NHS
University College London Hospitals
NHS Foundation Trust

uclh

Annual report and accounts 2018/19

UCLH is an NHS Foundation Trust comprising: University College Hospital (incorporating the Elizabeth Garrett Anderson Wing, the Macmillan Cancer Centre and University College Hospital at Westmoreland Street), Royal London Hospital for Integrated Medicine, Royal National Throat, Nose and Ear Hospital, National Hospital for Neurology and Neurosurgery at Queen Square and Cleveland Street, Institute of Sport, Exercise and Health, Hospital for Tropical Diseases, The Eastman Dental Hospital.

University College London Hospitals NHS Foundation Trust Annual Report and Accounts 2018/19

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

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1 Performance report

1.1 Overview of performance

The purpose of the performance report is to provide an overview of our organisation, its purpose, the key risks to achieving our objectives and our performance in the year.

The annual report has been prepared on the same group basis as the accounts.

1.1.1 Chair and chief executive's overview

The annual report is an opportunity to reflect on the achievements and challenges of the past year and to thank our amazing staff for all they do for our patients every day.

This has never been truer than for 2018/19, during which our staff started delivering the most ambitious change programme in our organisation's history. At 6.30am on 31 March 2019, we switched on our new electronic health record system, Epic, marking the start of an exciting new digital era at UCLH. This is a huge accomplishment and the result of years of preparation and hard work.

There have been many obstacles to overcome along the way and inevitably there have been some teething problems in the immediate period after go-live. However, our staff have shown great resilience and determination by not losing sight of why we are doing this: to provide better, safer, and more efficiently organised patient care. It will also improve our daily working lives. By working together as a team, and supporting each other, our staff have shown how much we can achieve.

Excellent teamwork and a commitment to continuous improvement were also among the key themes to emerge from the Care Quality Commission's (CQC) inspection of our services in the summer of 2018. Overall, the CQC rated UCLH as "good" for the services we provide to our patients.

Inspectors praised staff for the way in which they treat patients with compassion, patience and respect. They said feedback from patients about their care was consistently positive.

Many staff told the CQC they were proud to work at UCLH, a sentiment which we share wholeheartedly. Inspectors said there is a sense of common purpose based on shared values across the organisation.

They also praised the culture of learning and commitment to research and innovation. This acknowledgement is particularly significant for us in the year we launched as a research hospital. Together with our partner organisations such as UCL and the Alan Turing Institute, we are firmly committed to ensuring that research is embedded more deeply across our entire organisation. We are determined to push the boundaries of medicine and technology to drive improvements for patients and staff alike.

Among the many examples of outstanding practice cited by CQC inspectors was the research programme which led to UCLH launching a fetal surgery service for spina bifida. This service is the first of its kind in the UK. You can read more about it and our other

pioneering research collaborations, such as the launch of the UK's largest-ever lung cancer screening project, later in the report.

There were, of course, some areas where the CQC said we could do better. For example, in 2018/19, we did not meet the standard that 95 per cent of patients should spend less than four hours in our emergency department (ED). We also did not meet the standard that patients referred by a GP with suspected cancer should be treated within 62 days. We will do all we can to improve our services in both of these areas over the next year.

For example, we continue to review and modify our internal processes, as well as strengthen ties with our partners in health and social care, in order to improve patients' journeys through the health and care system. We know we deliver high quality care but we still have more work to do to ensure all of our patients receive timely treatment. For further information see section 1.2.3 Detailed review of our performance 2018/19.

We finished the year with an underlying deficit of £12.7m. This was £7.4m behind plan and primarily the result of losing £6.2m of sustainability funding for failing to meet the four hour ED target.

However, due to some one-off sources of income, we reported an overall surplus in 2018/19.

Our strong overall performance was underpinned by our staff's commitment to improving productivity and their delivery of an ambitious £45m savings programme.

Staff engagement in financial performance was a key factor in NHS Improvement rating UCLH as "good" when assessing how effectively we use our resources. This fed into our overall CQC inspection rating.

Next year will be very tough given many financial pressures that are specific to UCLH. This includes a significant loss of transitional funding associated with the reconfiguration of cardiac and cancer services, a further loss of education funding, a reduction in market forces funding for being located in a high cost area, and increased PFI (private finance initiative) costs.

In addition, the financial pressures of implementing Epic and moving the services at the Royal National Throat Nose and Ear Hospital and the Eastman Dental Hospital to their new facility will also impact upon our financial performance.

Within this context, we will focus on further reducing costs and increasing efficiency where possible. This in line with the wider NHS financial environment which is putting increased emphasis on controlling expenditure across sustainability and transformation partnerships (STPs). For further information see section 1.2.1 Finance director's report.

We have spoken a lot about how inspectors and regulators have rated our services but we should also reflect on what our patients and staff say about UCLH. In the 2018 Picker national inpatient survey, 88 per cent of patients rated their overall care at UCLH as seven out of 10 or better. This puts us above the national average for acute trusts.

The vast majority of staff also said they would recommend UCLH as a place to be treated and to work (2018 NHS staff survey). Once again we scored above the national average for staff engagement, a measure closely linked to patient experience.

Naturally, both of these surveys revealed areas where we can do better and we have plans in place to address the findings. We will focus on continuing to strengthen leadership and management, and creating a more supportive culture which reinforces our organisational

values of safety, kindness, teamwork and improving. We, along with our Board colleagues, are committed to improving both patient and staff experience wherever possible. We know these are not goals for which you cross the finish line and stop; they require continual attention and are central to what we do.

These are exciting times for the NHS. Following celebrations in July 2018 to mark the 70th anniversary of this national institution, a new chapter has begun. With the publication of NHS England's Long Term Plan for the future of the health service, we must work ever more closely with our partners to deliver the plan's ambitions in the months and years ahead. We remain committed to the North London Partners in Health and Care STP, providing leadership to many of its programmes of work to improve services for patients and ensure they are sustainable.

We have every confidence that – with the continued support of our talented and dedicated staff – we will successfully deliver positive change for patients for generations to come.

Baroness Julia Neuberger DBE
Chair

Professor Marcel Levi
Chief executive

23 May 2019

1.1.2 About UCLH

UCLH (University College London Hospitals NHS Foundation Trust) is situated in the heart of London. Our vision is to deliver top quality patient care, excellent education and world-class research. Our values of safety, kindness, teamwork and improving are at the heart of everything we do, for our patients and staff.

UCLH comprises:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing, the Macmillan Cancer Centre and University College Hospital at Westmoreland Street)
- Royal London Hospital for Integrated Medicine
- Royal National Throat, Nose and Ear Hospital
- National Hospital for Neurology and Neurosurgery at Queen Square, Cleveland Street and Chalfont
- Institute of Sport, Exercise and Health
- Hospital for Tropical Diseases
- The Eastman Dental Hospital

We became one of the first foundation trusts in 2004. As a foundation trust we remain firmly part of the NHS but we manage our own budgets and shape the services we provide to better reflect the needs and priorities of our patients.

UCLH has a devolved management structure with strong clinical leadership. The Board, led by the chair, sets the vision and values of UCLH and works to promote the success of the organisation. The Board comprises non-executive directors, who bring independent advice and judgement to the Board, and executive directors who manage day-to-day operational services.

The senior directors' team is chaired by chief executive Professor Marcel Levi and includes our medical and corporate directors. We have three clinical boards (medicine board, specialist hospitals board, and surgery and cancer board) led by medical directors Dr Charles House, Dr Gill Gaskin and Professor Geoff Bellingan, respectively. Our corporate clinical directorate is led by medical director Professor Tony Mundy. Our chief nurse, Flo Panel-Coates, oversees nursing and midwifery and delivery of care at UCLH in general. We also have a number of corporate directorates.

Our Council of Governors comprises patient, public and staff members, and appointed representatives from stakeholder organisations. The Council provides support and advice to UCLH and ensures we deliver services that meet the needs of the patients and communities we serve.

We provide acute and specialist services to a diverse local population and to patients from across England and Wales. We balance the provision of nationally recognised specialist services with delivering high quality acute services to our local population.

UCLH is part of North London Partners in Health and Care, which is made up of clinical commissioning groups, local authorities and NHS providers in Camden, Islington, Haringey, Barnet and Enfield to deliver the North Central London Sustainability and Transformation Plan (STP).

We are proud of our close partnership with UCL (University College London) which is consistently reported as one of the best performing universities in the world, especially for

biomedical science. UCL's facilities are embedded across much of our hospital campus and the partnership is linked through a large number of joint clinical and academic appointments.

We are one of England's 20 biomedical research centres (BRCs) and we are a founding partner of UCLPartners, one of the UK's first academic health science centres (AHSCs).

We have a turnover of £1,158m. We have approximately 9,000 staff who come from 120 nations and we care for more than one million patients a year. We are committed to the principles of equality and fairness for all of our staff and patients. We work with different communities to deliver better patient care that is inclusive, accessible and fair.

1.1.3 Strategic developments

NHS Long Term Plan

On 8 January 2019, the NHS set out a long term plan for the future of the service. Backed by extra investment, the plan aims to give everyone the best start in life, to deliver world-class care for major health problems and help people age well. Key areas of focus include prevention, mental health, maternity, cancer and emergency care.

We were proud that several of our services were highlighted in the report: our national proton beam therapy service, the pathway programme for homeless patients, and CAR-T cell cancer therapies which we are pioneering. Our multi-disciplinary diagnostic service for cancer was also used on the website as a case study of best practice.

We are now working with our partners to plan how we will achieve the Plan's ambitions in north central London and for our specialist services which treat patients from across the country.

North Central London Sustainability and Transformation Partnership (STP)

The North Central London Sustainability and Transformation Partnership (NCL STP) brings together councils, clinical commission groups (CCGs) and healthcare providers across the five boroughs of Haringey, Islington, Camden, Barnet and Enfield. Together we are the North London Partners in Health and Care. Our aim is to improve health and care for the 1.3 million people who live in the area and to reduce health inequalities across the sector.

Improving urgent and emergency care is a big focus for the STP. Our Discharge to Assess programme, which enables patients to go home as soon as they are medically well, is now firmly embedded at UCLH. Our Rapid Response Admission Avoidance scheme also means more patients can receive care in their own homes, rather than going to hospital.

In 2018 the sector began a review of orthopaedic services across north central London. UCLH responded to the first stage of the review and is providing clinical leadership as the work continues.

A project has begun to enable temporary facility staff and those in key clinical specialties to work across north central London healthcare providers, as part of a pooled arrangement.

Launch of our electronic health record system

Epic, our electronic health record system (EHRS), is one of the most ambitious projects ever undertaken by UCLH.

The new system, which went live on 31 March 2019, will revolutionise the way we work and further improve patient care and safety.

Since 2016, clinicians and digital experts across UCLH have helped to plan, design, test and implement our EHRS, in partnership with Epic a market leader in integrated health record technology.

Why have we introduced Epic?

- Many of our existing systems, hardware and technology were out-of-date and no longer fit for purpose

- Epic will reduce duplication and improve safety by replacing paper notes and many different IT systems with one electronic patient record. A single log-in allows access to accurate and up-to-date information and provides the clinical support that staff need to make the best decisions.

- Clinicians can track patients as they move between wards and services. Health professionals can document care, request diagnostic tests, medications and appointments on mobile devices at the bedside.

- Epic will make it easier to coordinate appointments and tests which we expect to reduce the number of cancelled appointments and unnecessary hospital visits.

- It will transform how we communicate with patients, GPs and other external healthcare providers.

- Patients will ultimately be able to view and manage information about their care through a secure online patient portal called MyCare UCLH.

- Epic will strengthen our research capabilities and make it easier for patients to take part in relevant research trials, if they choose to do so. Our ambition is that more of our patients should participate in such trials.

Go-live – and beyond

Epic went live on schedule on Sunday 31 March 2019. The initial go-live period has been successful with staff giving widely positive feedback. We are now resolving initial issues as staff get used to the new system and we are exploring ways to improve it further. We are mindful that the go-live period is only the beginning of our digital transformation journey and it will take many months to embed Epic fully. We will then move to the next phase of using Epic to drive innovation.

Coordination centre

We launched our digital coordination centre in December 2017. The technology provides real time information about bed availability, patients waiting for beds and supports planning of elective procedures. It also allows us to track the booking of porters, the status of requests to clean beds and the location of key mobile medical equipment.

Since the launch, wards at University College Hospital, Elizabeth Garrett Anderson wing, and the National Hospital for Neurology and Neurosurgery have made good progress in working with the new technology.

On 31 March 2019, the technology that the coordination centre had been using since its launch to manage patient flow was replaced with Epic. Clinical mobile equipment continues to be tracked using the original system.

Wards update their electronic patient status boards with information about confirmed and pending patient discharges, isolation status, and other useful data to help the coordination centre team manage ever-increasing demand on our inpatient beds.

The clinical utilisation review (CUR) tool allows us to escalate delays in discharge to the relevant staff. It helps to avoid a patient staying any longer than they need to in an acute bed.

Requests for porters and bed cleaning, information about jobs in progress and turnaround times are completely visible via electronic dashboards.

We are working with our facilities management partner Interserve on service turnaround times, which still need to be improved. Job requests are automatically dispatched to iPods and iPhones held by porters and bed cleaners.

The Wifi needed to receive requests has been hindered by poor connectivity in some areas of our hospitals and this has prevented the technology from working as well as it should. However, we now have improved Wifi coverage as a result of preparing for Epic.

New clinical facilities

Our ambitious programme to improve and expand our estate continued through 2018/19.

In July 2018 we completed a £23m programme to redevelop the National Hospital for Neurology and Neurosurgery. This included the creation of new wards, theatres and intensive care facilities.

The emergency department redevelopment at University College Hospital continued with its expansion of space and improvements to the children's and young people's emergency department.

Our new facility on Huntley Street, which will be the home for the Royal National Throat Nose and Ear Hospital (RNTNEH) and the Eastman Dental Hospital (EDH), is on track to open in the autumn of 2019. The clinical teams at the RNTNEH and EDH have already been implementing new ways of working and service improvements to mirror how they will work after the move. Information about the move is being made available to patients and on our website.

We are working with UCL on opportunities to occupy clinical space at the Eastman Dental Hospital after we move out. This will ensure continuing close connections between UCL researchers and UCLH clinical staff. UCL will be redeveloping the site as the dual hub for the national Dementia Research Institute and the Institute of Neurology.

Work on our new clinical facility for cancer and surgery on Tottenham Court Road and Grafton Way is progressing well. The facility will be home to one of only two NHS proton beam therapy (PBT) centres in the country. In the floors above the PBT service, we are creating one of Europe's largest centres for the treatment of blood disorders and a new surgical service with eight theatres. The facility is due to open in 2020.

During 2018/19 significant construction milestones were met for this facility, including the delivery of four treatment gantries and a 90-tonne cyclotron. Health secretary Matt Hancock visited the site and met staff on his first day in office.

In June 2018, we agreed that HCA (a private health care provider), could move its haematology oncology service from the current location on the 15th floor of University College Hospital, into the new facility. This will provide additional capacity within University College Hospital.

The UCLH Board of Directors agreed in January 2019 to retain the University College Hospital at Westmoreland Street site.

Patient and public involvement

For information on how we engage patients and the public in our strategic developments see section 2.1.8 Stakeholder relations.

1.1.4 Education and training

Delivering excellent education is integral to our mission as an organisation and one of our strategic objectives is to support staff to fulfil their potential.

The uclh Institute oversees education at UCLH and provides a wide range of training to all staff, starting with a comprehensive induction when they first join.

We provide postgraduate training to around 700 doctors and dentists, and placements for more than 400 undergraduate medical students each year. We train around 480 student nurses and midwives, as well as allied health professionals on placements. We aim to recruit as many of them as possible once they have completed their training.

