report that the Trust delivered the financial plan agreed with the regulator. This was especially gratifying as during the early part of the year it became clear that additional savings would be necessary. As a reward for this performance the Trust received a little over £48m from the renamed Provider Sustainability Fund (PSF, formerly known as STF) which moved our reported bottom line performance from £20m deficit into £28m surplus. £14m of the PSF was a 'bonus' and it is possible that the Trust may be permitted to invest this in patient care instead of taking out a loan which would otherwise be necessary to maintain our estate and essential equipment.

While it was satisfying to deliver the plan it is disappointing, but perhaps not surprising, to note that not all of the savings we were able to deliver can be continued into next year (2019/20). Therefore the improvement in our underlying deficit was less than planned and the financial challenge now facing the Trust is every bit as difficult as it was in 2018/19. This is despite the general injection of funds into the provider sector, which has for this Trust been offset to a significant extent by the reduction in the 'weighting' for the additional costs of providing care in inner London. I reported last year that the search for efficiencies in the Trust becomes more difficult each year and that we would become more dependent upon wider collaborative system change. Some progress has been seen in this direction during 2018/19 however it is becoming increasingly clear that the NWL region (STP) as a whole is facing serious financial constraints and we urgently require more efficient pathways of care to meet the needs of our patients effectively within the allocated budgets. This has a significant impact upon the Trust as it tends to be easier to find effective ways to care for more patients within marginally increased expenditure than it does to freeze or reduce expenditure.

In year, the Trust appointed a Director of Transformation to lead a small coordinating team to ensure that the Trust has the capacity and focus to address the more complex changes required for both Trust and STP financial stability.

Statutory financial duties and going concern

During 2018/19 the Trust met four out of the five key statutory financial duties (see table top right) and met its financial plan for the year. This performance included delivering efficiencies of £44.2m.

Duty	Requirement	Achievement
Breakeven duty	To ensure total expenditure does not exceed income, on a year-on-year cumulative basis	Achieved – cumulative surplus of £42.9m remaining
External financing limit (EFL)	To remain within DH borrowing limit	Achieved – external financing of £6.5m
Capital absorption rate of 3.5 per cent	To pay a dividend of 3.5 per cent to the Department of Health and Social Care	Achieved
Capital resource limit (CRL)	To ensure capital expenditure is within the limit set by Department of Health and Social Care	Achieved – net spend of £53.4m
Better payment practice code (BPPC)	To pay 95 per cent all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later	Not achieved – 74 per cent of invoices paid within the required standard

It was also pleasing during 2018/19 to have our financial recovery plan accepted and to move out of the financial constraints applied in our letter of undertakings from our regulator NHS Improvement. This recovery plan requires us to continue to reduce our underlying deficit through identifying additional efficiencies.

Achieving our statutory breakeven duty has been and will continue to be dependent upon receipt of PSF although our planned deficit before non-recurrent PSF in 2019/20 reduces to £6m as a result of £10m additional central funding for emergency care. Failure to meet the plan jeopardises all of the PSF and would cause the Trust to fail its breakeven duty. While the Trust is committed to meeting its plan, it should be noted that the poor condition of much of our estate and the limitations that places on our ability to provide the most efficient models of care represent significant and difficult-to–mitigate risks to the plan. Failure to commit to the target would jeopardise necessary funding to both maintain and potentially redevelop the estate. Our auditors have confirmed that it remains appropriate for the Trust to prepare accounts on a going concern basis, but have noted the material uncertainty in their report; please note 1.1.2 in the accounts where Trust management explain in more detail the risks mentioned above, in particular the realistic life of some of our estate compared with the realistic time to build a replacement.

While it is not yet a statutory duty, it is clear that the Trust will increasingly be held accountable with other partners for the financial performance of the NW London region (STP) of which we are a significant part.

Financial performance metrics

From October 2016, the Trust has been monitored based on the Single Oversight Framework. This was updated in November 2017. This uses five key metrics to measure the financial risk of an organisation. Each metric has a rating from 1-4 with 1 being the best performance (i.e. lowest risk) and 4 the worst. These ratings are then combined to give an overall score. If any metric has a score of 4 then the overall rating cannot score better than a 3.

Metric	Explanation	Rating
Capital servicing capacity	Does the organisational income cover loans and other financing costs	1
Liquidity	Days of operating costs that can be covered by cash in the organization	3
Income & expenditure (I&E) margin	Surplus/deficit as a percentage of income	1
Distance from financial plan	Variance between the planned I&E margin and actual	1
Agency spend against cap	The variance between the agency cap and the actual agency costs spent	2

Averaging the five metrics the Trust's rating is determined as a 2.

There are no triggers which cause this rating to be overridden.

Income and expenditure

The Trust's total operating income (see notes 4 and 5 to the accounts), before the allocation of PSF, grew approximately two-and-a-half per cent, or £29m, against the previous year. This increase in income resulted largely from the net increases in clinical commissioning income from Clinical Commissioning Groups.

The total operating expenditure (see note 7 to the accounts) was £1,170m. After adjusting for the asset revaluation explained below, overall expenditure has increased by approximately two-and-a-quarter per cent, or £23m, when compared to the previous year. This increase has been driven primarily by the cost of delivering additional activity, together with costs associated with inflation, other NHS policy driven cost pressures alongside high costs of maintaining a poor quality estate and some additional costs required to reduce patient waiting times. This position includes the increase in respect of North West London Pathology which since 2017/18 has been fully consolidated into our accounts.

In line with established accounting practice, the Trust commissioned an independent professional firm to undertake a valuation of its estate. The accounts record an overall net increase of £2.2m in the value of the Trust asset base, £2.1m of this was recorded within operating expenditure. There was also a movement of £4.8m on assets related to an assessment of assets under construction. These adjustments are excluded from the Department of Health and Social Care's assessment of the Trust's breakeven duty.