Induction: In 2018/19, around 2,300 staff attended our corporate induction programme. We continue to deliver an informative welcome on a weekly basis, focusing on quality improvement, safety, and patient and staff experience.

Mandatory training: As at 31 December 2018, 93.5 per cent of staff had completed their mandatory training. We keep staff fully informed about their progress with their training. Staff are sent automated reminders and have access to a personalised dashboard with up-to-date training information. We provide e-assessment packages for staff to complete. From January 2019, we focused on training staff for the launch of our electronic health record system, Epic.

Epic training: We trained more than 9,000 clinical and administrative UCLH staff to use Epic, as well as staff from partner organisations such as Bank Partners. More than 20,000 training sessions were delivered by more than 60 trainers, in 35 training rooms. For further information see section 1.1.3 Strategic developments.

Appraisals: A total of 81.5 per cent of staff had a full annual appraisal review during 2018/19. Appraisals are designed to encourage meaningful dialogue and support coaching-style discussions.

Coaching and mentoring: A coaching and mentoring service is available to all staff to support their professional and career development. It includes a programme to nurture our clinical leaders of the future and support new consultants to develop their leadership and management skills.

UCLH education centre: We continue to expand our portfolio of training to ensure we fully utilise our hi-fidelity simulation suite and state-of-the-art mannequins. Our aim is to teach about the importance of communication and teamwork, alongside technical skills. The centre replicates the working environment of our hospitals but we have taken this a step further and are taking the equipment into clinical areas, so that teams can train together during the normal working day.

The centre supports internal training events, and programmes for external delegates. It also provides rooms and equipment hire for external organisations. The centre generates income to support the training and development of UCLH staff.

At the end of December 2018, the centre was converted into a training hub for Epic, our new electronic health record system.

Quality improvement (QI): The Institute's improvement team continues to train staff across the organisation in QI methodology. It has provided coaching and support to a wide range of improvement projects, particularly within the exemplar ward programme which recognises wards providing great care and supports those trying to improve. In the latter part of the year, the team had a particular focus on supporting improvement work in the emergency department (ED), and actively participated in preparations for the implementation of EHRS.

Enhanced apprenticeships: We continue to develop our apprenticeship programmes for new and existing employees by offering 15 different qualifications ranging from level two to five. These include the trainee nurse associate apprenticeship and qualifications in leadership and management. During 2018/19 we enrolled 85 staff on apprenticeship programmes, 26 of whom were new apprentice recruits.

Leadership and change management: Our development programmes continue to support leaders in their roles. We have introduced a communication skills for team leaders course this year and a management fundamentals programme.

Women in leadership: Our Women in Leadership Network, which was established in 2016, continues to offer a forum for staff to share experiences and new ideas. In the past year, the network hosted several workshops, including leadership development opportunities for women working in the NHS.

Access and patient administration programme: The Institute supported the development aspects of this programme with training days on change and how it affects individuals and teams, and communication skills. More than 700 admin and clerical staff attended these sessions.

1.1.5 Research and development

NIHR biomedical research centre

UCLH, in partnership with UCL, continues to be a leading centre for research. Our biomedical research centre (BRC), funded by the National Institute for Health Research (NIHR), entered the third year of its five-year funding term worth £115m.

Data reported by the NIHR in 2018 showed that our BRC ranked first among the UK's 20 BRCs in 2017/18 for the number of active research studies and first-in-human studies. We were also top for the number of collaborations with industry and small- and medium-sized enterprises (SMEs). We ranked seventh for the number of patients recruited onto research studies.

This year 267 new research studies were approved to begin recruitment at UCLH.

There are currently 1,654 studies involving UCLH patients that are open to recruitment or follow-up. Of these, 66 per cent are adopted onto the NIHR clinical research network (CRN) portfolio of research.

We recruited 15,564 participants to research studies at UCLH this year compared to 14,511 in 2017/18. (The change in reported recruitment figure for 2017/18 follows a data cleansing exercise.)

To increase participation in research, we are holding focus groups with ethnic minority residents in Camden and Islington to explore new ways of raising awareness. We are working with Healthwatch to promote research opportunities for the local community. The implementation of Epic will also support recruitment to research studies (see below).

UCLH enters a new era as a research hospital

This year UCLH launched as a research hospital, marking the beginning of a new era where research and learning become more deeply embedded across the entire organisation.

Together with our patients, staff and colleagues at surrounding academic institutions (such as UCL and the Alan Turing Institute), we want to improve diagnostic and therapeutic management of a wide range of diseases. We will do this by translating findings from novel biomedical discoveries into better patient care.

At the same time, we want to improve our operational performance by harnessing the power of data science and artificial intelligence. For example, we have created machine learning models which can accurately predict whether or not a patient will attend their radiology appointment. This means we can target those less likely to attend with more frequent and personalised reminders.

Research and our electronic health record system

Epic, our new electronic health record system (EHRS), will provide huge potential to harness data for health research.

Epic comes with many tools to support the clinical trial process. Clinicians will be able to see if a patient is on a trial. All research procedures – tests, scans, consenting etc. – will be recorded and available for clinicians to review on Epic. The system will notify researchers if a study participant is unexpectedly admitted to our emergency department or a ward.

Researchers will also be able to see if there are enough patients who meet the criteria to run a particular trial.

UK’s largest ever lung cancer screening study launched

UCLH and UCL launched the UK’s largest-ever lung cancer screening project in conjunction with GRAIL – a US-based healthcare company focused on early detection of cancer. The study aims to detect lung cancer early in those Londoners at risk of developing the disease. It also aims to develop a blood test to detect multiple cancers early, including lung cancer.

The study will indicate the potential for a national lung cancer screening programme. The four clinics involved in the study will be located at University College Hospital, Finchley

Memorial Hospital, Mile End Hospital and King George Hospital. For further information see section 2.1.8 Stakeholder relations.

First UK surgery in the womb for babies with spina bifida

A team of leading clinicians and researchers from UCLH, UCL and Great Ormond Street Hospital (GOSH) successfully operated in the womb on five babies with spina bifida. In the first operations of their kind in the UK, the team repaired the babies' abnormally developed spinal cords to give them a significantly better chance in life, compared to having postnatal surgery. Infants with spina bifida are often incapable of walking, and need surgery in later life to drain fluid from their brain.

Bethan Simpson, whose baby was one of the first to be operated on in the womb, is pictured on the front cover of this annual report. The photograph shows Bethan on the day of surgery. Photo credit: David Bishop, UCL.

New algorithm gives better diagnosis of brain and spine tumours

Researchers have found that a computer-based algorithm can better diagnose tumours in the brain and spine.

Scientists have developed a method which detects patterns of chemical tags (DNA methylation) within the genetics of the tumour. DNA methylation is a process by which hydrogen and carbon atoms are added to DNA, with the potential to change its function. When tested in clinic, the algorithm corrected initial diagnosis in about 12 per cent of cases.

New approach to treating Alzheimer's disease

The first clinical trial of a novel approach to modifying the progression of Alzheimer's disease opened at UCLH. The trial will test whether a drug that removes a protein called serum amyloid P (SAP) from the brain helps patients with Alzheimer's disease.

MRI for prostate cancer diagnosis could reduce biopsies

UCL researchers who are also honorary consultant urologists at UCLH led a trial which found that using MRI (Magnetic Resonance Imaging) for prostate cancer diagnosis could cut biopsies by 28 per cent.

Results of the study could herald a change to current clinical practice. The study found that using MRI at the beginning of the diagnosis process, instead of the currently used biopsy, leads to diagnosis of more of the harmful prostate cancers.

If MRI scans were implemented across Europe, more than 250,000 men could avoid invasive biopsies.

Groundbreaking CAR T-cell therapy for young cancer patients

UCLH has the largest set of clinical trials of CAR T-cell therapy in Europe. These innovative treatments enable the patient's immune cells (T-cells) to be extracted and genetically modified so that they are programmed to attack tumour cells when they are re-infused back into the patient.

Children with leukaemia will receive the treatment after the NHS agreed a deal with the manufacturer Novartis.

Transforming blood pressure treatment

UCLH research was key to new guidelines which recommend that patients with high blood pressure should use a single pill containing two drugs.

These European Society of Cardiology (ESC) and European Society of Hypertension guidelines could lead to a reduction in strokes, heart disease and early deaths.

Roll out of MS treatment trialled at UCLH

Use of the drug cladribine to treat multiple sclerosis (MS) is to be rolled out more widely across the NHS, as a result of research at UCLH.

The treatment will be provided to more patients through the Accelerated Access Collaborative (AAC) which speeds up access to treatments.

Cladribine is traditionally used to treat leukaemia and lymphoma. UCLH and Barts Health ran clinical trials of the drug as an oral treatment for highly active MS. We were early adopters of the treatment with around 30 MS patients at UCLH currently receiving the drug.

UCLH completes the first '3 in 1' MS trial

Researchers have completed a clinical trial on multiple sclerosis (MS) in which three different drugs were tested at the same time instead of one after the other. This is a world first in progressive neurological disease research.

The study meant that tests for all three drugs could be completed in five years instead of around 15 years. This approach saves both time and money.

Psychiatric disorders share common genetic causes

UCLH and UCL researchers oversaw a study which found psychiatric disorders like schizophrenia and bipolar disorder share similar genetic causes, and probably have important similarities at a molecular level.

The study, published in the journal Science, concludes that this could have implications for how these disorders are treated.

Community celebrates research and NHS 70

Hundreds of visitors attended our annual Celebrating Research open day at which we had a birthday tea party to mark the 70th anniversary of the NHS. Our researchers and clinicians hosted stands across three floors of University College Hospital showcasing the latest research and innovation happening across our organisation.

1.1.6 Corporate objectives 2019/20

Provide the highest quality of care within our resources and increase our focus on safety

- Continue to reduce avoidable harm through agreed safety priorities and annual infection targets
- Maintain patient experience, with improvements in agreed areas
- Work towards all contact and booking with patients and GPs being timely, accurate and professional

Become a world-class academic research hospital embedding research throughout the organisation and all disciplines

- Deliver the promises of the biomedical research centre bid
- Develop advanced analysis and urban health programmes as key parts of the research hospital
- Develop and encourage research opportunities for junior doctors, nurses and other clinical staff across UCLH

Operational excellence through our electronic health record system and optimised processes

- Go live with our electronic health record system, stabilise it, and start delivering the improvements we have planned for patients
- Improve our patients' experience of waiting, both from referral to diagnosis and treatment, and while waiting in the building
- Shorten waits for patients in our emergency department and patients waiting for discharge from the Trust
- Shorten waiting times at all stages of pathways for cancer patients, including earlier diagnosis for patients in the UCLH Cancer Collaborative
- Work with local and specialist partners to develop new pathways, improve integration and support preventative care for local patients
- Open phase 5, complete the emergency department development, and deliver phase 4 and Westmoreland Street milestones

Develop all of our diverse staff to deliver their potential and foster talent

- Promote equality and inclusion and demonstrate we are an employer of choice
- Improve staff experience
- Enable high quality training

Improve the financial sustainability of UCLH and the wider health economy

- Achieve financial targets with a focus on controlling expenditure
- Deliver productivity improvements in line with NHS Improvement's Model Hospital and Use of Resources programmes
- Further develop our role within the North Central London Sustainability and Transformation Partnership to deliver financial sustainability

1.1.7 Key risks to delivering our 2019/20 strategic objectives

The table below identifies some of the risks that could prevent us from achieving our five strategic objectives and how we are seeking to reduce these risks.

Strategic objective: Provide the highest quality of care within our resources and increase our focus on safety	
Risk	**Mitigation**
The quality of care we provide could deteriorate because we need to save money.	Our cost improvement plans (CIP) focus on improving patient experience by reducing waste and increasing efficiency so that quality and savings targets can be achieved together. We carry out an assessment of each saving scheme to make sure we have understood and are able to manage any risks to quality before deciding to carry on with the scheme. Medical directors (and where appropriate, other senior clinical staff) scrutinise cost improvement plans before they are implemented. We use the national Safer Nursing Care Tool to determine ward staffing levels.
Older parts of UCLH are in a state of disrepair which could impact on the quality of our services.	We undertake regular maintenance, focusing on preventative checks and repairing areas in need. We are developing a new facility to replace large sections of the older parts of our estate, namely the Royal National Throat Nose and Ear Hospital and Eastman Dental Hospital sites on Grays Inn Road. We conduct an annual survey to fully evaluate the condition of our buildings.

Insufficient capacity to deal with the number of patients referred to UCLH. This could result in missed access targets, financial penalties, lost income and activity, and could lead to regulatory or contractual interventions.	We work with commissioners to review the demand and capacity of UCLH services. We also work with commissioners to try to reduce the number of patients who need to come to hospital for treatment. Our new building projects are designed to increase capacity. We have recently changed our plans for selling current buildings in the light of our capacity requirements. We routinely assess whether our overall building stock is sufficient to meet waiting time targets. Our planned new models of care and our Sustainability and Transformation Partnership (STP) aim to improve pathways and reduce length of stay. (For information on our STP see section 2.1.8 Stakeholder relations)
A cyber-attack could lead to some of our critical IT systems not being available.	We carry out extensive risk assessments of our ability to defend against cyber attacks. We have good technical controls provided by our IT provider which include anti-virus, anti-malware, firewalls and data encryption. We test these controls on a regular basis, and have a good system for keeping up-to-date with the latest protections for computers and servers.
Strategic objective: Become a world-class academic research hospital embedding research throughout the organisation and all disciplines	
Risk	**Mitigation**
Some annual research funding streams will be constrained over time.	Our biomedical research centre (BRC) and clinical research facility are working with the wider research community to achieve the standards needed to generate future income.

Strategic objective: Operational excellence through an electronic health record system (EHRS) and optimised processes	
Risk	**Mitigation**
UCLH fails to deliver benefits from technology change (due to lack of investment or implementation failures) leading to quality issues or financial loss.	We implemented an electronic health record system (EHRS) in March 2019 which will improve patient care and also help us make financial savings. Our digital transformation partner, Atos, will help us deliver benefits from our investment in technology. Our digital services delivery board is actively involved in North Central London (NCL) plans to improve the use of digital patient records across GP surgeries, hospitals and mental health trusts. We participate in NHS England's (NHSE) regional and national digital programmes. We are aware of the latest standards and involved in national strategy.
We could fail to provide high quality care because of weaknesses in patient tracking.	We track whether future bookings have been provided to patients marked as needing an appointment. Our new EHRS will provide much better functionality for tracking all the events that patients need on their pathways at UCLH.
Strategic objective: Improve patient pathways through innovation and collaboration with partners	
Risk	**Mitigation**
The redesign of services under the STP proposals may not be sufficient to accommodate the rise in demand. This could then impact on waiting times.	We have a number of governance arrangements to help develop our role in the local health economy, including an integrated care division. We will continue to work very closely with our STP colleagues to identify those services which could be more effectively and efficiently provided outside of a hospital environment. The transfer of services in this way is one of the principal objectives of our STP.

Strategic objective: Develop all our diverse staff to deliver their potential and foster talent	
Risk	**Mitigation**
Brexit may make it more difficult to retain some staff and to fill certain vacancies.	Our workforce framework details action to sustain recruitment and aid retention. A supporting retention and recruitment group oversees action. We are closely monitoring trends in starters and leavers data to assess any impact from Brexit and/or tighter labour supply in national and international contexts. In 2018/19 the chief executive directly communicated with staff born in mainland EU to assure them of our support during any Brexit process. We have provided free legal support to colleagues wanting to remain in the UK.
Not having enough nurses and midwives to cover some roles will make it difficult to deliver the highest quality of care.	We monitor all of our wards very closely for risks associated with staffing levels. We also monitor how well we are getting temporary staff to fill vacancies, as well as recruitment rates and national/international markets. We learn from colleagues across the NHS as to how we can attract more nursing staff and redesign our staffing models to manage with fewer nurses.
An estimated 10-15 per cent of junior doctor posts are vacant at UCLH, which places an additional workload on those in post and impacts on the quality of their training and education.	We have introduced new schemes to create education and research fellowships, and registrar posts which allow for enhanced research time. We continue to pursue fresh opportunities for doctors to join us from abroad. UCLH relies on the contribution of hundreds of clinical academics from UCL who hold honorary contracts to undertake clinical roles at UCLH.

Strategic objective: Improve financial sustainability of UCLH and the wider health economy	
Risk	**Mitigation**
UCLH is unable to achieve efficiency targets.	We are working to maximise potential cost savings through the Carter productivity programme led by the finance director. This links closely with our cost improvement programme. We have a productivity and cost improvement team to help us maximise savings in key areas and to support those clinical divisions with the greatest financial challenges.
We could lose income due to commissioner-driven changes in models of care and tariff structures.	We closely monitor the commissioning landscape to anticipate any changes to funding streams. We have developed closer working relationships with commissioners and other local providers, through the STP, to find more efficient ways of delivering care. We have a commercial and contracts function at UCLH which helps design payment models that support improved patient care without passing too much risk to providers.
NHS-wide financial constraints force commissioners into offering much lower prices to hospitals or not paying for services that we have provided for patients.	We have a strong approach to cash management internally and will ensure close engagement with commissioners in relation to service developments and activity growth. We are working with commissioners to help solve wider affordability issues. We will continue to work with NHS Improvement (NHSI) and NHS England (NHSE) to ensure local prices properly reflect costs and that control totals are set fairly. We participate in all relevant specialised commissioning programmes of work in London.
London property values may decline, so we cannot make as much money as expected when selling our assets in the future.	Our long-term financial planning takes into account the changing value of London property. The retention of our University College Hospital at Westmoreland Street site means that disposals will play a much reduced part in future finances.

Brexit will generate risks across a range of issues. For example, the impact of withdrawal from European Union (EU) regulation on medicines and procurement. Other examples include a potential reduction in funding for research, as well as wider economic changes such as potential changes in property values.	We have a working group dedicated to tracking all potential risks arising from Brexit, and add issues to our risk management frameworks as they emerge.

1.1.8 Going concern disclosure

The directors have considered the application of the going concern concept to UCLH based upon the continuation of services provided by UCLH.

NHS Improvement (NHSI), the regulator for health services in England, states that anticipated continuation of the provision of a service in the future is sufficient evidence of going concern, on the assumption that upon any dissolution of a foundation trust the services will continue to be provided.

The directors consider that there will be no material closure of NHS services currently run by UCLH in the next business period (considered to be 12 months) following publication of this report and accounts.

For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

Given the challenging financial context within the Trust and the wider NHS, the directors have also given serious consideration to the financial sustainability of UCLH as an entity and in relation to UCLH's available resources.

In relation to UCLH as an entity, the directors have a reasonable expectation that UCLH has adequate resources to continue to service its debts and run operational activities for at least the next business period (considered to be 12 months) following publication of this report.

UCLH has sufficient cash to ensure its obligations are met over this time period given the potential mitigations identified for a downside scenario.

1.2 Performance analysis

1.2.1 Finance director's report

Introduction

UCLH set a plan in 2018/19 to deliver an underlying deficit of £5.3m, including the one-off costs of preparing for the implementation of Epic, our new electronic health records system. This, when combined with the planned profit on disposal of £19.8m relating to the sale of the Eastman Dental Hospital (EDH) to University College London (UCL), enabled us to accept the target surplus of £14.5m set by our regulator, NHS Improvement (NHSI).

Against this plan, we reported an underlying deficit of £12.7m, which was around £7.4m worse than planned. This was mainly due to the loss of £6.2m of sustainability funding linked to performance against the four hour ED target, which has continued to be a challenge throughout the year. For further information see section 1.2.3 Detailed review of our performance 2018/19.

This underlying deficit is calculated before the impact of exceptional items such as asset sales, one-off additional sustainability funding from NHSI, capital donations and reversal of impairments arising from the upward revaluation of land and buildings. It therefore is the best measure of our underlying financial performance.

As part of the Care Quality Commission's (CQC) inspection in summer 2018, UCLH was rated "good" in relation to its Use of Resources. The CQC and NHSI gave positive feedback in relation to our approach to clinical and operational productivity, and the engagement of staff across the Trust in improving financial performance.

Our financial performance

UCLH was set, in common with all other NHS providers, a control total for our overall financial performance in 2018/19. This required us to deliver a £14.5m surplus, including a maximum £20.7m of core sustainability funding available for achieving financial and ED targets. This involved setting and delivering a significant savings target, totalling £45m. While this was achieved in full, our overall underlying deficit for the year was £12.7m.

This was a pleasing result overall given the challenging financial context within UCLH and the investment made in preparing for Epic. It also reflects the huge effort from staff across the Trust in delivering a further efficiency gain of more than four per cent.

There was a number of exceptional transactions that were reported in the 2018/19 financial year, which contributed significantly to the overall reported surplus of £78.8m. These are summarised in the table below:

	2018/19 plan £m	2018/19 actual £m
Deficit before exceptional items:	**(5.3)**	**(12.7)**
Capital donations (less donated asset depreciation)	(0.2)	(1.2)
Net profit on disposal of assets	19.8	45.1
Other exceptional items (£42.6m unplanned sustainability funding from NHSI and £5m income in relation to vacating the Royal National Throat Nose and Ear Hospital)	-	47.6
I&E surplus after exceptional items (before impairments / reversal of impairments)	14.3	78.8

There were two significant one-off transactions during the year. Firstly, we reached agreement with the Royal Free Charity to bring forward a payment of £5m due to UCLH. This relates to vacating the Royal National Throat Nose and Ear Hospital (RNTNEH) when this hospital's services move to our new facility on Huntley Street later in 2019.

Secondly, as part of UCLH's strategic development we exercised the agreement to sell the current EDH site to UCL. The disposal proceeds, to be received in three tranches, secure the necessary funds to contribute to the cost of our new facility on Huntley Street that will provide services currently delivered at EDH and the RNTNEH.

The first tranche of the site was sold in 2017/18. We had planned to sell the second tranche in 2018/19 and the third tranche in 2019/20. However, the UCLH Board made the decision to bring forward the third tranche to 2018/19 in light of the changing regulatory rules around asset disposals coming into force in 2019/20. UCL will take possession of the site when it is vacated later in 2019.

The sale of the EDH site to UCL was driven by UCLH's long term accommodation and financial strategy and will allow UCL to redevelop the site as the dual hub for the national Dementia Research Institute and the Institute of Neurology. The facility will include space for patient treatment. This will further strengthen UCLH's partnership with UCL, ultimately for the benefit of patients.

Additional unplanned sustainability funding from NHSI of £42.6m was received as part of a national scheme to reward NHS organisations that over-achieved their plan at the end of the year, even if this related to exceptional items such as asset sales. However, this and the associated cash benefit does not affect our underlying financial position which continues to present a very significant challenge to the delivery of 2019/20 and future year financial targets.

Total income for UCLH grew by just under seven per cent to £1,158m compared to £1,085m the previous year. Just over half of this increase related to clinical income, with the remainder due to other factors such as an increase in provider sustainability funding and one-off income relating to vacating the RNTNEH, as described above.

Total non-NHS income represented eight per cent of total operating income, significantly lower than the cap laid out in the Health and Social Care Act.

Operating expenditure excluding impairments grew by just over eight per cent to £1,079m compared to £997m the previous year. Within this, pay costs increased by around five per cent. After taking into account the significant cost of the pay award to NHS staff in 2018/19, this represented an improvement in efficiency given the rise in activity. However, it remains a top priority to ensure that we are deploying our staff as efficiently and productively as possible.

As forecast in last year's annual report, agency costs increased in 2018/19, from £7.9m to £10.2m, reflecting specific workforce challenges in a number of clinical areas together with the additional resource required to train and backfill staff preparing for the Epic implementation. Despite this increase, the overall level remains one of the lowest figures as a proportion of total pay expenditure across the NHS. We expect there to be continued challenges in 2019/20 in relation to the need to cover posts in shortage areas with temporary staff.

The Trust's cash balance has increased during the year, from an opening position of £147m to a closing balance of £257m at 31 March 2019. This is primarily as a result of the EDH sale proceeds, as described above, together with the additional sustainability funding we received during the year in recognition of our previous year's financial performance.

However, our gross borrowing increased during the year by more than the increase in our cash balance, from £402m to £530m (including the private finance initiative (PFI), which is a particularly expensive form of borrowing). This increase is primarily as a result of further loan draw down to fund the ongoing construction of our two new hospital sites and the implementation of Epic.

UCLH continues to focus on improving performance in relation to recovery of debts, although in the current financial context in the NHS it is increasingly challenging to collect money from other NHS trusts which are themselves facing financial challenges.

Better payment practice code

UCLH aims to pay its suppliers within 30 days of receipt of goods or a valid invoice (whichever is later) in line with the Better Payment Practice code and monitors performance against this target.

The majority of delays are due to the complexity of internal and external processes – for example receiving invoices late and processing invoices that do not have a purchase order number or sufficient supporting information to enable payment.

Progress on improving our performance has been slower than anticipated due to the implementation of a new finance and procurement system. In time, however, this and other process improvements will allow us to automate and streamline the approval and payment process to improve our performance in this area further.

	Actual 2018/19 Number	Actual 2018/19 £'000	Actual 2017/18 Number	Actual 2017/18 £'000
Non NHS				
Total bills paid in the year	149,436	884,721	143,180	813,367
Total bills paid within target	100,735	681,768	92,667	600,630
Percentage of bills paid within target	67.4%	77.1%	64.7%	73.8%
NHS				
Total bills paid in the year	3,259	33,045	4,481	34,993
Total bills paid within target	911	11,940	1,311	16,763
Percentage of bills paid within target	28.0%	36.1%	29.3%	47.9%
Total				
Total bills paid in the year	152,695	917,766	147,661	848,360
Total bills paid within target	101,646	693,708	93,978	617,393
Percentage of bills paid within target	66.6%	75.6%	63.6%	72.8%

Improving productivity and efficiency

UCLH is a strong supporter of the national work led by NHSI to help trusts benchmark against each other and identify opportunities to increase productivity and efficiency in ways that improve, or at the very least sustain, patient experience and the quality of care we offer. We have worked closely with NHSI in the development of the “Model Hospital” initiative to help identify and spread good practice.

While there are some challenges with data quality and comparability across hospitals, most notably in relation to PFI costs and specialist drugs and patient devices, UCLH’s overall level of efficiency improved for a second year running in absolute terms and relative to other hospitals.

Our headline productivity index improved significantly, bringing us to within four per cent of national average (down from 10 per cent two years ago and seven per cent last year). This remaining four per cent is almost exclusively related to the PFI, which costs UCLH £33m a year in interest.

We continue to focus on improving productivity in a sustainable way, working hard both internally to maximise the use of expensive resources such as theatres, and externally with partners such as other hospitals. However, it is likely, given the increased costs associated with implementing Epic, that we will see a temporary reduction in overall levels of productivity as measured by the Model Hospital in 2018/19 and 2019/20.

Outlook for 2019/20 and beyond

UCLH has been set a control total of a £14.2m deficit by NHSI for 2019/20, including a maximum of £25.2m of sustainability and financial recovery funding if UCLH meets its financial targets.

This represents the biggest financial challenge that UCLH has faced in recent years, given the context of the implementation of Epic and the move of EDH and RNTNEH to the new hospital facility. These are both complex programmes of work that have a planned additional cost and also significantly increase the financial risk to the organisation.

2019/20 also represents the final year of transitional funding loss for UCLH in relation to both undergraduate teaching and the transfer of cardiac services to Barts Health a number of years ago. This loss brings the total exceptional losses specific to UCLH, over and above the year-on-year reduction in real terms in what we are paid for each patient that we treat, to around £80m over the last five years.

Our PFI costs continue to rise in line with the retail price index each year, which is well in excess of the inflation that we are funded for through the NHS tariff. This is becoming increasingly unaffordable without additional funding, or support for UCLH to terminate its PFI contract and bring it back into the public sector.

The overall impact of the additional costs relating to Epic and the planned hospital moves, the loss of transitional funding, and the impact of the PFI, is an efficiency requirement of £45m for 2019/20. This is the joint highest ever annual target for UCLH, and is extremely challenging. We will continue to ensure that the quality and safety of the care that we provide to our patients is protected, through our clinical leadership model, as we take on this challenge.

UCLH is fully committed to working with our partner organisations within the North London Partners in Health and Care sustainability and transformation partnership (STP). As part of this commitment we agreed to a marginal rate contract with local commissioners, which was in place in 2018/19, where we were not paid the full tariff for growth in local activity. This has further encouraged us to work across the local health economy to reduce the number of admissions to, and attendances at, acute hospitals. It helps both commissioners and providers to focus on delivering schemes to look after patients in the most appropriate setting and improve the cost effectiveness of the NHS in our area of London.

In 2019/20 we plan to contract with our main commissioners on the basis of a “block” funding arrangement. This will provide income certainty and support further organisational focus on reducing whole system costs across the STP. This approach also brings financial risk, if the number of patients requiring treatment continues to increase, so we will reassess the approach in future years.

Despite the continued short term focus of the NHS on in-year financial performance, the UCLH Board remains committed to taking a medium-term view of financial sustainability. We will do this while maintaining an absolute focus on maintaining quality and safety, providing the necessary support to all areas of the Trust to meet the challenges ahead.

(Continued…)

The implementation of Epic will bring significant medium to long term benefits to our patients but represents a significant financial investment, with an adverse impact on our financial performance in the short to medium term. This, together with ongoing collaboration with partner organisations across health and social care within North Central London, will help UCLH to deliver world-class care to our patients, as well as continuously improving how efficiently we provide that care.

Tim Jaggard
Finance director

23 May 2019

1.2.2 Overview of our performance 2018/19

The following table outlines our performance against our corporate objectives for 2018/19.