The Trust's efficiency programme was initially set at £48m, and delivered £44.2m against this. All efficiency plans are risk assessed and reviewed by the medical and nursing directorates for impact on patient safety, quality and experience, which are rigorously monitored. Separately, the programme support office maintains a framework to assure the effective delivery of these improvement programmes. The key themes included increased productivity through delivering greater NHS activity with minimal expenditure increase, as well as increases in private work. It also included reduced costs through reviewing key contracts, negotiating better prices with suppliers, and reducing overheads.

Capital expenditure

The Trust continues to invest in its capital infrastructure to help achieve its strategic service objectives. During 2018/19, the Trust invested a gross total of £55.1m to modernise its estate, deal with the most critical backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2018/19 included:

- Backlog maintenance £18.7m
- IT investment £10m (including £3m global digital exemplar funding)
- Charing Cross Hospital emergency department £5.5m
- St. Mary's Hospital paediatric intensive care unit £3.4m
- Medical equipment £4.6m

Liquidity, cash and working capital

The Trust focused successfully on its cash management throughout the year; remaining within its external financing limit (EFL), with a year-end cash position of £26.7m. The Trust has maintained the revolving working capital facility (which was initially provided by the Department of Health and Social Care in 2015/16) at £15.8m.

Financial outlook

As explained earlier, the Trust has entered 2019/20 with an underlying deficit higher than expected, and has therefore set another challenging target for improving productivity and cost reduction with an efficiency programme exceeding £53m; around 4.5 per cent of turnover. This is a high target relative to both history and peers, however, the way that our targets have been set for 2019/20 means that delivering that target would reduce our underlying deficit significantly.

Taking into account the known pressures to the Trust from national and local decisions, such as changes to market forces factor, tariff, research and development and education funding models and critical investments in safety, a planned deficit of £6m before PSF (which equates to a planned deficit of £16m before central MRET, new for 2019/20, and PSF) has been set by the Trust board. Delivery of this target would take the Trust to a reported surplus of £11m after MRET and PSF.

The Trust will continue to need to invest a significant portion of its available capital to meet a very significant programme of backlog maintenance across its estate and has once again submitted a request for £15m additional support to achieve this without jeopardising essential investment in other areas of Trust activity. This request was rejected last year but we were permitted to spend a little more of our cash on essential works. The capital programme has been set at £53m including external donations (but before the £15m loan request). The Trust continues to work with partners including local commissioners and sector provider trusts in developing business cases which will deliver the very best care for patients across north west London. The Trust continues to actively explore the extent to which funding, commercial and public, can be secured to provide new facilities for patients.

Independent auditor's report to the directors of Imperial College Healthcare NHS Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Imperial College Healthcare NHS Trust (the 'Trust'):

- give a true and fair view of the financial position of the trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements of the trust which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 33.

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

- the table of salaries and allowances of senior managers on page 123
- the table of pension benefits of senior managers and related narrative notes on page 124; and
- the disclosure of pay multiples and related narrative notes on page 122.

The financial reporting framework that has been applied in their preparation is applicable law and the 'Accounts Direction'.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Local Audit and Accountability Act 2014 (the 'Act') and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

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

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that, whilst the Trust has a balanced plan for 2019/20, there are significant risks to the trust's cash flows which cannot easily be mitigated should they occur without access to further as yet uncommitted borrowing. As stated in note 1.1.2, these events or conditions, along with the other matters as set forth in note 1.1.2 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

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

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

We have nothing to report in respect of these matters.

Responsibilities of directors

As explained more fully in the directors' responsibilities statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give

a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the trust or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements

Opinions on other matters

In our opinion:

- the parts of the Remuneration Report subject to audit has been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Conclusion on the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required to report to you if, in our opinion the trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matters reported in the basis for qualified conclusion section below, we are satisfied that, in all significant respects, Imperial College Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

As disclosed in the Annual Governance statement, the Trust is subject to a series of undertakings that have been agreed with NHS Improvement following the receipt of formal notification from NHS Improvement on 7 November 2017. This notification stated that NHSI had "reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following equivalent conditions to that of the Monitor Licence: FT4 (5) (a)-(c) (d)."

This letter was superseded by a letter dated October 2018, which continued to reference these conditions of the licence. Specifically, NHSI required the Trust to take action to address the breaches with regards to a financial recovery plan, and performance against national targets, particularly with regards to emergency department admissions and referral to treatment metrics, along with associated data quality actions. As described in the Annual Governance Statement, management have taken further actions to make progress in these areas during the year which have resulted in:

- the lifting of the conditions in relation to financial recovery
- improvement of A&E admissions to 88.4 per cent in March 2019
- reduction in 52 week referral to treatment waits to zero.

Additionally note 1.1.2 in the financial statements describes management's assessment that there are material uncertainties with regards to the Trust's ability to continue as a going concern, in particular with regards to the Trust's ability to adequately fund the on-going maintenance of its estate. Whilst the Trust has been performing work to respond to undertakings and address these concerns, these improvements had not operated over the whole year, and at 31 March 2019 the undertakings were still extant.

This is evidence of weaknesses in the proper arrangements for securing economy, efficiency and effectiveness in sustainable resource deployment, including its ability to plan finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

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

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

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the Local Audit and Accountability Act to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion, published by the Comptroller & Auditor General in November 2017, as to whether the trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

The Comptroller & Auditor General determined this overall evaluation criterion as that necessary for us to consider under its Code of Audit Practice in satisfying ourselves whether the trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Matters on which we are required to report by exception

We are required to report in respect of the following matters if:

- in our opinion, the governance statement does not comply with the NHS Trust Development Authority's (NHS Improvement) guidance; or
- we refer the matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act.

We have nothing to report in respect of these matters.