Objectives	Deliverable	Good	Acceptable	Limited
Provide the highest quality of care within our resources and increase our focus on safety	Continue to reduce avoidable harm through our agreed safety priorities		✓	
	Improve how we learn from mortality and serious incidents	✓		
	Improve patient experience		✓	
	Work towards all contact and booking with patients and GPs being timely, accurate and professional		✓	
	Improve patient involvement in their care	✓		
	Achieve hospital-acquired infection targets	✓		
Become a word class academic research hospital embedding research throughout the organisation and all disciplines	Deliver the promises of the biomedical research centre bid	✓		
	Give as many of our patients as possible the opportunity to be part of a research trial		✓	
	Align medical and academic leadership at all levels in our organisation	✓		
	Develop operational research in the hospital with key partners		✓	
	Plan for using electronic health record system (EHRS) informatics to drive research	✓		
	Draw up a plan for research into the health needs of our local population		✓	
	Develop and encourage research opportunities for junior doctors, nurses and other clinical staff across UCLH	✓		

Objectives	Deliverable	Good	Acceptable	Limited
Operational excellence through our electronic health record system (EHRS) and optimised processes	Implement our electronic health record system (EHRS)	✓		
	Embed our coordination centre to improve how patients move through our services		✓	
	Improve our ability to interact with patients in a more customer-focused way		✓	
	Improve our patients' experience of waiting, both from referral to diagnosis and treatment, and while waiting in the building		✓	
	Improve the quality and timeliness of our IT services		✓	
Improve patient pathways through innovation and collaboration with partners	Work with system partners to shorten waits for patients in our emergency department and avoid admission where possible			✓
	Shorten waiting times at all stages of pathways for cancer patients		✓	
	Deliver earlier diagnosis for cancer patients across the sector through the London Cancer Alliance		✓	
	Continue to develop our relationship with Whittington Health NHS Trust in support of population health and prevention		✓	
	Work with local and specialist sustainability and transformation partners (STPs) to develop new pathways and support preventative care for local patients		✓	
	Deliver phase 4, phase 5 and emergency department development milestones	✓		
	Develop regional and national specialist services, working with our specialist partners in UCLPartners (UCLP)	✓		

Objectives	Deliverable	Good	Acceptable	Limited
Develop all our diverse staff to deliver their potential and foster talent	Promote equality and inclusion and demonstrate we are an employer of choice		✓	
	Improve staff experience		✓	
	Improve the quality of education and development		✓	
	Improve working conditions for junior doctors and other staff in training	✓		
	Develop our staff to achieve transformational change, particularly in research, productivity and digital programmes		✓	
Improve financial sustainability of UCLH and the wider health economy	Achieve financial targets and deliver the cost improvement programme	✓		
	Deliver clinical and non-clinical productivity efficiencies in line with the Carter agenda		✓	
	Continue our leading role within the North Central London (NCL) and specialist sustainability and transformation partnerships (STPs) to support financial objectives	✓		
	Improve management of commercial relationships		✓	
	Achieve value for money from our assets and estate	✓		
	Deliver more efficient use of non-pay resources	✓		

1.2.3 Detailed review of our performance 2018/19

National access standards

In 2018/19, we experienced challenges in delivering key access targets, in particular the emergency department (ED) four-hour wait, the 62-day cancer treatment target, the 18-week referral to treatment standard (RTT) and the six-week diagnostic wait.

Emergency department (ED) four-hour standard

In every month of 2018/19 we did not achieve the standard that 95 per cent of patients should spend less than four hours in our ED.

The volume of patients attending ED who require admission due to complex conditions, lack of available beds and staffing challenges within the department have led to patients waiting longer than four hours.

To improve performance we have developed an action plan with our commissioners and partners in health and social care. This is monitored by the system-wide A&E delivery board, chaired by UCLH's chief executive. The plan includes actions for ED, other departments in UCLH and the wider healthcare system. The aim is to improve patient flow through our hospitals, to improve ED processes, and support earlier discharge of patients.

As part of our plan we have:

- Recruited GPs and emergency nurse practitioners to our urgent treatment centre to see and treat patients with minor illnesses and injuries.

- Introduced a rapid assessment and treatment process to reduce the length of time ambulance crews wait to hand over patients to ED staff.

- Strengthened our partnership with Camden and Islington NHS Foundation Trust to reduce the amount of time our mental health patients have to wait in ED for a mental health bed.

- Embedded our digital coordination centre to provide real-time information on patient movement through our hospitals. We use this alongside an electronic tool which provides clinical staff with information about patients who no longer require hospital care but have not yet been discharged. This helps us to understand and respond to the reasons for delays both within and outside of the hospital. To support this, we have implemented:

    - A daily huddle meeting with staff from a variety of specialties. The purpose of the meetings is to identify patients who are medically fit for discharge and to arrange any assistance needed to enable these patients to leave hospital safely.

    - Improved regular reviews of patients who have been in hospital for more than seven days.

- Focused on delays in patients' treatment pathways which are caused by UCLH, rather than external healthcare partners. This work has included:

    - improving turnaround times for support services such as bed-cleaning and portering to enable patients to move from ED to wards more quickly.

    - providing extra therapy and pharmacy staff at weekends to support discharge.

- Continued to work with community providers, and mental health and social care colleagues to address the system-wide factors affecting delays where patients are medically fit for discharge but need some support from social care and community services.

As a result of the actions listed above, there has been some improvement in patient flow through University College Hospital. Improvements include: reduced ambulance handover times; reduced waits for patients requiring mental health inpatient care and reduced internal delays due to pharmacy and therapies. There has also been improved collaborative working with our community partners, including a more responsive escalation process to address delays that are not quickly resolved. We know that we still have much more work to do and we will continue to focus on implementing our action plan.

Cancer waiting times

For seven months of the year, we met the standard that 93 per cent of patients who are urgently referred with suspected cancer should have their first appointment within 14 days. We missed the target in five months of the year, which was mostly the result of patients choosing to delay their first outpatient appointment.

For nine months of 2018/19, we achieved the standard that all cancer patients should receive treatment within 31 days of the date of decision to treat. In July, August and September 2018 we did not meet this standard. In these three months non-compliance was mostly due to a large volume of patients being referred to us from other trusts for specialist prostate surgery at a late stage in their treatment pathway.

In every month we missed the standard that patients referred by a GP with suspected cancer should be treated within 62 days. Our performance has been consistently low compared to other trusts. However, as a specialist cancer treatment centre approximately half of our patients on the 62-day pathway are referred to us for specialist treatment from other trusts, already having had the early part of their care at their local hospital. Breaches often occur because patients are referred too late in their pathway for us to deliver treatment within 62 days. We are working closely with referring trusts and their commissioners to co-design pathways so patients receive their treatment quickly.

To improve performance, we are implementing a recovery plan. This follows the 2017/18 clinically-led external review of cancer performance, jointly commissioned with NHS Improvement (NHSI).

We have:

- Introduced a monthly review of cancer waiting time breaches for patients whose care began at UCLH. One of our non-executive directors (NEDs), who is a clinician, performs the reviews. The NED ensures that we have correctly identified the reasons for breaches and determines whether these could have been avoided. We have strict definitions for "unavoidable delays" which include the most complex treatment

pathways or when a patient chooses to delay their treatment for a prolonged period. Our aim is to identify ways to ensure avoidable delays do not happen in future.

- Increased our surgical capacity to treat the sudden surge in referrals for robotic prostatectomy. This included extending normal operating sessions into evenings and weekends, as well as working with the private sector.

- Focused on speeding up treatment times for breast cancer. This included commissioning a second mammogram machine, following the breakdown of the old machine. It also included increasing the number of radiologists and breast surgeons.

- Undertaken reviews of areas facing particular challenges to identify demand and capacity shortfalls.

- Continued to audit access to diagnostic services to ensure faster turnaround times for imaging, pathology and endoscopy.

- We agreed further joint action plans with referring organisations in the North Central and East London sector to reduce waiting times for patients who receive care at several hospitals. This has included our clinical teams providing support at referring organisations to speed up the earlier diagnostic phase of the pathway prior to transfer to UCLH for specialist treatment.

Referral to Treatment (RTT)

In every month of 2018/19, we narrowly missed the standard that 92 per cent of our patients should wait less than 18 weeks for treatment following referral to UCLH. However, throughout the year our performance was better than the national average (NHS England data).

The following services have experienced challenges in meeting the RTT standard:

We continue to experience pressure on our waiting lists for services at the Eastman Dental Hospital (EDH). This is a result of challenges created by the closure of other paediatric dental units and national workforce challenges. Additionally, during summer 2018, there was a flood in the pipes that service the treatment chairs, which meant these could not be used for a couple of weeks and therefore increased our waiting times.

We continue to experience a particular challenge in the restorative dentistry service which is staffed by a postgraduate workforce. This means patients are allocated to students in a way which meets their training requirements, rather than always in order of patients who have been waiting longest. We continue to address this through improved electronic booking processes so we can ensure the most appropriate patients are seen by the students in order of longest wait.

Our neurosurgery service is a national specialist centre and therefore receives complex tertiary referrals from across the country. This puts pressure on the waiting list size. A redevelopment programme of theatres at the National Hospital for Neurology and Neurosurgery was completed during summer 2018. This has enabled the service to undertake additional theatre sessions. The number of patients waiting longer than 18 weeks is now reducing faster than we forecast in our recovery plan but the service is not yet compliant with the RTT standard.

In 2018 we experienced a surge in referrals for our general gynaecology and specialist uro-gynaecology services. In addition to reviewing how we can better use our capacity to treat more patients, we have been working with commissioners to identify other appropriate services with shorter waiting times for new referrals.

To improve our RTT performance we have:

- Continued with a fortnightly RTT improvement group to lead our recovery plan.
- Made use of predictive reporting tools so managers can more promptly identify developing issues affecting waiting lists and take early action to address these.
- Focused on developing Epic, our new electronic health record system, so that it supports us to meet waiting time targets. For example, Epic will reduce the likelihood of issues arising because of poor data quality.

NHS England set all trusts a target to halve the number patients waiting 52 weeks for treatment in March 2019 compared to March 2018. In March 2019 there were five patients waiting 52 weeks for treatment, compared to six in March 2018 so we did not achieve the target.

We investigate all cases of patients who wait longer than 52 weeks. In 2018/19 these investigations found no evidence of detrimental impact on clinical outcomes. We do not want any of our patients to experience such delays so we are working hard to improve our data quality through continued audit and improved staff training. Epic will also help us to track patients more effectively.

NHS England set all trusts a target to maintain or reduce their total waiting list size at March 2019 compared to March 2018. On 31 March 2019, 43,252 patients were waiting for treatment, compared to 42,402 patients on 31 March 2018. This is largely attributable to the challenges at the EDH described above.

Diagnostic waiting times

We met the standard that 99 per cent of our patients should wait less than six weeks for a diagnostic test in October, November and December. In all other months, we narrowly missed the target.

In April to September our underachievement was primarily driven by waiting times for MRI due to: scanner breakdown, the need to rebook cancellations following the severe weather in March 2018, and administrative issues following an upgrade of our imaging software. We resolved these issues and recovered the standard in quarter three. In quarter four, however, performance slipped to an average of 98.6 per cent. This was partly driven by a reduction in data validation while we prioritised preparing for the launch of Epic.

To continue to meet the standard we have:

- Clear roles and responsibilities for managers and administrative teams to deliver short waiting times
- Classroom and electronic training on all aspects of managing waiting times
- Proactive management of waiting lists

Care Quality Commission inspection

The Care Quality Commission (CQC) rated UCLH "good" overall for the services it provides to patients.

Between July and September 2018, inspectors visited 11 services across three of the UCLH's sites: University College Hospital and Elizabeth Garrett Anderson Wing, the National Hospital for Neurology and Neurosurgery and the Sir William Gowers Centre.

Inspectors rated UCLH as "good" in the categories of effective, caring, responsive and well-led. We received a "requires improvement" rating for safety.

NHS Improvement rated UCLH as "good" when assessing how effectively the organisation uses its resources to provide high quality, efficient and sustainable care for patients.

All of the ratings above were combined with the ratings of services the CQC inspected in 2016, to give an overall rating of "good" for 2018.

Areas of praise within the report included:

- Inspectors applauded staff for the way in which they treat patients with "compassion, patience and respect". They said feedback from patients about their care was "consistently positive".

- They observed "good teamwork among staff at all levels" and said there was a "sense of common purpose based on shared values". Staff said they were proud to work at UCLH.

- Inspectors also praised the "strong culture of improvement, research and innovation" and cited many examples of research being used to improve patient care.

- They added that "leaders at every level were visible and approachable" and had a "clear vision and strategy" with action plans to achieve this.

- Inspectors found a number of areas of outstanding practice including: our fetal surgery service for spina bifida which is the first of its kind in the UK, and our specialist service for women at high risk of developing ovarian cancer.

- They also commended the breadth of research and clinical trials at both the National Hospital for Neurology and Neurology, and outstanding practice within our specialist epilepsy service at the Sir William Gowers Centre.

Actions

There were of course some areas where the CQC said we can do better and we are taking action as an organisation and with our partners to address inspectors' feedback.

For example, we have been experiencing significant challenges in meeting the target that 95 per cent of patients should spend less than four hours in our emergency department. We have also been struggling to meet the standard that patients referred by a GP with suspected cancer should be treated within 62 days. Our action plans to improve performance in these areas are described earlier in this section.

Our other key areas of focus in response to the CQC's findings are to:

- ensure medicines are managed and stored appropriately in line with Trust requirements
- ensure we meet our target that 90 per cent of medical staff are up-to-date with their mandatory training
- ensure high standards of infection control practices are consistent across the organisation.

For further information see section 3 Quality report.

Care Quality Commission maternity survey

In January 2019, the Care Quality Commission (CQC) published findings from its national maternity survey. The survey, which was undertaken in February 2018, covered all aspects of maternity provision: antenatal care, care during labour and birth, and post-natal care.

The overwhelming majority of women said they were treated with respect and dignity at UCLH, trusted our staff and felt involved in decisions about their care.

However, in response to other feedback we have recruited more peer support workers to prepare mothers for breastfeeding and to support those who cannot, or choose not to. We are also supporting our midwives to have more detailed conversations with mothers about their emotional well-being and to ensure women are not left alone when they are worried.

Patient feedback

We achieved good results in the 2018 Picker national inpatient survey. Eighty-eight per cent of patients rated their overall care as seven out of 10 or better. This puts us above the national average for acute trusts.

We ask patients in a number of departments the following question from the national friends and family test (FFT): "Would you recommend our services to your friends and family if they needed similar care or treatment?"

We have maintained our recommendation scores in inpatients (94 per cent) and outpatients (92 per cent). We have seen an improvement in our score for ED from 83 per cent in 2017/18 to 85 per cent in 2018/19.

In 2018, we did not collect feedback for non-emergency patient transport between May and October while we improved our methodology for collecting data, which now includes calling recent service users. For the other eight months of 2018/19, our FFT score was 88 per cent, an improvement on 69 per cent in 2017/18.

For further information about our performance in these areas see the Quality report.

Healthcare associated infections

There were 56 *Clostridium difficile* toxin positive cases reported in 2018/19 (69 cases in 2017/18), against a threshold of less than 96 cases.

Each case is reviewed with the lead Clinical Commissioning Group (CCG) to determine whether or not it was due to the care the patient received at UCLH.

Of the 56 cases, only three were assessed to be a result of lapses in care at UCLH.

Our plan to reduce *Clostridium difficile* aims for the highest standards of environmental cleanliness, ensuring staff follow infection control practice and that there are sufficient hand washing facilities available. We are also improving testing methods and treatment of cases.

There was one case of Trust-attributable Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia in 2018/19 (one case in 2017/18). The national standard is zero.

There was an 8.4 per cent increase in the number of *Escherichia coli* bacteraemia cases compared to last year (103 cases in 2018/19 and 95 cases in 2017/18). We will further develop our multidisciplinary programme related to oral hydration and use of appropriate antibiotic treatment for urinary infection both in hospital and the community.

The prevalence of infections due to carbapenemase-producing Gram negative bacteria has remained low and 13 were detected at UCLH this year (10 cases in 2017/18).

There has been a 13.1 per cent reduction in the number of *Pseudomonas aeruginosa* bacteraemia cases compared to last year (53 cases in 2018/19 and 61 cases in 2017/18). We are monitoring the situation closely. The number of cases is related to the number of immune-suppressed patients across the Trust, particularly at University College Hospital. However, all showers across the Trust have been changed to quarterly-renewable shower hoses and heads to reduce patients' exposure to the organism.

In the winter of 2018/19, our virology team used rapid flu and RSV testing in our emergency department (ED) for the second year. This provided highly-valued support to ED clinicians and the infection prevention and control team. The test facilitates clinical decision-making, bed management and patient flow in the acute wards of University College Hospital.

Mortality

UCLH's Summary Hospital-level Mortality Indicator (SHMI) is consistently good. We ranked third out of 131 trusts in England in the latest SHMI performance ratings (October 2017 to September 2018). The ratings are compiled by NHS Digital.

We have continued to improve how we learn from deaths in order to improve safety and care. Our quarterly reports to the Board highlight learning from complaints, serious incidents and mortality reviews, including where we have changed practice to improve care.

Sepsis

In 2018/19 we participated in the national sepsis CQUIN (Commissioning for Quality and Innovation) to measure whether screening for sepsis is happening and antibiotics are being given within one hour, and antibiotic prescriptions are reviewed within 72 hours.

The target for screening for sepsis in the emergency department (ED) was 90 per cent of patients and we achieved 100 per cent. The target for screening for sepsis in inpatients was 90 per cent and we achieved 100 per cent.

The target for giving antibiotics to patients with sepsis within an hour in ED was 90 per cent and we achieved 90.4 per cent.

The target for giving antibiotics to inpatients with sepsis within an hour was 90 per cent and we achieved 72.7 per cent.

Our combined achievement in ED and inpatients was 86.1 per cent (76 per cent in 2017/18).

We had a quarterly incremental target for clinical review of antibiotics within 72 hours of giving the first dose in patients with sepsis. The outcome of the review is documented. For example, whether a decision was made to continue with intravenous (IV) treatment or whether to switch from IV to oral medication. The quarter four target was 90 per cent and we achieved 100 per cent.

These results are averages for the year unless otherwise stated.

Hospital-acquired pressure ulcers

We set ourselves the target of no more than 84 hospital-acquired pressure ulcers in total in 2018/19, including zero category three and four cases (with category four being the most severe).

We performed well against our target and in comparison to our national peers for hospital-acquired pressure ulcers, as recorded in NHS England's National Patient Safety Thermometer.

We recorded 74 hospital-acquired pressure ulcers, of which five were category three and one was category four. The latter was due to exceptional circumstances. (In 2017/18, we recorded 81 hospital-acquired pressure ulcers, of which two were category three and zero were category four).

In November our tissue viability team led UCLH's participation in Stop the Pressure Week. This was part of our campaign to increase awareness among clinicians about how to prevent hospital-acquired pressure ulcers. The campaign also encouraged patients and their families to take a proactive role by regularly inspecting and caring for their skin.

Patient falls

In 2018/19 we set ourselves the target of no more than 240 falls which result in any level of harm. We agreed with our commissioners that this total should not include falls on our specialist epilepsy ward which occurred during seizure, unless the patient suffered moderate or severe harm. We recorded a total of 308 falls under these criteria. (In 2017/18, we recorded 231 falls under these criteria).

To help reduce the number of preventable falls, a falls practitioner has trained more than 150 clinical staff. Wards with a high number of falls have received training tailored to their specific area. A new harm-free care matron, whose remit includes reducing falls and pressure ulcers, has also been appointed.

Quality rounds have been introduced at the National Hospital for Neurology and Neurosurgery to review risk assessments and documentation relating to falls. We have also renewed our focus on supporting patients with lowered blood pressure when they stand by encouraging them to sit up first and improving their hydration.

Non-emergency patient transport

The performance of our non-emergency patient transport provider, G4S, has steadily improved this year. The improvement follows an amended contract agreed in February 2018 which included revised performance targets aligned to the principle that "every patient matters".

In 2018/19 we implemented a number of measures to improve the service, including:

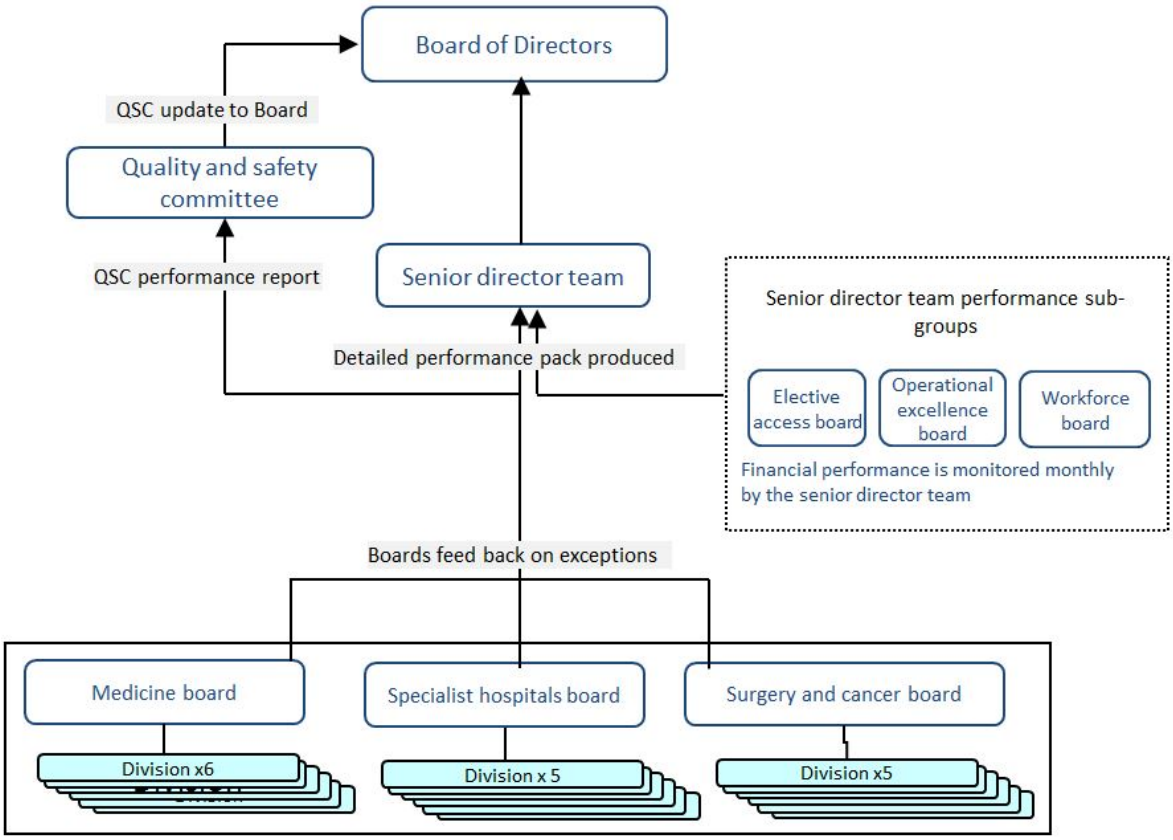
- Introducing daily pre-booked transport reports to help staff plan for patients being discharged home.
- Trialling software called Patient Zone which shows staff on the wards the exact location of vehicles due to pick up their patients.
- G4S provided two additional stretcher vehicles to transport more patients with complex health needs.

We recognise, however, that we still need to do more to support G4S to improve the quality and efficiency of the service and we will continue to work closely with them to do this.

Monitoring quality and performance

We undertake a detailed review of performance against metrics and monitor the effect of recovery action plans. Results are presented to executive directors at the senior directors' team (SDT) meeting, and to the quality and safety committee for assurance monitoring, and to the Board as part of detailed performance and quality packs. This enables monitoring of performance, and workforce and quality indicators.

Our reporting structure is shown in the following diagram:



1.2.4 Environmental matters and sustainability

We remain committed to improving the environmental sustainability of our organisation. As an NHS trust, we have a responsibility to make efficient use of resources and improve the health and wellbeing of the communities we serve.

In line with our corporate objectives, our priorities are to:

1. Comply with all statutory sustainability requirements and implement national strategy
2. Minimise our carbon footprint through technical measures and staff behaviour change
3. Embed sustainability into our core business strategy
4. Work with our contractors and stakeholders to deliver a shared vision of sustainability

Our sustainable development, carbon, and waste management policies integrate the latest requirements and guidance from the NHS Sustainable Development Unit.

Energy, water, waste and carbon emissions

Improving energy and water efficiency helps us to manage our utility budgets as demand for services continues to increase. We are developing a proposal for a programme of upgrades and efficiency measures under the RE:FIT scheme, supported by the Mayor of London and NHS Improvement.

UCLH is working hard to cut emissions by more than 28 per cent by 2020 against our 2007/08 baseline. This represents a target of 0.16 tCO2e (carbon dioxide equivalent) per patient contact. Our reported carbon footprint includes those sources where we have a good understanding of emissions. We are working to quantify and reduce emissions from procurement, our supply chain, waste, and transport sources.

Achievements in 2018/19 included:

- Our water use decreased by 3.3 per cent compared to 2017/18.

- Our carbon emissions reduced to 0.0157 tCO2e per patient contact, compared to 0.0169 tCO2e per patient contact in 2017/18. This equates to a seven per cent reduction.

- We have retained our certification against the Carbon Trust Standard for carbon, waste and water.

- We continue to build on our successful use of Warp IT, avoiding about 5.2 tonnes of bulk waste, and saving about £30,900 this year.

- We received an award from Camden Climate Change Alliance (CCCA) in December 2018 in recognition of our commitment to reduce our emissions. We are one of 19 CCCA members who have reduced our footprint by at least 20 per cent in the past decade.

Staff and community engagement

Engaging staff and raising awareness throughout the organisation helps us to improve our environmental efficiency. We encourage members of staff who are passionate about sustainability to get involved.

We completed the second year of our innovative green impact programme in partnership with the National Union of Students (NUS).

Building on this success, we have started work on a sustainability action plan with our support services colleagues, Interserve Facilities Management.

We are one of the local business partners working with the London Borough of Camden to develop a clean air action plan.

We attend meetings with representatives from Camden Town Unlimited and Euston Town Business Improvement District (BID) who have been appointed by the business community to improve Camden and Euston Town as a place to work, live and visit.

1.2.5 Social, community and human rights issues

We are committed to ensuring our services meet the needs of all people, including those with protected characteristics under the Equality Act 2010. This is in accordance with our public sector equality duties under the NHS Constitution.

Under the Equality Act 2010 there are nine protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

We recognise the importance of respecting and protecting the human rights of our patients, staff and members, in line with Equality and Human Rights Commission guidance.

Our equalities objectives are to improve patient care, staff experience and reduce inequalities among staff and patients. We publish an annual equality report that sets out how UCLH meets specific employment duties and includes monitoring data, achievements and priorities for action.

We are committed to safeguarding all our patients, in particular the most vulnerable adults and children. We participate in our local multi-agency safeguarding boards and work with our partners to safeguard vulnerable adults and children. We react promptly to safeguarding issues and our trained safeguarding champions apply our policies and procedures around the clock. They are supported by a team of safeguarding child and adult leads who have expert knowledge. There are named executive leaders for child and adult safeguarding and six-monthly reports are presented to the Board. Safeguarding training is given to all staff as part of mandatory training.

We provide a comprehensive patient information and language support services to meet the needs of our diverse population. Interpreting services are available in most common languages, as well as British Sign Language. We provide core information leaflets in an easy read format.

A multi-faith spiritual care team is available to support patients and staff. The team reflects the diverse faiths and beliefs of our local population and staff.

We carry out assessments to confirm that our policies, functions and services are not discriminatory. We develop and implement action plans to address any shortcomings. Monitoring data is included in the Annual Equality Report.

For further information see section 2.1.9 Equality reporting (patients) and section 2.3.14 Equality reporting (staff).

For information about anti-bribery matters see section 2.3.6 Staff policies and actions.

1.2.6 Modern slavery and human trafficking statement

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Individuals may be trafficked into, out of, or within the UK. They may be trafficked for a number of reasons, including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 introduced changes in UK law which focus on increasing transparency in supply chains.

UCLH is committed to improving our practices to combat slavery and human trafficking. We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and in so far as is possible, to requiring our suppliers have a similar ethos.

UCLH will:

- Comply with legislation and regulatory requirements in this area
- Make suppliers and service providers aware that we promote the requirements of this legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues throughout UCLH
- Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions
- Encourage suppliers and contractors to take their own actions and understand their obligations under this legislation
- Ensure that modern slavery is included in safeguarding work plans
- Monitor compliance with mandatory safeguarding training, and training in equality, diversity and human rights
- Ensure that procurement staff also receive regular legal briefings and appropriate training so that they are aware of legislative requirements in this area.

1.2.7 Important events after year end

Between 1 April 2019 and the date of this report, there were no important events affecting the organisation which need to be disclosed.

1.2.8 Overseas operations

There were no overseas operations in 2018/19.

Signature to the performance report:

Professor Marcel Levi
Chief executive

23 May 2019

2 Accountability report

2.1 Directors' report

2.1.1 UCLH Board and committees

The Board, led by the chair, sets the vision and values of UCLH and works to promote the success of the organisation. It is responsible for the organisation's decision-making and performance to ensure UCLH delivers high quality, safe and efficient services.

The Board meets six times a year in public, although part of these meetings is held in private to deal with confidential matters. In 2018/19, the Board held three additional meetings wholly in private which included a meeting to approve the annual report and financial statements.

In July 2018, we agreed to increase the number of non-executive directors on the Board by one. The Board now comprises nine non-executive directors (including the chair), and seven executive directors.

The chief executive is accountable to the Board for running all aspects of the operational business of the Trust.

The chair leads the Board and ensures its effectiveness. The chair sets the agenda for the Board. The agenda includes reports from the standing committees of the Board and reports on performance and finance.

During the year, the Board also received various presentations. These helped to assure the Board that the organisation is focused on the key objectives to improve safety, effectiveness and patient experience.

The Board held five seminars this year to discuss strategic issues facing UCLH. Topics covered included our electronic health record system (EHRS), staff experience, integrated care, equality and diversity, and our Care Quality Commission (CQC) inspection report.

Board papers for the public meeting are published on the UCLH website and shared with governors. Governors also receive a monthly performance report, and the agenda and minutes of confidential meetings.

Board members

Directors' details, together with their committee membership as at 31 March 2019, are given below. Board members declare their interests at the time of their appointment and annually. The register of directors' interests is published annually. It can be found on our website on the Board of Directors' pages or can be obtained from the Trust secretary.

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

To contact the Board there is a dedicated email address, uclh.directors@nhs.net, as well as a telephone and postal address, which can be found on the UCLH website.

Non-executive directors

Baroness Julia Neuberger DBE
Chair
Chair of remuneration committee

Baroness Neuberger became UCLH chair on 25 February 2019.

Throughout her career, Julia has made an extensive contribution to healthcare policy and management. In the 1990s she was chair of the Camden and Islington Community Trust, and chief executive of The King's Fund from 1997 to 2004. Julia was also chair of the Liverpool Care Pathway Review and one of the vice chairs on the 2018 Independent Review of the Mental Health Act. She is a local resident.

Dr Harry Bush CB
Vice chair
Member of finance and investment, and remuneration committees

Harry Bush joined the Board in February 2012 and was appointed vice chair in March 2013. He has extensive senior management experience at HM Treasury and in the economic regulation of the aviation industry. He was most recently a member of the Civil Aviation Authority Board with executive responsibility for its economic output. Prior to that, he held a number of senior posts at HM Treasury during a long career there.

Harry was interim chair from 1 November 2018 to 24 February while we were appointing a new chair.

Dr Junaid Bajwa
Member of finance and investment, and remuneration committees

Dr Junaid Bajwa was born at UCLH and is a practising GP with experience of serving a deprived London community. He has been interested in the use of technology and data to improve patient outcomes for many years, and has worked with NHS England on projects involving artificial intelligence (AI) and data analytics. In addition he also works for Merck Sharp and Dohme as the global executive director for partnerships and strategic alliances, within its digital accelerator. He joined UCLH as a non-executive director in September 2018.