We are required to report in respect of the following matters if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's (NHS Improvement) guidance; or
- we refer the matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts of Imperial College Healthcare NHS Trust in accordance with requirements of the Act and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of Imperial College Healthcare NHS Trust in accordance with Part 5 of the Act and for no other purpose, as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Craig Wisdom
ACA (Engagement Lead)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
28 May 2019

Financial statements

Statement of comprehensive income for the year ended 31 March 2018

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	4	1,030,874	973,974
Other operating income	5	182,085	186,829
Operating expenses	7,9	(1,169,891)	(1,146,852)
Operating surplus/(deficit) from continuing operations		**43,068**	**13,951**
Finance income	12	309	104
Finance expenses	13	(1,167)	(1,216)
PDC dividends payable		(11,764)	(10,105)
Net finance costs		**(12,622)**	**(11,217)**
Surplus/(deficit) for the year		**30,446**	**2,734**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	63	(1,042)
Total comprehensive income/(expense) for the period		**30,509**	**1,692**
Adjusted financial performance (control total basis):			
Surplus/(deficit) for the year		30,446	2,734
Remove net impairments not scoring to the departmental expenditure limit		(2,138)	5,804
Remove I&E impact of capital grants and donations		(143)	(5,515)
Adjusted financial performance surplus/(deficit)		**28,165**	**3,023**

An NHS trust's financial performance is derived from its retained surplus/(deficit), but is adjusted for impairments and reversal of prior year impairments to property, plant, equipment and elimination of income and expenditure arising from donations and donated assets, as these are not considered to be part of the organisation's operating position.

Statement of financial position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	3,158	3,247
Property, plant and equipment	15	511,326	494,135
Total non-current assets		**514,484**	**497,382**
Current assets			
Inventories	16	13,934	13,071
Receivables	18	148,964	165,354
Cash and cash equivalents	17	26,692	24,464
Total current assets		**189,590**	**202,889**
Current liabilities			
Trade and other payables	19	(157,137)	(174,615)
Borrowings	21	(1,807)	(1,583)
Provisions	22	(33,715)	(44,971)
Other liabilities	20	(26,012)	(35,041)
Total current liabilities		**(218,671)**	**(256,210)**
Total assets less current liabilities		**485,403**	**444,061**
Non-current liabilities			
Borrowings	21	(32,341)	(33,603)
Other liabilities	20	(2,058)	-
Total non-current liabilities		**(34,399)**	**(33,603)**
Total assets employed		**451,004**	**410,458**
Financed by			
Public dividend capital		716,420	706,383
Revaluation reserve		1,777	1,714
Income and expenditure reserve		(267,193)	(297,639)
Total taxpayers' equity		**451,004**	**410,458**

The notes on pages 79 to 107 form part of these accounts.

The financial statements on pages 75 to 107 were approved by the Board on 28 May 2019 and signed on its behalf by

Name: Professor Tim Orchard
Position: Chief executive
Date: 28 May 2019

Statement of changes in equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 – brought forward	**706,383**	**1,714**	**(297,639)**	**410,458**
Surplus/(deficit) for the year	-	-	30,446	30,446
Impairments	-	63	-	63
Public dividend capital received	10,037	-	-	10,037
Taxpayers' equity at 31 March 2019	**716,420**	**1,777**	**(267,193)**	**451,004**

Statement of changes in equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 – brought forward	**694,844**	**2,756**	**(300,373)**	**397,227**
Surplus/(deficit) for the year	-	-	2,734	**2,734**
Impairments	-	(1,042)	-	**(1,042)**
Public dividend capital received	11,539	-	-	11,539
Taxpayers' equity at 31 March 2018	**706,383**	**1,714**	**(297,639)**	**410,458**

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 and Social Care 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 expenditure. 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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit)		43,068	13,951
Non-cash income and expense:			
Depreciation and amortisation	7.1	35,326	36,263
Net impairments	8	2,693	5,804
Income recognised in respect of capital donations	5	(1,680)	(6,934)
(Increase)/decrease in receivables and other assets		15,766	(57,443)
(Increase)/decrease in inventories		(863)	603
Increase/(decrease) in payables and other liabilties		(14,954)	43,576
Increase/(decrease) in provisions		(11,256)	1,073
Net cash generated from/(used in) operating activities		**68,100**	**36,893**
Cash flows from investing activities			
Interest received		309	110
Purchase of non-current assets		(64,432)	(45,387)
Sales of property, plant, equipment and investment property		-	3,716
Receipt of cash donations to purchase capital assets		1,680	6,935
Net cash generated from/(used in) investing activities		**(62,443)**	**(34,626)**
Cash flows from financing activities			
Public dividend capital received		10,037	11,539
Movement on loans from the Department of Health and Social Care		(1,226)	(1,226)
Movement on other loans		163	2,451
Interest on loans		(1,170)	(1,219)
PDC dividend (paid)/refunded		(11,232)	(10,323)
Net cash generated from/(used in) financing activities		**(3,429)**	**1,222**
Increase/(decrease) in cash and cash equivalents		**2,228**	**3,489**
Cash and cash equivalents at 1 April – brought forward		**24,464**	**20,975**
Cash and cash equivalents at 31 March	17	**26,692**	**24,464**

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 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 the 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

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the entity's ability to continue as a going concern. Financial statements should be prepared on a going concern basis unless there is an intention to cease activities or there is no realistic alternative but to do so. Current guidance is that Department of Health and Social Care bodies should prepare their financial statements on a going concern basis unless informed by the Department of Health and Social Care (DHSC) of the intention for dissolution without transfer or service or function to another entity.

The Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate for the foreseeable future.