Dr Jane Collins
Member of audit, and remuneration committees

Dr Jane Collins qualified in medicine at Birmingham University. After training jobs in Southampton and London, she was appointed as a consultant paediatric neurologist at Guy's Hospital and then moved to Great Ormond Street Hospital. She was appointed chief executive of both Great Ormond Street Hospital for Children and the Great Ormond Street Hospital Children's Charity in 2001. From 2012 until early 2019 she was chief executive of Marie Curie. Jane was on the advisory board of the King's Fund from 2013 until 2017 before becoming a board member. She was chairman of the London Clinical Senate Council between 2013 and 2018. She is an honorary fellow of UCL and the Institute of Child Health, UCL. Other external roles included co-chairing the Ambitions for Palliative and End of Life Care group.

Althea Efunshile CBE
Member of audit, quality and safety, and remuneration committees

Althea Efunshile was appointed in May 2016. She has had a 30-year career in local and central government, during which she gained extensive senior management experience. She was deputy chief executive of Arts Council England where she was responsible for the national investment strategy, corporate governance and operational delivery.

Prior to that she held a number of director level posts within the Department for Education all of which were concerned with improving outcomes for disadvantaged children and young people. She has been the executive director for education and culture in the London Borough of Lewisham, and assistant director of education in the London Borough of Merton. Althea was awarded a CBE for services to art and culture in the 2016 Queen's birthday honours.

Dr Clare Gerada
Member of quality and safety, and remuneration committees

Dr Clare Gerada trained at UCLH. She is senior partner at the Hurley Group practice in Lambeth serving 100,000 patients. She has also trained in psychiatry and set up the NHS Practitioner Health Programme, an organisation which supports doctors with mental health issues. She has a national reputation and significant experience of integrated care. She is interested in how digital transformation can support clinicians. She was the chair of the Royal College of General Practitioners. She is the clinical chair of the new NHS Assembly. She joined UCLH as a non-executive director in September 2018.

Professor David Lomas
Chair of quality and safety committee and member of remuneration committee

David Lomas joined in September 2015. He is UCL vice-provost (health), head of the UCL School of Life and Medical Sciences, head of UCL Medical School, academic director of the UCLP Academic Health Science Centre and works as a respiratory physician at UCLH. He received his medical degree from the University of Nottingham and undertook his PhD at Trinity College, Cambridge.

He was a Medical Research Council (MRC) clinician scientist, university lecturer and professor of respiratory biology in Cambridge before moving to UCL in 2013 to be chair of medicine and dean of the faculty of medical sciences. He was deputy chief executive at the Medical Research Council and previously chaired the respiratory therapy area unit board at GlaxoSmithKline. He is also a senior investigator for the National Institute for Health Research (NIHR).

Dr Rima Makarem
Chair of audit committee and member of remuneration committee

Rima Makarem joined in July 2013. Rima has extensive experience in healthcare and the pharmaceutical industry. She currently runs her own interim management and consultancy business and holds a portfolio of non-executive positions. Rima has significant experience as an audit chair. She was previously audit chair at NHS London and NHS Haringey before that and is currently audit chair of the National Institute for Health and Care Excellence (NICE). Previously, Rima was director of competitive excellence at GlaxoSmithKline and prior to that, a management consultant. Rima holds a PhD in biochemistry and an MBA from INSEAD Business School.

Caspar Woolley
Chair of finance and investment committee and member of remuneration committee

Caspar Woolley joined in January 2015. Caspar is a Cambridge University graduate who started his career as a design engineer. He founded and is a board member at Hailo Network Ltd, the taxi app. He also served as the chief executive officer of E-Courier (UK) Ltd and led the eCourier.co.uk management team. He was also vice president for fleet at Avis. Previously, he served as the head of business development for the John Lewis Partnership. He served as vice president of operations at buy.com (UK) Ltd. He was an independent non-executive director of GAME Digital plc from May 2014 to January 2018. He has also been a governor at a foundation trust.

Executive directors

The remuneration committee of the Board appoints executive directors on permanent contracts.

Professor Marcel Levi
Chief executive

Marcel Levi joined UCLH as chief executive in January 2017. Marcel has had a distinguished career as a clinician, academic, educator and clinical leader. Prior to joining UCLH he was chairman of the executive board of the Academic Medical Center at the University of Amsterdam for six years and before that, he was chairman of its department of medicine and division of medical specialisms for 10 years. Marcel is a practising consultant physician at UCLH, specialising in haemostasis, thrombosis and vascular medicine. He was named the best specialist in internal medicine in the Netherlands for three consecutive years. Marcel obtained his PhD in 1991 and was appointed a member by the Royal Netherlands Academy of Science.

Professor Geoff Bellingan
Medical director, surgery and cancer board

Geoff Bellingan was appointed as a medical director in September 2009. He previously held posts as clinical director and divisional clinical director between 2006 and 2009. He trained as a chest physician and then in intensive care in which he has been a consultant at UCLH since 1997. He was appointed as a professor in intensive care medicine at UCL in 2015.

As medical director for surgery and cancer, Geoff has a particular interest in cancer care across North and East London and West Essex, working closely with London Cancer, Macmillan and a number of other major partners. This led to the successful UCLH Cancer Collaborative application. Geoff is also the senior responsible officer for the development which incorporates one of the UK's first two NHS proton beam therapy units, and a short stay surgical centre.

Dr Gill Gaskin
Medical director, specialist hospitals board

Gill Gaskin was appointed medical director of the specialist hospitals board in January 2010. Gill graduated from Cambridge and trained in renal and general medicine at Hammersmith Hospital and the Royal Postgraduate Medical School, completing a PhD on the biology of systemic vasculitis. Between 1995 and 2010 she held consultant-level posts at Hammersmith Hospitals and Imperial College Healthcare trusts. She had additional responsibilities as director of postgraduate medical education and professional development, clinical director and director of the medicine clinical programme group. Gill is a member of

the Faculty of Medical Leadership and Management. She is the senior responsible officer (SRO) for the implementation of Epic, our electronic health record system.

Dr Charles House
Medical director, medicine board

Charles House was appointed medical director of the medicine board in July 2017, having previously been interim medical director since March 2016. He studied medicine at St Mary's Hospital Medical School. He trained in radiology at UCLH, being appointed here as a consultant radiologist in 2005, with subspecialist interests in bone and soft tissue sarcoma, myeloma and orthopaedic imaging. After spells as college tutor for the UCLH radiology training scheme and clinical lead in radiology, Charles held posts as divisional clinical director of imaging and associate medical director. Charles has a keen interest in clinical leadership and evolving models of healthcare, with focus on collaboration between organisations and across sectors.

Tim Jaggard
Finance director

Tim Jaggard was appointed finance director in April 2016 having previously held the posts of interim finance director and deputy finance director at UCLH. He joined from the Whittington Hospital in 2010 where he was deputy finance director for two years. Prior to this, Tim held senior finance positions in service line reporting, patient level costing, commissioning and financial management. He graduated from the NHS graduate training scheme in 2006. He has a degree in psychology from Cambridge which was followed by further study at the Judge Business School.

Professor Tony Mundy
Medical director, corporate

Tony Mundy has been a medical director since 2001. Since November 2006 he has been the corporate medical director with UCLH-wide responsibility for quality and safety and for research and development. He is the UCLH responsible officer for the revalidation of doctors under the GMC registration regulations. He was previously clinical director of urology and nephrology and then medical director for medicine and surgery from 2001 to 2006. Tony is a professor of urology at the University of London and director of the Institute of Urology.

Flo Panel-Coates
Chief nurse

Flo Panel-Coates was appointed UCLH chief nurse in April 2015, coming to the organisation from Barking, Havering and Redbridge University NHS Trust where she was chief nurse for two and a half years. Prior to that, she was director of nursing and quality at Maidstone and Tunbridge Wells NHS Trust from August 2008 until September 2012. She also held positions of director of nursing and midwifery, and director of infection prevention and control at the North Middlesex University Hospital NHS Trust from September 2005 to August 2008. She has a keen interest in organisational culture and in creating different ways of working to release more time to care.

Other directors who attend the Board:

Ben Morrin
Workforce director

Ben Morrin joined UCLH as the workforce director in September 2014. In the preceding decade he worked across the Department of Health and within the Prime Minister's Delivery Unit. Ben is a fellow of the Chartered Institute for Personnel and Development.

Professor Bryan Williams
Director of research

Bryan Williams joined the UCLH Board in December 2017. Bryan is chair of medicine at University College London (UCL) and director of the UCL and UCLH National Institute for Health Research (NIHR) Biomedical Research Centre (BRC). He is a consultant physician at UCLH and a NIHR senior investigator.

Board members who stood down during the year:

David Prior (Lord Prior of Brampton)

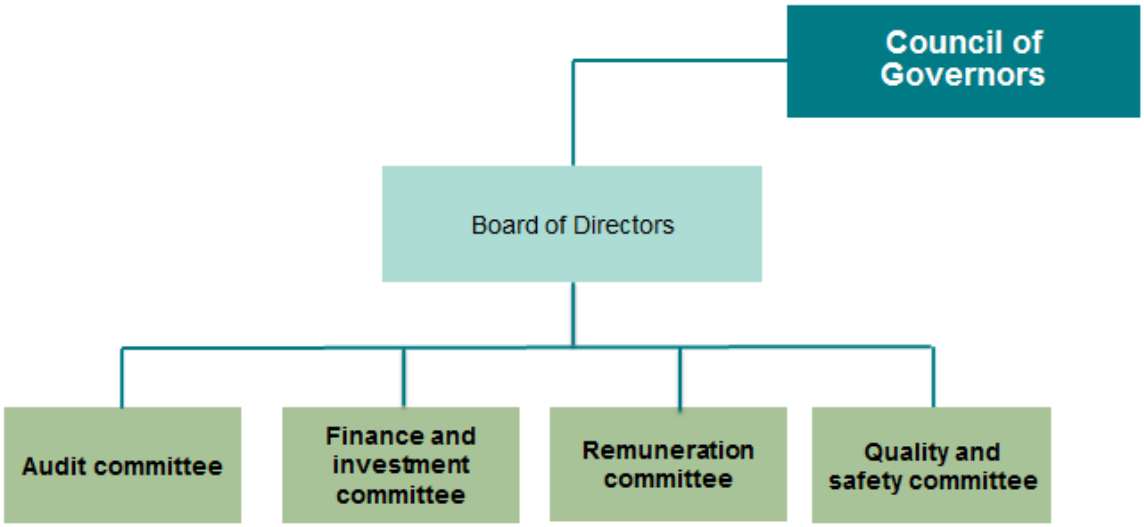
David Prior was UCLH chair from 1 January 2018 to 31 October 2018.

Kieran Murphy

Kieran Murphy was a non-executive director from January 2014 until December 2018.

Board committees

In 2018/19, we reviewed our committee structure in order to engage the Board more fully in decision making. Our new committee structure is as follows:



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

Directors' attendance at the Board 2018/19:

Non-executive director	Board attendance	Executive director	Board attendance
Junaid Bajwa	4/6	Geoff Bellingan	8/9
Harry Bush	8/9	Gill Gaskin	9/9
Jane Collins	4/5	Charles House	9/9
Althea Efunshile	7/9	Tim Jaggard	9/9
Clare Gerada	5/6	Marcel Levi	8/9
David Lomas	5/9	Ben Morrin*	7/9
Rima Makarem	8/9	Tony Mundy	6/9
Kieran Murphy	4/6	Flo Panel-Coates	8/9
Julia Neuberger	1/2	Bryan Williams*	6/9
David Prior	4/4		
Caspar Woolley	9/9		

* The workforce director and director of research attend Board meetings in a non-voting capacity

Audit committee

Membership comprises at least three non-executive directors (including the committee chair) selected for their skills and experience. Rima Makarem, audit chair has significant audit committee experience.

Others attending can include our external auditors, Deloitte LLP, local counter-fraud specialists RSM Risk Assurance Services LLP, KPMG our internal auditors, the UCLH finance director, and Trust secretary. Other executive directors and senior managers are invited to attend when necessary and the chief executive attends annually when the committee reviews the financial statements.

The committee meets seven times a year to discharge its duties. Its primary role is to review the adequacy and effectiveness of the systems of integrated governance (corporate, clinical and financial) and ensure internal control and risk management is in place to support the achievement of UCLH's objectives. Its responsibilities are set out in its terms of reference which can be found on our website.

Members' attendance at audit committee in 2018/19:

Member	2018/19 membership term dates	Attendance
Harry Bush	April 2018 to October 2018	4/4
Jane Collins	January 2019 to March 2019	1/2
Althea Efunshile	April 2018 to March 2019	7/7
Rima Makarem	April 2018 to March 2019	7/7
Kieran Murphy	November 2018 to December 2018	1/1

The committee is well-placed to fulfil its assurance role. Audit committee members attend other committees of the Board. This broad coverage of knowledge strengthens the audit committee's effectiveness.

The audit committee provides the Board with an independent view of financial management, corporate governance and risk management. During the year the committee approved the internal audit plan for 2018/19 and received audit reports from KPMG. The reports included information governance and data security, data quality, management of risk registers and core financial controls. The committee reviewed the appropriateness and implementation of management's response to the findings.

The committee monitored counter fraud arrangements through the review of quarterly progress reports, including fraud risk assessments. It also received regular updates from management on the financial metrics in place to meet the better payment practice standards.

The head of internal audit opinion is one of significant assurance with minor improvement opportunities.

The committee reviewed key areas of judgement in both financial and non-financial reports, including those relating to the significant audit risks identified by the external auditors, Deloitte:

- recoverability of NHS revenue and related collection of debt
- accounting for capital expenditure
- valuation of land and buildings
- management override of controls.

The committee received Deloitte's conclusions from its audits of the 2018/19 quality report and annual accounts and considered the annual report and annual governance statement before submission to the Board for approval.

The committee monitored the performance and independence of the external auditors and the effectiveness of both internal audit and local counter fraud. It also reviewed its own effectiveness.

In 2018/19 the audit committee held a workshop on the organisation's preparedness for the launch of our new electronic health record system, Epic.

The external and internal audit partners and the local counter-fraud specialists have direct access to the committee. The committee members held private meetings without management present with both the external audit partner and the head of internal audit during the year.

External auditors

The Council of Governors appointed Deloitte LLP as external auditors for three years commencing with the 2016/17 audit, with an option to extend for a further two years. The auditors' opinion and report on the financial statements is included in the annual accounts.

Deloitte may also provide non-audit services with the agreement of the committee and the Council of Governors. No non-audit work was provided in 2018/19.

The total cost of the external audit of the financial statements and quality report for 2018/19 was £138K (£141K in 2017/18).

Remuneration committee

The remuneration committee sets pay and employment policy for the executive directors and other senior staff designated by the Board. It also considers the performance of the executive directors. The committee sets remuneration using benchmarking information and survey data of other comparable senior posts within the NHS. All UCLH's non-executive directors are members of this committee. It is chaired by the chair of the Board.

The remuneration committee met on one occasion this year on 11 April 2018.

All non-executives attended the meeting. Marcel Levi, the chief executive, attended in an advisory capacity, supported by Steve Campbell, head of workforce.

Details of salary and pension entitlements for the directors of UCLH are set out in section 2.2 Remuneration report.

There is also a governors' nomination and remuneration committee which deals with non-executive appointments – see section 2.1.2 Governors and members.

Finance and investment committee

The finance and investment committee provides oversight and scrutiny of all aspects of financial management and investment decisions. It provides assurance to the Board on the management of financial risk. It examines financial performance and reviews costing and benchmarking work. It also oversees UCLH's approach to contracting and considers longer-term financial performance issues.

The committee also reviews the annual capital programme and reports to the Board on major capital investment proposals. In conducting an independent review of investment proposals, it considers strategic fit and ensures business cases have been appropriately assessed with regards to risk. It also reviews medium-term investment strategy, including the financial and economic aspects of the estate strategy.