The Trust board has considered the advice in the Department of Health and Social Care's GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

In line with its expectation of continued operation the Trust's 2019/20 plan has been submitted to NHSI and the board has accepted the control total, thereby meeting the conditions for allocation of additional MRET Central Funding and Provider Sustainability Funding (PSF). The Trust is consequently planning to deliver a surplus during 2019/20 and on this basis management has the reasonable expectation that the Trust will continue to have adequate resources to service its operational activities in cash terms for the next 12 months and into the first half of 2020/21.
It is likely that during 2020/21 the Trust will need to renegotiate the terms of a working capital loan of £15.8m due for repayment in February 2021.The Trust's 2019/20 plan is for an agreed control total of a deficit of £5.7m prior to PSF of £16.8m. The Trust's future cashflows are highly dependent on making this plan, which includes areas of uncertainty, such as the ability to meet the cost improvement targets, and to maintain the condition of the estate required to deliver the planned services, which could impact on the attainment of the control total and the receipt of the PSF upon which the Trust depends. Additionally, the Trust is a significant component of the north west London health and care partnership (Trust receives income in excess of £435m) which has declared a challenged financial position for 2019/20 which may endanger their ability to pay the Trust. As disclosed on page 52 of the annual report the Trust's estate is in a poor condition due to its age and this gives two specific causes for concern. Firstly, should the Trust miss its financial target and not qualify for PSF then there is little flexibility in the capital programme to release additional cash to mitigate the shortfall. Secondly should the level of expenditure required to maintain a safe and acceptable Estate exceed that planned for then this would require further, possibly material, departmental funding which is not yet committed. Additionally, there are cashflow risks which do not impact surplus, for example, should provisions disclosed in note 22 crystallise during the year, this would result in a potentially significant outflow of cash resources, meaning that the Trust would not be able to meet its liabilities as they fell due without additional departmental funding. For these reasons, there is a material uncertainty about the financial viability of the Trust if it does not receive centrally agreed funding which may cast significant doubt as to the Trust's ability to continue as a going concern. No adjustments have been made to the financial statements as a result of this potential uncertainty.

The Trust board, however, is in regular contact with the Department of Health and Social Care, and as such, should any of these circumstances arise, has a reasonable expectation that funding would be provided, although this funding is not yet committed.

Note 1.2 Critical judgements and key sources of estimation uncertainty in applying accounting policies

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. The estimates and underlying assumptions are reviewed on an on-going basis. 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.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see 1.2.2) that management have made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.1.1 Land and buildings valuation

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See note 1.7 for further details.

In line with this policy land and building assets are valued using the Modern Equivalent Asset (MEA) approach. Both physical and functional obsolescence is applied to buildings, to reflect their actual characteristics and value. As part of this process management consider whether an alternative rebuild location remains appropriate.

The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes although the MEA aligns with the Trust's proposals for site redevelopment.

The valuation carried out on 31 January 2019 is based on assumptions made by a suitably qualified professional in accordance with HM Treasury Guidance. The valuer provided the Trust with a valuation of land and building assets. This process leads to revaluation adjustments as set out in note 15 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

Whilst it is not possible to quantify the impact, it is possible that the ongoing uncertainty in relation to the UK's exit from the EU could have an impact on future property price indices, which may result in future fluctuations of the Trust's property valuation.

Note 1.2.2 Key sources of estimation uncertainty

The following are the estimations that management have made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.2.1 Provisions

Where the Trust is subject to challenge or outcome on as yet undetermined matter e.g. employment tribunal, redundancy claim, pay claims, etc. the Trust takes a prudent view and provides for such claims within the accounting period in which they arose. See note 1.14 for further details.

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events.

Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.The carrying amounts of the Trust's provisions are detailed in note 22 to these accounts.

Note 1.2.2.2 Allowance for credit losses

The provision for impairment of receivables is based on assumptions concerning the future and other sources of information about the age and recoverability of the debt. Management provides for the potential of impaired receiveables according to its classification, age and status (i.e. disputed or otherwise). Management uses its judgement to decide when to provide against other specific debts which are considered are risk of impairment other than the risk generated by classification, age and status.

The carrying amounts of the Trust's provisions are detailed in note 18.2 to these accounts.

Note 1.2.2.3 Preparations for the United Kingdom's exit from the European Union

The Trust made preparations through 2018/19 for the potential impact of the UK's exit from the European Union (EU), including planning for the case of a 'no deal' EU exit, including following recommendations in the Department of Health and Social Care's *EU Exit Operational Guidance*. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

The director of operational performance is the Trust's EU exit senior responsible officer, reporting to the board and executive management committee on a regular basis with other committees considering issues as relevant through the year. The Trust has completed a risk assessment of the impact of a 'no deal' exit from the EU and associated risks in respect of the UK's exit from the EU (including the potential impact in areas such as workforce), board assurance framework and has implemented appropriate mitigations. These are included in the Trust's risk register and have been monitored through the year by the board.

Note 1.3 Interests in other entities

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its full share of the assets, liabilities, income and expenses for north west London Pathology (NWLP), which it is a joint operator of, with a corresponding debtor or creditor with the other joint operators for their share of operational performance.

Note 1.4 Income

Note 1.4.1 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.

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.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

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

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

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

Revenue from research contracts

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

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income

when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 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 1.4.3 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 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs NHS

Pension Scheme

Past and present employees are covered by the provisions of the 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 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic 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 assets are measured subsequently at valuation.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 of IFRS 5.

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 economic 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' ceases 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

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

- land and non-specialised buildings – market value for existing use basis
- specialised buildings – depreciated replacement cost basis.

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

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

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 1.8 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 and where the cost is more than £5,000.

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

operation of hardware, e.g. application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.9 Other relevant asset disclosures

Note 1.9.1 Derecognition

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 i.e.:
  - 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 dropped 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 or amortisation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.Assets which is are 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.9.2 Donated and grant funded assets

Donated and grant funded 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 assets in that class.

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

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 above/below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the statement of comprehensive income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of comprehensive income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the statement of financial position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the statement of comprehensive income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the statement of comprehensive income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the statement of financial position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Note 1.13 Leases

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

Note 1.13.1 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 an item of property plant and equipment.

The annual rental 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 1.13.2 The Trust as lessor

Finance leases

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

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the statement of financial position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

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

Non-clinical risk pooling

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

Note 1.15 Contingencies

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

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

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

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 per cent) 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

(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 1.17 Value added tax

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

Note 1.18 Third party assets

Assets belonging to third parties (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 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, 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 1.20 Gifts

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

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The Department of Health and Social Care GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are either being implemented in 2019/20 or are still subject to implementation.

IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.It is expected that adoption of this standard will have a significant effect on financial statements. It has not been possible to quantify any impact at this time.

Note 1.22 Restatement

In some instances the Trust has deemed it appropriate to represent prior year disclosures. These adjustments although not strictly required under UK generally accepted accounting practice are reclassifications between lines and have no bottom line impact on last year's accounts. This is intended to ensure that the classification of current and prior year disclosures are aligned and, in so doing, make the accounts of greater value to the reader. Where a disclosure has been restated, the disclosure will be marked with the heading 'restated'.

Note 2 Operating Segments

The Trust board led by the chief executive is the chief operating decision maker within the Trust. It is the duty of the chief operating decision make to consider classes of activities, services or locations that constitute discrete operating segments meriting separate disclosure within the accounts.

The Trust provides a range of healthcare services to which are reported internally in four divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and children's, and clinical support services; corporate services. The Trust is also party to a joint arrangement for the north west London Pathology Hub.

However, having considered the requirements, the Trust Board considers that for the purpose of statutory reporting the Trust's activities fall under the single heading of healthcare. Consequently, there are no additional disclosures to made as regards the statutory accounts with regard to operating segments.

Note 3 New standards

Note 3.1 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 £28k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £8,068k increase in the carrying value of receivables due to the fact that previous provisions disclosed within bad debt provisions are now treated as other provisions.

Note 3.2 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).

Note 4 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 4.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Acute services		
Elective income	181,756	158,692
Non elective income	250,645	234,638
First outpatient income	57,199	55,685
Follow up outpatient income	73,460	67,540
A&E income	34,805	34,027
High cost drugs income from commissioners (excluding pass-through costs)	117,012	116,056
Other NHS clinical income	201,137	186,528
Community services		
Community services income from CCGs and NHS England	9,112	12,690
Income from other sources (e.g. local authorities)	539	7,203
All services		
Private patient income	52,221	50,659
Agenda for Change pay award central funding	7,661	-
Other clinical income	45,327	50,257
Total income from activities	**1,030,874**	**973,974**

Note 4.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	351,184	353,783
Clinical commissioning groups	539,202	508,501
Department of Health and Social Care	7,666	391
Other NHS providers	57,738	39,155
NHS other	8,552	2,763
Local authorities	667	7,203
Non-NHS: private patients	52,221	50,686
Non-NHS: overseas patients (chargeable to patient)	6,739	4,483
Injury cost recovery scheme	2,651	2,273
Non NHS: other	4,254	4,736
Total income from activities	**1,030,874**	**973,974**

Note 4.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19 £000	2017/18 £000
Income recognised this year	6,739	4,483
Cash payments received in-year	2,390	1,468
Amounts added to provision for impairment of receivables	3,505	1,548
Amounts written off in-year	1,927	1,001

Note 5 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development	46,418	47,717
Education and training	52,001	57,934
Non-patient care services to other bodies	15,191	17,835
Provider sustainability (PSF)	48,401	25,537
Income in respect of employee benefits accounted on a gross basis	7,165	6,966
Other contract income	6,529	19,650
Other non-contract operating income		
Receipt of capital grants and donations	1,680	6,934
Charitable and other contributions to expenditure	2,380	2,218
Rental income from operating leases	2,320	2,038
Total other operating income	**182,085**	**186,829**

Note 6.1 Additional information on revenue from contracts with customers 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	3,066
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	4,952

Note 6.2 Transaction price allocated to remaining performance obligations

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 7.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	16,692	14,868
Purchase of healthcare from non-NHS and non-DHSC bodies	16,114	15,467
Staff and executive directors costs	678,778	639,663
Remuneration of non-executive directors	54	72
Supplies and services – clinical (excluding drugs costs)	134,430	135,616
Supplies and services – general	37,529	36,949
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	124,595	124,872
Inventories written down	496	405
Consultancy costs	2,093	291
Establishment	7,630	7,524
Premises	50,122	45,926
Transport (including patient travel)	15,049	13,799
Depreciation on property, plant and equipment	33,639	34,588
Amortisation on intangible assets	1,687	1,675
Net impairments	2,693	5,804
Movement in credit loss allowance	(13,502)	4,790
Statutory audit fee payable to the external auditor	107	112
Other external auditor remuneration	18	18
Internal audit costs	275	307
Clinical negligence	30,510	30,332
Legal fees	711	1,166
Insurance	620	570
Research and development	24,835	25,539
Education and training	1,790	2,381
Rentals under operating leases	1,640	1,350
Redundancy	66	333
Hospitality	159	103
Other	1,061	2,332
Total	**1,169,891**	**1,146,852**

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments:		
Abandonment of assets in course of construction	4,831	-
Changes in market price	(2,138)	5,804
Impairments charged to the revaluation reserve	(63)	1,042
Total net impairments	**2,630**	**6,846**

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	533,344	501,954
Social security costs	57,404	53,650
Apprenticeship levy	2,566	2,394
Employer's contributions to NHS pensions	57,690	54,554
Pension cost – other	50	22
Termination benefits	-	333
Temporary staff (including agency)	29,806	28,370
Total staff costs	**680,860**	**641,277**
Of which		
Costs capitalised as part of assets	2,016	1,281

Note 9.1 Retirements due to ill-health

During 2018/19 there was one early retirement from the trust agreed on the grounds of ill-health (five in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £60k (£311k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 per cent of pensionable pay from this date (currently 14.38 per cent).

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.