Quality and safety committee

The quality and safety (QSC) committee provides the Board with assurance on three key areas of quality: safety, effectiveness and patient experience. It is responsible for ensuring appropriate arrangements are in place for measuring and monitoring quality, challenging assurance and determining what needs to be drawn to the Board's attention. The QSC identifies and escalates potential risks to the quality of services, shares learning from serious incidents and deaths, and ensures that agreed actions are implemented. It reviews compliance and receives assurance on meeting regulatory standards set by the Care Quality Commission (CQC). For further information see section 3 Quality report.

Board, committee and directors' evaluation

The description of each director's experience demonstrates the balance and relevance of skills and expertise of the Board. To help the Board assure itself in this regard it undertakes a collective self-assessment of its performance and governance practices.

The Council of Governors sets objectives for the chair of the Board. The chair of the Council of Governors' nomination and remuneration committee and vice chair of the Board appraise the chair of the Board.

The chair undertakes the performance review of the non-executive directors and the chief executive.

The chief executive reviews the performance of the executive directors during their annual appraisal.

Directors' expenses

For 2018/19 the total amount of expenses claimed by two directors was £373. (In 2017/18, seven directors claimed a total of £4,252.90).

2.1.2 Governors and members

Being a member gives people interested in UCLH the opportunity to find out more about the services we provide and to get involved.

We have three membership constituencies, as defined in the Trust constitution:

- Public
- Patient
- Staff

Anyone aged 14 or over can become a patient or public member of UCLH.

Public membership includes individuals living in one of the 32 London boroughs or the City of London.

Patient membership is divided into three groups:

- Patients living in one of the 32 London boroughs or the City of London (London)
- Patients from elsewhere in England (out of London)
- Individuals who are unpaid carers of patients of UCLH

Anyone who joins as a patient or carer member must have attended a UCLH hospital within the last three years.

Staff membership comprises:

- Individuals who have a permanent contract with UCLH
- Individuals who have a fixed term contract of at least 12 months with UCLH
- Individuals who have had an honorary contract of at least 12 months with UCLH
- Individuals who are not employed by UCLH but who have provided services to the Trust continuously for at least 12 months

There are four staff groups:

- Medical and dental practitioners
- Nurses and midwives
- Other clinical staff
- Non-clinical staff

When staff join UCLH they become members unless they choose to opt out. This right is explained to staff. No staff are currently opted out. Staff cannot be members of the public or patient constituencies.

Our overall membership numbers are as follows:

Constituency	**31 March 2019**	**31 March 2018**
Staff	10,460	10,026
Public	2,654	2,723
Patient	8,089	8,422
Total	**21,203**	**21,171**

Membership engagement and strategy

Our membership strategy was revised and approved by the Council of Governors in January 2019. It sets out a vision to focus on engagement and communication with members.

We are working closely with our public and patient involvement team to ensure we listen to our members and inform them of events and engagement opportunities. Members receive regular communication through the UCLH Magazine, by email and at events such as the Annual Members' Meeting and our annual research open day and Christmas event.

Members have been recruited to join groups looking at improving patient experience. They have also been invited to take part in research projects covering diabetes and tinnitus, and been given the opportunity to help shape the Camden musculoskeletal service.

Members are also involved in the Patient-Led Assessments of the Care Environment (PLACE).

Governors chaired three MembersMeet health seminars on topics influenced by members' interests including ataxia, bowel cancer and cardiovascular prevention and care. This allows

members to ask governors questions and talk about matters of interest to them. Governors follow up on members' concerns and communicate any issues to the Board.

Demographic information provided by public members show our membership is broadly representative of the population we serve. However, we need to actively increase our membership from black communities and also from the population aged 14 to 29.

Work is ongoing to target hard-to-reach groups. We have implemented a new database and are developing new membership materials including sign-up forms. This will help us gather more information about our potential membership and improve our diversity in terms of gender, age and ethnicity.

A member has the option to vote for, or stand to become, a governor. There is an annual session for interested members to ask questions about the role.

Council of Governors

UCLH is accountable to the communities it serves through the Council of Governors which represents the views of patients, the public, stakeholders and staff.

The Council works closely with UCLH to help shape and support its future strategy and ensure that we focus on issues that benefit patients. With the support of the governors on the Council, UCLH can take into account the views of members and stakeholders in the wider community.

Who sits on the Council?

The Council has 33 governors of which 24 are elected governors and nine are appointed governors. (In 2018/19, we increased the number of elected governors from 23 to 24 and decreased the number of appointed numbers from 10 to nine following a change to the UCLH Constitution).

Of the 24 elected governors:

- 5 are public
- 12 are patients
- 1 is a carer of a patient
- 6 are staff

On 31 March 2019, 30 of the 33 governor seats were occupied.

Governors normally hold office for three years and are eligible for re-election or re-appointment at the end of their first term. Governors may not hold office for more than six consecutive years.

The Council also elects one of its members to be the lead governor. Claire Williams has held the position since September 2017.

The Council meets four times a year in public, although part of these meetings can be held in private to deal with confidential matters. In April 2018, the meeting was not quorate but attendance was still recorded for those present. In December 2018, the Council held an additional meeting in private to agree the appointment of the new chair of UCLH.

The following tables give details of the governors, their terms in office during 2018/19 and attendance at Council meetings.

Elected governors

Name of governor	Constituency	Current term	Current term start date	Current term end date	Meetings attended 2018/19
Amanda Gibbon	Public	third	1 January 2019	31 December 2020	1/1
Maggie Gormley	Public	first	1 September 2016	31 August 2019	4/5
Isaac Kohn	Public	first	1 September 2017	31 August 2020	3/5
Frances Lefford	Public	second	1 September 2018	31 August 2021	5/5
Brian Steve Potter	Public	first	1 September 2017	31 August 2020	5/5
Veronica Beechey	Patient – London	third	1 September 2016	31 August 2019	2/5
Sally Bennett	Patient – London	first	1 September 2018	31 August 2021	3/3
Maggie Clinton	Patient – out of London	first	1 September 2018	31 August 2021	3/3
Graham Cooper	Patient – London	first	1 September 2016	31 August 2019	5/5
Ann Fahey	Patient – London	first	1 September 2017	31 August 2019	4/5
John Green	Patient – London	third	1 September 2017	31 August 2020	5/5
Michael Goss	Patient – out of London	first	1 January 2019	31 August 2020	1/1
Jonathan Harper	Patient – London	first	1 September 2018	31 August 2021	2/3
Christine Mackenzie	Patient – London	third	1 September 2017	31 August 2020	4/5
Loraine Rogers	Patient – out of London	first	1 September 2018	31 August 2019	0/3*
Andrew Todd-Pokropek	Patient – London	second	1 September 2018	31 August 2021	0/3*
Vacant	Patient				

Martha Wiseman	Patient carer	first	1 September 2017	31 August 2020	4/5
Allesa Baptiste	Staff	first	1 September 2018	31 August 2021	3/3
Donna Beck	Staff	first	1 September 2017	31 August 2020	0/5*
Janet Clarke	Staff	second	1 September 2016	31 August 2019	4/5
Richard Cohen	Staff	first	1 September 2018	31 August 2021	2/3
Caroline Dux	Staff	second	1 September 2018	31 August 2021	5/5
Jessica Lipman	Staff	first	1 September 2016	31 August 2019	4/5

* Non-attendance due to ill health

Appointed governors

Name of governor	**Constituency**	**Current term**	**Current term start date**	**Current term end date**	**Meetings attended 2018/19**
Katie Coleman	GP Islington CCG	first	1 December 2017	30 November 2020	3/5
Kate Hall	UCLPartners	first	1 September 2017	31 August 2020	1/5
Mike Hanna	University College London	second	8 November 2016	7 November 2019	3/5
Rishi Madlani	Camden Council	first	23 October 2017	22 October 2020	3/5
Diarmid Ogilvy	National Brain Appeal UCLH Charities Committee	first	1 December 2017	30 November 2020	3/5
Warren Turner	London South Bank University	second	17 October 2017	16 October 2020	1/5
Claire Williams	Friends of UCLH	second	1 July 2018	30 June 2021	4/5
Vacant	Islington Council				
Vacant	Camden/Islington CCGs				

Governors whose term ended in 2018/19

Name of governor	Constituency	Term	Term end	Meetings attended 2018/19
Javed Ahmed	Staff	first	31 August 2018	2/2
John Bird	Patient – London	second	31 August 2018	2/2
Leslie Brantingham	Patient – out of London	first	31 August 2018	1/2
Adam Elliot	Patient – London	first	31 August 2018	2/2
John Knight	Patient – London	second	31 August 2018	1/2
Jo Wagerman	Patient – London	first	Deceased October 2018	2/2
Claudia Webbe	Islington Council	second	30 June 2018	0/1

Governors who stood down in 2018/19

Name of governor	Constituency	Term	Term end	Meetings attended 2018/19
Kathryn Harley	Staff	first	Left UCLH 1 April 2018	0/0
Annabel Kanabus	Patient – out of London	second	Stood down 26 July 2018	2/2
Gareth Long	Patient – London	first	Stood down 1 July 2018	0/1

Role of the Council

The Council has a number of statutory responsibilities including:

- Holding the non-executive directors to account for the performance of the Board
- Appointing or removing the chair and non-executive directors
- Deciding the remuneration of non-executive directors
- Appointing or removing UCLH's auditors

The Council also has the final decision on significant transactions; receives the annual report, quality report, accounts and auditor's report; approves changes to the constitution and gives its views on the development of our forward plan.

How the Council works

The chair of the Board is also chair of the Council. This establishes an important link between the two bodies and helps governors to fulfil their statutory responsibilities. Other Board members, both executive and non-executive, may also attend Council meetings.

Directors' attendance at the Council of Governors 2018/19:

Non-executive director	Council attendance	Executive director	Council attendance
Junaid Bajwa	0/2	Marcel Levi	4/4
Harry Bush*	3/5	Geoff Bellingan	4/4
Jane Collins	1/1	Gill Gaskin	3/4
Althea Efunshile	1/4	Charles House	3/4
Clare Gerada	1/2	Tim Jaggard	4/4
David Lomas	1/4	Flo Panel-Coates	4/4
Rima Makarem	0/4	Tony Mundy	0/4
Kieran Murphy	2/3		
Julia Neuberger	0/0		
David Prior	3/3		
Caspar Woolley	2/4		

*Harry Bush attended the extraordinary Council meeting in December 2018 when governors considered the appointment of the new chair: other non-executive and executive directors were not permitted to attend this meeting.

The Council receives regular reports from the Board on clinical and financial performance and is presented with a report from the chair of the audit committee annually. It also considers reports from the Council's nomination and remuneration committee and a governors' group with a focus on high-quality patient care.

The chair and the lead governor seek the views of governors when preparing the agendas for meetings. During the year, the Council has presentations on specific topics. In 2018/19 this included presentations on cancer performance, emergency department performance, the Care Quality Commission (CQC) inspection report, the CQC maternity survey and the financial plan for 2019/20.

The link between the Board and the governors is further strengthened through a series of seminars to support governors in their role. In 2018/19 five were held. Sessions included presentations on the staff survey, our electronic health record system (EHRS), equality and

diversity, mental health and the North Central London Sustainability and Transformation Partnership (STP).

The lead governor holds regular meetings with governors to keep in touch with opinion and further enhance communication between the Council and Board members. Governors also meet separately with the non-executives to hear first-hand how they have sought assurance from the executive on areas of performance. This is also an opportunity for the non-executives to hear the views of the governors.

In addition, governors meet with the chair and director of quality and safety three times a year to talk about serious incidents, risks and the quality report.

Governors and Board members also undertake walkarounds to keep in touch with patients.

Information for governors is uploaded to a secure webpage which includes an event calendar.

Papers for the council meetings are published on the UCLH website.

Training

On joining UCLH each governor attends an induction session and meets with the membership manager, Trust secretary, chair and lead governor.

Externally facilitated training is also provided to help governors gain greater understanding of their role in specific areas. These sessions are run by NHS Providers and cover governor core skills, finance and accountability.

Governors' expenses

Governors can claim reasonable expenses for carrying out their duties. For the year 2018/19 the total amount claimed by seven governors was £9,867.28. (In 2017/18, six governors claimed a total of £7,080.64).

Register of interests

Governors sign a code of conduct and declare any interests that are relevant and material at time of appointment or once elected. The register of governors' interests is published annually and can be found on our website on the Council of Governors' page. It can also be obtained by emailing uclh.directors@nhs.net or calling 020 3447 9290.

UCLH Constitution

A working group, comprising governors and the director of corporate services, was established to review the UCLH Constitution. The group proposed a number of changes which the Board considered in May 2018. Key changes which the Board approved included:

- Increasing the number of non-executive directors on the Board from eight to nine (including the chair)

- Increasing the number of governors in the public constituency from four to five, thereby increasing the number elected seats on the Council of Governors from 23 to 24

- Reducing the number of appointed governors on the Council of Governors from ten to nine

- Restricting governors' time in office to no more than nine years – that is three terms of three years. A governor who has served two consecutive terms cannot serve a third term without having a least a two-year break in service.

In July 2018, the Council of Governors approved the changes to the Constitution agreed by the Board.

Committees of the Council

The Council of Governors is responsible for approving the reappointment or appointment of non-executive directors as recommended by the Council's nomination and remuneration committee, or by a non-executive or chair appointment panel.

Non-executive directors are appointed by the Council for an initial period of three years, which may be extended for a further three years. In exceptional circumstances a non-executive director can serve for one or more additional defined periods.

The Council may also remove the chair or another non-executive director: this requires the approval of at least three-quarters of the members of the Council.

Nomination and remuneration committee

The nomination and remuneration committee was chaired by John Knight, a patient governor, until August 2018. The committee has been chaired by Diarmid Ogilvy, an appointed governor, since September 2018.

The committee comprises nine governors (including the committee chair). It is responsible for reviewing the remuneration of non-executive directors and contributes to the appraisal of the chair.

It also acts as the appointment committee for the non-executive director nominated by UCL and for those non-executive directors seeking reappointment. In these circumstances the committee is chaired by the Trust chair.

The committee met seven times during the year. The chair/interim chair attended all meetings to which they were invited (six out of seven).

On 11 June 2018, the committee considered the reappointment of David Lomas, non-executive director nominated by UCL. The committee extended his position for a further three years from 1 September 2018. The Council approved the reappointment on 16 July 2018.

On 1 October 2018, the committee considered the appointment of Harry Bush as interim chair. The committee agreed the appointment for the period of 1 November 2018 to 12 February 2019 during which a permanent chair was to be recruited. The Council approved the appointment of interim chair on 16 October 2018.

On 18 January 2019, the committee considered an extension of Harry Bush's appointment as interim chair. The committee agreed to extend his appointment from 13 February to 24 February 2019 (ahead of the new chair starting on 25 February 2019). The Council approved the extension on 30 January 2019.

On 18 January 2019, the committee considered an extension of Harry Bush's appointment as non-executive director and vice chair. The committee agreed to extend his position from 25 February to 31 August 2019 so he could work alongside the new chair for six months. The Council approved the extension on 30 January 2019.

On 18 January 2019, the committee considered the reappointment of Althea Efunshile, non-executive director. The committee extended her position for a further three years from 3 May 2019. The Council approved the reappointment on 30 January 2019.

On 18 January 2019, the committee recommended that the remuneration for non-executive directors should increase to £15,000 a year from 1 April 2019. The Council approved the committee's recommendation on 30 January 2019. The Council also decided that for the period 1 July 2018 to 31 March 2019, non-executive remuneration should increase from £13,140 to £14,000 a year.

Membership of the nomination and remuneration committee is reviewed each year.

Meeting dates were 9 April 2018, 2 May 2018, 11 June 2018, 1 October 2018, 16 November 2018, 18 January 2019 and 8 March 2019.