Note 11 Operating leases

Note 11.1 Imperial College Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Imperial College Healthcare NHS Trust is the lessor.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	2,320	2,038
Total	**2,320**	**2,038**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
– not later than one year;	1,735	1,127
– later than one year and not later than five years;	5,454	3,283
– later than five years.	5,142	1,649
Total	**12,331**	**6,059**

Note 11.2 Imperial College Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Imperial College Healthcare NHS Trust is the lessee.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,640	1,350
Total	**1,640**	**1,350**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
– not later than one year;	1,598	1,505
– later than one year and not later than five years;	4,790	4,407
– later than five years.	2,119	2,164
Total	**8,507**	**8,076**

Note 12 Finance income

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	309	104
Total finance income	**309**	**104**

Note 13.1 Finance expenditure

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	1,167	1,216
Total finance costs	**1,167**	**1,216**

Note 14.1 Intangible assets – 2018/19

	Information technology £000	Total £000
Valuation/gross cost at 1 April 2018 – brought forward	**10,304**	**10,304**
Valuation/gross cost at start of period for new FTs	**-**	**-**
Additions	-	-
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	1,598	**1,598**
Disposals	-	**-**
Valuation/gross cost at 31 March 2019	**11,902**	**11,902**
Amortisation at 1 April 2018 – brought forward	**7,057**	**7,057**
Provided during the year	1,687	**1,687**
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Disposals/derecognition	-	-
Amortisation at 31 March 2019	**8,744**	**8,744**
Net book value at 31 March 2019	**3,158**	**3,158**
Net book value at 1 April 2018	**3,247**	**3,247**

Note 14.2 Intangible assets – 2017/18

	Information technology £000	Total £000
Valuation/gross cost at 1 April 2017 – as previously stated	**8,775**	**8,775**
Additions	-	-
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	1,529	**1,529**
Disposals/derecognition	-	-
Valuation/gross cost at 31 March 2018	**10,304**	**10,304**
Amortisation at 1 April 2017 – as previously stated	**5,382**	**5,382**
Provided during the year	1,675	**1,675**
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Disposals/derecognition	-	-
Amortisation at 31 March 2018	**7,057**	**7,057**
Net book value at 31 March 2018	**3,247**	**3,247**
Net book value at 1 April 2017	**3,393**	**3,393**

Note 14.3 Useful economic lives of intangible assets

The Trust amortises all intangible assets over a period of five years.

Note 15.1 Property, plant and equipment – 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 – brought forward	**71,216**	**315,252**	**66,498**	**156,894**	**48,497**	**1,082**	**659,439**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	-	53,378	1,680	-	-	**55,058**
Impairments	-	(15,623)	(4,831)	-	-	-	**(20,454)**
Reversals of impairments	7,945	(13,075)	-	-	-	-	**(5,130)**
Reclassifications	-	18,438	(32,612)	4,910	7,514	152	**(1,598)**
Disposals/derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2018	**79,161**	**304,992**	**82,433**	**163,484**	**56,011**	**1,234**	**687,315**
Accumulated depreciation at 1 April 2018 – brought forward	**-**	**6,174**	**-**	**121,316**	**37,153**	**661**	**165,304**
Provided during the year	-	21,014	-	8,002	4,488	135	**33,639**
Impairments	-	3	-	-	-	-	**3**
Reversals of impairments	-	(22,957)	-	-	-	-	**(22,957)**
Reclassifications	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2019	**-**	**4,234**	**-**	**129,318**	**41,641**	**796**	**175,989**
Net book value at 31 March 2019	**79,161**	**300,758**	**82,433**	**34,166**	**14,370**	**438**	**511,326**
Net book value at 1 April 2018	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**
Owned – purchased	79,161	278,728	75,559	31,055	14,370	438	479,311
Owned – government granted	-	1,113	-	336	-	-	1,450
Owned – donated	-	20,916	6,874	2,775	-	-	30,565
Net book value total at 31 March 2019	**79,161**	**300,758**	**82,433**	**34,166**	**14,370**	**438**	**511,326**

Note 15.2 Property, plant and equipment – 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 – as previously stated	**63,286**	**304,191**	**62,278**	**154,105**	**44,322**	**936**	**629,118**
Additions	-	6,044	49,302	2,029	-	7	57,382
Impairments	-	21,200	-	-	-	-	(21,200)
Reversals of impairments	7,930	(8,546)	-	-	-	-	(616)
Reclassifications	-	34,763	(45,082)	4,476	4,175	139	(1,529)*
Disposals/derecognition	-	-	-	(3,716)	-	-	(3,716)
Valuation/gross cost at 31 March 2018	**71,216**	**315,252**	**66,498**	**156,894**	**48,497**	**1,082**	**659,439**
Accumulated depreciation at 1 April 2017 – as previously stated	**-**	**1,436**	**-**	**111,733**	**31,964**	**553**	**145,686**
Provided during the year	-	19,708	-	9,583	5,189	108	34,588
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	(14,970)	-	-	-	-	(14,970)
Reclassifications	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2018	**-**	**6,174**	**-**	**121,316**	**37,153**	**661**	**165,304**
Net book value at 31 March 2018	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**
Net book value at 1 April 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**
Owned – purchased	71,216	288,135	60,492	31,824	11,344	421	463,432
Owned – government granted	-	1,285	185	396	-	-	1,866
Owned – donated	-	19,658	5,821	3,358	-	-	28,837
Net book value total at 31 March 2018	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**

*Asset reclassification has occurred between tangible and intangible assets.

Note 15.3 Useful economic of property, plant and equipment

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:

Life (years)	Minimum	Maximum
Buildings, excluding dwellings	25	60
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	10	10

Note 16 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	7,029	7,228
Consumables	6,656	5,654
Energy	249	189
Total inventories	**13,934**	**13,071**

Inventories recognised in expenses for the year were £166,193k (2017/18: £128,439k). Write-down of inventories recognised as expenses for the year were £496k (2017/18: £405k).

Note 17 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.

	2018/19 £000	2017/18 £000
At 1 April	**24,464**	**20,975**
Net change in year	2,228	3,489
At 31 March	**26,692**	**24,464**
Broken down into:		
Cash at commercial banks and in hand	139	124
Cash with the Government Banking Service	26,553	24,340
Total cash and cash equivalents as in SoFP and SoCF	**26,692**	**24,464**

Note 17.1 Third party assets held by the Trust

The 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.

	31 March 2019 £000	31 March 2018 £000
Monies on deposit	73	68
Total third party assets	**73**	**68**

Note 18.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	136,796	112,479
Capital receivables	-	332
Accrued income*	-	56,197
Allowance for impaired contract receivables/assets*	(8,324)	(21,826)
Prepayments (non-PFI)	12,439	8,071
PDC dividend receivable	-	295
VAT receivable	5,069	6,334
Other receivables	2,984	3,472
Total current trade and other receivables	**148,964**	**165,354**
Of which receivables from NHS and DHSC group bodies:		
Current	118,540	109,749

*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 18.2 Allowances for credit losses – 2018/19

	All receivables £000
Allowances as at 1 April 2018 – brought forward	**21,826**
Transfer to variable pricing estimate under IFRS 15	(15,873)
New allowances arising	6,432
Reversals of allowances	(911)
Utilisation of allowances (write offs)	(3,150)
Allowances as at 31 March 2019	**8,324**

Note 18.3 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.

	All receivables £000
Allowances as at 1 April 2017 – as previously stated	**33,886**
Increase in provision	4,896
Amounts utilised	(16,851)
Unused amounts reversed	(105)
Allowances as at 31 March 2018	**21,826**

Note 18.4 Exposure to credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31 March 2019 is in receivables from customers, as disclosed in the trade and other receivables note. At the 31 March 2019 the main customer (excluding NHS entities) debts totaled £30.5m for which the Trust feels it has made adequate provision.

Note 19 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	45,977	46,848
Capital payables	13,548	23,252
Accruals	67,432	77,600
Social security costs	8,708	7,834
Other taxes payable	7,393	6,738
PDC dividend payable	237	-
Accrued interest on loans*		28
Other payables	13,842	12,315
Total current trade and other payables	**157,137**	**174,615**
Of which payables from NHS and DHSC group bodies:		
Current	13,072	19,392

*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

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	26,012	35,041
Total other current liabilities	**26,012**	**35,041**
Non-current		
Lease incentives	2,058	-
Total other non-current liabilities	**2,058**	**-**

Note 21 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	1,251	1,226
Other loans	556	357
Total current borrowings	**1,807**	**1,583**
Non-current		
Loans from the Department of Health and Social Care	29,271	30,497
Other loans	3,070	3,106
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	**32,341**	**33,603**

The Trust is party to five loans as follows:

Loan 1 – capital investment of £24.5m. Commencing 15 March 2011 and continuing until settled on 31 March 2031. Fixed interest rate of 3.95 per cent

Loan 2 – working capital facility of £15.8m. Commencing 7 April 2016 and continuing until settled on 31 March 2021. Fixed interest rate of 3.5 per cent

Loan 3 – energy efficiency loan of £1m. Commencing 10 March 2017 and continuing until settled on 1 February 2021. Interest free loan

Loan 4 – energy efficiency loan of £1.05m. Commencing 20 October 2017 and continuing until settled on 1 April 2023. Interest free loan

Loan 5 – joint arrangement loan of £1.6m. Commencing 1 April 2017. Interest free loan, non-repayable subject to going concern of the arrangement

Note 21.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2018	**31,723**	**3,463**	**35,186**
Financing cash flows – payments and receipts of principal	(1,226)	163	(1,063)
Financing cash flows – payments of interest	(1,170)	-	(1,170)
Impact of implementing IFRS 9 on 1 April 2018	28	-	28
Application of effective interest rate	1,167	-	1,167
Carrying value at 31 March 2019	**30,522**	**3,626**	**34,148**

Note 22 Provisions for liabilities and charges analysis

	Redundancy £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**98**	**489**	**44,384**	**44,971**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	(14,982)	**(14,982)**
Arising during the year	64	40	5,891	**5,995**
Utilised during the year	(83)	(51)	(113)	**(247)**
Reversed unused	-	(36)	(1,986)	**(2,022)**
At 31 March 2019	**79**	**442**	**33,194**	**33,715**
Expected timing of cash flows:				
– not later than one year	79	442	33,194	**33,715**
Total	**79**	**442**	**33,194**	**33,715**

The other classification within provisions includes provisions against a number of potential liabilities, details of which cannot be disclosed due to commercial sensitivity. As has been disclosed in note 1.1.2, there is significant uncertainty as to the timing of these outflows.

Note 22.1 Clinical negligence liabilities

At 31 March 2019, £450,858k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2018: £397,194k).

Note 23 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(65)	(87)
Net value of contingent liabilities	**(65)**	**(87)**

Note 24 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	5,104	3,761
Total	**5,104**	**3,761**

Note 25 Financial instruments

Note 25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed mean the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities. The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors and within scope of internal auditor.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust also borrows from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31 March 2019 is in receivables from non-NHS customers, as disclosed in the trade and other receivables note. At the 31 March 2019 the main customer debts totaled £30.5m for which the Trust feels it has made adequate provision.

Liquidity risk

Liquidity risk reflects the risk that the Trust will have insufficient resources to meet its financial liabilities as they fall due. Management have noted areas affecting liquidity in the going concern disclosure in note 1.12. Mitigating this, the Trust's operating costs are incurred in relation to contracts with CCGs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure from internally generated resources. The Trust's strategy is to manage liquidity risk by ensuring that it has sufficient funds to meet all of its potential liabilities as they fall due. Liquidity forecasts are produced regularly to ensure the utilisation of current facilities is optimised and liquidity is maintained. The Trust also continually assesses its loan funding.

Note 25.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively 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.

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	131,456	131,456
Cash and cash equivalents at bank and in hand	26,692	26,692
Total at 31 March 2019	**158,148**	**158,148**

	Loans and receivables £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	150,654	150,654
Cash and cash equivalents at bank and in hand	24,464	24,464
Total at 31 March 2018	**175,118**	**175,118**

Note 25.3 Carrying value 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.

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	30,522	**30,522**
Other borrowings	3,626	**3,626**
Trade and other payables excluding non financial liabilities	140,799	**140,799**
Provisions under contract	-	**-**
Total at 31 March 2019	**174,947**	**174,947**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	31,723	**31,723**
Other borrowings	3,463	**3,463**
Trade and other payables excluding non financial liabilities	151,995	**151,995**
Provisions under contract	23,118	**23,118**
Total at 31 March 2018	**210,299**	**210,299**

Note 25.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	142,607	**176,696**
In more than one year but not more than two years	1,878	**-**
In more than two years but not more than five years	20,240	**17,798**
In more than five years	10,222	**15,805**
Total	**174,947**	**210,299**

Note 26 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	50	87	20	93
Bad debts and claims abandoned	423	2,185	217	15,418
Stores losses and damage to property	12	505	12	403
Total losses	**485**	**2,777**	**249**	**15,914**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	2	6
Ex-gratia payments	69	35	60	1,582
Total special payments	**70**	**36**	**62**	**1,588**
Total losses and special payments	**555**	**2,813**	**311**	**17,502**

Details of cases individually over £300k

There are no individual cases over £300k.

Note 27 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Imperial College Healthcare NHS Trust. During the year 2018/19 the Trust has had a significant number of material transactions with:

Department of Health and Social Care

NHS England

NHS Foundation Trusts including:

- Chelsea and Westminster NHS Foundation Trust
- Hillingdon Hospitals NHS Foundation Trust

CCGs including:

- Brent CCG
- Camden CCG
- Central London (Westminster) CCG
- Ealing CCG
- Hammersmith and Fulham CCG
- Harrow CCG
- Hillingdon CCG
- Hounslow CCG
- Richmond CCG
- West London (Kensington & Chelsea) CCG

NHS Trusts including:

- London North West University Healthcare NHS Trust

Other NHS Bodies including:

- Health Education England
- NHS Litigation Authority
- NHS Pension Scheme
- NHS Blood & Transplant

Other non-NHS entities:

- Imperial College London
- Imperial College Healthcare Charity
- HM Revenue and Customs

Note 28 Events after the reporting date

There are no events after the end of the reporting period that warrant disclosure in these accounts.

Note 29 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	172,068	554,545	157,636	522,267
Total non-NHS trade invoices paid within target	144,673	418,873	129,732	413,185
Percentage of non-NHS trade invoices paid within target	84.1%	75.5%	82.3%	79.1%
NHS Payables				
Total NHS trade invoices paid in the year	7,312	78,183	5,255	78,301
Total NHS trade invoices paid within target	3,658	49,249	2,776	45,802
Percentage of NHS trade invoices paid within target	50.0%	63.0%	52.8%	58.5%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. No interest or compensation has been paid under this legislation.

Note 30 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Net cash (generated from)/used in operations	(68,100)	(36,893)
Net cash (generated from)/used in investing activities	62,443	34,626
Relevant cash adjustments from financing activities	12,403	11,542
External financing requirement	**6,746**	**9,275**
External financing limit (EFL)	14,794	13,946
Under/(over) spend against EFL	**8,048**	**4,671**

Note 31 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	55,058	57,382
Less: Disposals	-	(3,716)
Less: Donated and granted capital additions	(1,680)	(6,935)
Charge against Capital Resource Limit	**53,378**	**46,731**
Capital Resource Limit	54,175	47,529
Under/(over) spend against CRL	**797**	**798**

Note 32 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus/(deficit) (control total basis)	28,165
Remove impairments scoring to Departmental Expenditure Limit	4,831
Breakeven duty financial performance surplus/(deficit)	**32,996**

Note 33 Breakeven duty rolling assessment

	>2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)	(15,330)	3,023	32,996
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283	6,953	9,976	42,972
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905	1,096,575	1,160,803	1,212,959
Cumulative breakeven position as a percentage of operating income		3.8%	4.2%	3.2%	4.1%	5.6%	7.0%	2.2%	0.6%	0.9%	3.5%

Appendices

Appendix 1: Glossary of terms

Term	Definition
Relevant public sector employer	Section 7 of the regulations defines what is a relevant public sector employer. This specifies: • Government departments, which include executive agencies and non-ministerial departments (other than the Secret Intelligence Service, the Security Service and the Government Communications Headquarters) • the Scottish Ministers and • public authorities described or listed in Schedule 1 of the regulations
TU representative	A relevant union official. An official of an independent TU recognised by the employer.
Relevant period	A period of 12 months beginning with 1 April, the first relevant period starts on 1 April 2017.
Total pay bill	Is the total amount of (the total gross amount spent on wages) + (total pension contributions) + (total national insurance contributions) during the relevant period.
Full-time equivalent (FTE) employee number	The (total number of full time employees) + (the total fractions of full time employee hours worked by all employees who are not full time).
TU duties	Duties where there is a statutory right to reasonable paid time off during normal working hours to undertake recognised duties and to complete training relevant to their TU role. This arises under: (a) section 168, section 168A of the 1992 Act (TULR(C)A) (b) section 10(6) of the Employment Relations Act 1999; (c) regulations made under section 2(4) of the Health and Safety at Work etc. Act 1974.
TU activities	Means time taken off under section 170 (1) (b) of the 1992 Act. TU activities could include: • meetings – where the purpose or principal purpose is to discuss internal union matters • TU conferences • internal administration of the union e.g. answering internal union correspondence, dealing with financial matters, responding to internal surveys. There is no statutory entitlement to paid time off to undertake activities. However, TU representatives are entitled to be granted reasonable unpaid time off to participate in TU activities.
Paid TU activities	Time taken off for TU activities under section 170 (1) (b) of the 1992 Act in respect of which a TU representative receives wages from the relevant public sector employer. There is no statutory entitlement to paid time off to undertake activities. It is accepted that there could be exceptional circumstances where paid time off for activities may be appropriate, however it is recommended the organisations ensure they have appropriate controls in place to monitor this.
Total paid facility time hours	Total number of hours spent on facility time by TU representatives during a relevant period. Does not include hours attributable to time taken off under section 170(1)(b) of the 1992 Act in respect of which a TU representative does not receive wages.
Hourly cost	For each employee: (the gross amount spent on wages) + (pension contributions) + (national insurance contributions) divided by the number of hours during the relevant period.
Total cost of facility time	For each employee who was a TU representative during the relevant period, facility time cost is calculated by: (Hourly cost for each employee x number of paid facility time hours) Total facility time cost is calculated by adding together the amounts produced by the calculation of facility time cost for each employee. In calculating this figure the wages of any employee who can be identified from the information being published must be expressed as a notional hourly cost to represent the employee's wages.

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