Members and attendance at the committee is as follows:

Member	**Attendance**
John Knight (chair until August 2018)*	2/3
Diarmid Ogilvy (chair from September 2018)	7/7
John Bird*	3/3
Leslie Brantingham*	2/3
Sally Bennett**	3/3
Graham Cooper**	2/3
John Green	5/7
Frances Lefford**	3/3
Jessica Lipman***	3/7
Christine Mackenzie	6/7
Claire Williams	7/7

* stood down in August 2018
** appointed in October 2018
*** on maternity leave part of the year

Chair appointment panel

On 31 October 2018, Lord David Prior departed as chair to take up the position of chair of NHS England.

To oversee the appointment of his successor, the Council established a chair appointment panel in early October 2018, comprising five governors:

- one appointed governor (Diarmid Ogilvy)
- one staff governor (Caroline Dux)
- three public/patient governors (Christine Mackenzie, Maggie Gormley, Sally Bennett)

The lead governor was co-opted to join the panel along with the interim chair – both were non-voting members.

The panel met on 5 November, 26 November, 10 December and 11 December 2018.

External search advisors Saxton Bampfylde and external advisor, Sir Hugh Taylor, chairman of Guys and St Thomas' Hospitals NHS Foundation Trust, supported the process.

The Council approved the appointment of Baroness Julia Neuberger CBE as chair of UCLH on 18 December 2018. She took up her position on 25 February 2019.

Contacting the governors

The UCLH membership office is the point of contact for members, patients and the public who wish to contact governors.

Email: uclh.governors@nhs.net

Post: Membership office
University College London Hospitals NHS Foundation Trust
2nd Floor Central
250 Euston Road
London NW1 2PG

Phone: 020 3447 9290

2.1.3 Cost allocation and charging guidance

UCLH has complied with all cost allocation and charging guidance issued by HM Treasury.

2.1.4 Political and charitable donations

UCLH donated £1 for every member of staff who had the flu vaccination in November and December 2018 to the charity Centrepoint. In total, we donated £2,020 to the charity.

UCLH did not make any political donations in 2018/19.

2.1.5 Better payment practice code

See section 1.2.1 Finance director's report.

2.1.6 NHSI's well-led framework

UCLH continued its review against NHS Improvement's well-led framework which was overseen by the senior directors' team and reported to the Board. Our internal auditors reviewed the governance of executive functions in September 2018. The Care Quality Commission (CQC) inspected UCLH against the well-led domain in September 2018.

The Board considered the Key Lines of Enquiry and associated prompts. The Board considers that there are robust arrangements in place to ensure that services are well-led. The CQC rated the well-led domain as good. Following the change of chair, an external well-led review will be commissioned to begin in January 2020.

In 2018/19, the Board committee structure was streamlined to promote transparency and to ensure that performance is monitored more closely at Board meetings. There are now four Board committees – remuneration, audit, quality and safety, and finance and investment. The effectiveness of the Board committee structure will be reviewed again in 2019/20.

The Guardian Service is embedded in the Trust and is a well-established route for staff to raise concerns.

We have identified the following actions to improve further:

- We will review how we present information to the Board and how possible issues of concern can be identified more clearly.
- The Board has agreed actions for the recruitment of non-executive directors to ensure the Board better reflects our local population and staff profile.
- The Board has prioritised succession planning and our remuneration committee will review a succession plan for senior roles in early 2019/20.
- We continue to review the ways we communicate with the public to see if this can be improved. We will increase opportunities for patient and public engagement in our activities and decision-making.
- We are using the Workforce Race Equality Standard and will be using the Workforce Disability Equality Standard to drive improvements in the experience of staff working at UCLH.
- The "Where do you draw the line?" campaign, to tackle workplace conflict and promote the UCLH values, will continue to be rolled out and closely monitored by the Board.

Delivery of the plan will be overseen by the senior directors' team and the Board will receive quarterly updates on progress.

2.1.7 Patient care activities

Care Quality Commission inspection 2018

See section 1.2.3 Detailed review of our performance 2018/19.

National Inpatient Survey 2018

See section 1.2.3 Detailed review of our performance 2018/19.

Patient experience groups

To increase engagement and focus on improving patient experience, we replaced the monthly improving experience group (IEG) and the quarterly patient experience committee (PEC) with a monthly patient experience and engagement committee (PEEC). Membership includes two patient representatives and senior representatives from each clinical board. PEEC reports to the quality and safety committee (QSC).

Patient information

To support our patient information officer, we recruited a volunteer to help develop a core set of accessible patient information leaflets. These include information about travel costs, making a complaint and our Patient Advice and Liaison Service (PALS).

We are working with another volunteer to review leaflets about the Royal London Hospital of Integrated Medicine (RLHIM) to make them easier to read. She is also delivering workshops for staff at the RLHIM on how to write more clearly and persuasively. The volunteer is a writer and editor and has won a Plain English award.

Mobile charging stations

We have installed nine more mobile phone charging stations across our sites. This is in addition to the three charging stations already in our emergency department. Each unit provides 30 minutes of free mobile phone charging, with each additional hour charged at £1. The service allows patients to stay connected to their friends and family while waiting for treatment. The units are very popular and have raised more than £600 this year for the volunteers' fund.

Complaints

See section 3.2.2 Learning from complaints.

Further information

For further information about how we are seeking to improve and monitor patient experience see section 3 Quality report.

2.1.8 Stakeholder relations

North Central London Sustainability and Transformation Partnership (STP)

See section 1.1.3 Strategic developments.

UCLH Cancer Collaborative

We host the UCLH Cancer Collaborative, the cancer alliance which brings together healthcare organisations across north central London, north east London, with links to west Essex.

The Collaborative, formerly a Cancer Vanguard, has become one of 19 alliances in England. They provide local clinical and operational leadership by bringing together commissioners and providers to improve cancer services for patients.

Our achievements this year include:

- **Launch of the SUMMIT study**. The UK's largest ever lung cancer screening project, delivered by UCLH and UCL, in conjunction with GRAIL – a US-based healthcare company focused on early detection of cancer. Over the next 12 to 15 months, lung health checks and low dose CT scans will be offered to 25,000 patients with a significant smoking history. An additional 25,000 patients with no significant smoking history will asked to provide a blood sample to support the development of an early cancer detection test. For further information see section 1.1.5 Research and development.

- **Launch of the Aldo (Avoiding late diagnosis in ovarian cancer) project.** This research aims to confirm the feasibility of monitoring women with the faulty BRCA gene for ovarian cancer as NHS standard practice. An innovative test detects ovarian cancer in BRCA-carriers before symptoms occur. It is a significant step towards meeting National Cancer Strategy recommendations to improve early diagnosis.

- **Early diagnosis centre (EDC).** The Cancer Collaborative announced that Mile End Hospital will be the early diagnosis centre for north east London. This is a major investment for north east London. Planning is under way to define the clinical and operational models, and technology needed to underpin the service. The EDC will open in December 2019 for selected patients.

- **London Cancer leadership.** Clinically-led boards and expert reference groups support the improvement of local cancer services, focusing on waiting time targets. We have addressed treatment delays for prostate cancer. We supported the implementation of the National Optimal Lung Cancer Pathway. We also supported the merger of the head and neck cancer multidisciplinary teams (MDT) at UCLH and Barts Health. We have facilitated medical image sharing between trusts.

- **Cancer Academy workforce development.** The Academy continues to develop the cancer workforce using clinical education, practical communication training, and provides support for changes in ways of working. The Academy worked with primary care leaders to encourage uptake of cancer-specific online training and launched a peer-to-peer scheme to improve multidisciplinary team meetings (MDT). It also developed patient education resources and worked with radiographers to enhance their diagnostic role.

Patient and public involvement (PPI) activities

We are committed to involving patients, their families and the local community in the decisions we make and to delivering improvements that matter to them. Most of this engagement is done by clinical services and teams at a local level. However, we have a number of Trustwide projects too, including those described below.

EHRS patient engagement

In June 2018, we created a patient group to support the development of our new electronic health record system (EHRS). The group meets monthly and comprises seven patients. The group has provided feedback on the patient portal element of the system which will allow patients to access information about their care remotely online. The group proposed a new name for the portal, MyCare UCLH, which the Board approved. We have also created a list of frequently asked questions about the portal, as a result of the group's feedback.

In November 2018, we recruited a patient to the paid, part-time role of patient lead for EHRS. They have been working with the patient experience team to engage patients in the programme and to seek the views of the EHRS patient group, carers and families.

Listening events

We held a listening event in September in which we asked patients about their experience of waiting in our hospitals and how we can improve, particularly in our outpatient waiting areas. Thirteen people attended.

Allied health professionals video

We involved patients in making a promotional video about the work of allied health professionals (AHPs). The patients, who use a variety of our services, talked about their experiences of being supported by AHPs.

Engaging with members

For information on our membership engagement strategy see section 2.1.2 Governors and members

2.1.9 Equality reporting (patients)

Our Equality, Diversity and Inclusion Plan 2018/19 supported the delivery of the UCLH Equality Objectives 2017–2020. Performance against these objectives is monitored by our diversity and equality group, with progress reported to the senior directors' team (SDT).

Our main areas of focus this year were to:

Improve the environment for patients, their families and carers

- Improve physical access to our services by building upon recommendations made by the charity AccessAble (formerly known as DisabledGo)
- Continue to improve "way-finding" across our hospitals such as updating signage and physical access to our buildings
- Support outpatient services to provide a dementia-friendly environment

Improve access to our services for patients with specific interpreting requirements

- Continue to ensure that data can be collected on all protected characteristics for patients and that multiple disabilities can be recorded on a patient's record
- Ensure our electronic health record system (EHRS) meets Accessible Information Standards (AIS) requirements

- Install hearing loops across our admin and front-line services

Specialist priorities

- Develop additional activity specialist roles for both adults and adolescents whose behaviours may be chaotic or disturbed

We have made good progress against these objectives. Developments this year included:

- We recruited a volunteer to help develop a core set of accessible patient information leaflets. These include information about travel costs, making a complaint and our Patient Advice and Liaison Service (PALS).

- We recruited a learning disability health support specialist for adults, funded by UCLH Charity. We believe this is the first role of its kind in the country and mirrors the support specialist we already have for our young patients. The role provides therapeutic support for patients with learning disabilities and autism when they are under our care.

- We have involved patients, their families and carers, as well as the charity AccessAble, in the development of the new building for the Royal National ENT and Eastman Dental Hospitals. Their involvement will help to make the building accessible to all patients.

We continue to meet the expectations of the Equality Act 2010 and the NHS Equality Delivery System 2. Further information about our work in this area is available in UCLH's Equality and Diversity Report.

2.1.10 Income disclosures

In 2018/19, eight per cent of our total operating income was derived from non-NHS income (6.2 per cent in 2017/18).

Surpluses from non-NHS income have been used to support the provision of NHS services.

2.1.11 Disclosure to auditors

So far as UCLH’s directors are aware, there is no relevant audit information of which the auditors are unaware.

The directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

2.2 Remuneration report

2.2.1 Annual statement on remuneration

All decisions regarding the pay of our very senior managers are made by the remuneration committee.

All of UCLH's non-executive directors are members of this committee. It is chaired by the chair of the Board.

The committee is responsible for determining and agreeing, on behalf of the Board, the broad policy for the remuneration of our very senior managers.

The committee is also responsible for considering the performance of the chief executive and executive directors.

In 2018/19, in line with guidance from NHS Improvement, a flat rate consolidated increase of £2,075.00 was offered to very senior managers whose terms and conditions were not covered by nationally-determined contracts.

The medical directors' basic salaries are defined through national agreements for medical and dental staff.

Three medical directors received the nationally-set uplift of 1.5 per cent to base salary in 2018/19, in line with the agreement for medical and dental staff whose terms and conditions are covered by nationally-determined contracts. A fourth medical director is an employee of University College London.

No appointments were made to executive director posts in 2018/19.

We strive to operate with openness and transparency when reviewing and setting the pay levels for senior management.

Baroness Julia Neuberger DBE
Chair

23 May 2019

2.2.2 Senior managers' remuneration policy

The remuneration committee sets pay and employment policy for executive directors and other senior staff on behalf of the Board.

The committee sets basic salary remuneration with due regard to benchmarking information and survey data of other comparative senior posts within the NHS.

NHS foundation trusts are free to determine their own rates of pay for very senior managers (VSMs). However, benchmarking is informed by: the VSM pay framework published by NHS Employers and updated in July 2013; and data provided by NHS Providers and the Shelford Group of NHS teaching trusts.

There is no local consultation with affected employees on VSM pay. However, the framework takes account of the Will Hutton Fair Pay Review and the Senior Salaries Review Body (SSRB) report on pay, which involved wide consultation.

Decisions on any annual uplift to basic salary are informed by government decisions following recommendations from the SSRB. This includes government recommendations on non-consolidated basic pay increases.

We use our Leader Model to review our leaders' abilities to deliver priorities in a manner which demonstrates our values and develops effective working relationships. This assessment will continue to support the short and long term strategic objectives of UCLH.

Senior managers are employed on contracts with a standard six-month notice period and are substantive employees of UCLH.

UCLH's disciplinary policies apply to senior managers, including the sanction of dismissal for gross misconduct.

UCLH's redundancy policy is consistent with NHS redundancy terms for all staff.

No compensation for early termination was paid during this financial year. No early terminations are expected and no accounting provisions are therefore required. No awards have been made to any past senior managers or directors.

There were no benefits in kind paid to executive directors in the year.

The only non-cash element of senior managers' remuneration packages are pension-related benefits accrued under the NHS Pension Scheme. Contributions are made by the employer and employee in accordance with the rules of the national scheme.

The following table includes a description of each component of senior manager remuneration:

Component	Applicable	Description
Basic salary inclusive of London weighting	All senior managers	Agreed at appointment by the remuneration committee.
Clinical Excellence Award (CEA)	Applicable to medical directors only	The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care and to the continuous improvement of NHS services, including those who do so through their contribution to academic medicine.
Additional programme activity	Applicable to medical directors only	The remuneration for this is covered by Schedules 13 and 14 of the Terms and Conditions – Consultants (England) 2003.
Medical director allowance	Applicable to all medical directors	Recognises the increased responsibilities associated with the role of medical director.
Medical on call	Applicable to medical directors only	The on-call availability supplement recognises the time spent being available while on call. It does not recognise the work actually done while on call.

In 2018/19, seven very senior managers were paid in excess of the threshold of £150,000.

UCLH has taken the following steps to satisfy itself that this remuneration is reasonable:

- The remuneration committee sets pay and employment policy for the executive directors and other senior staff designated by the Board.
- The committee sets remuneration with due regard to benchmarking information and survey data of other comparative senior posts within the NHS.
- All non-executive directors are members of the remuneration committee and provide objective scrutiny of salaries set in excess of the threshold.
- A substantial part of the medical directors' remuneration is made up of an NHS consultant's basic salary determined in accordance with NHS national terms and conditions.

The remuneration and expenses for the UCLH chair and non-executive directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as NHS Providers.

In 2018/19, the Council reviewed the remuneration of the non-executive directors as it had remained at the same level for five years. The Council agreed that the remuneration of non-executive directors should increase from £13,140 a year to £14,000 a year from 1 July 2018 to 31 March 2019, and to £15,000 a year from 1 April 2019. No changes were made to the remuneration for the chair and to the additional responsibility allowance for the chair of the audit committee.

2.2.3 Annual report on remuneration

Senior manager remuneration

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

Note: all salary paid in the year is reflected in the first column. The table also shows the notional increase / (decrease) in pension-related benefits (see note below). Therefore the final column should not be interpreted as the total salary paid in the year.

	Year Ended 31 March 2019				Year Ended 31 March 2018			
Name and Title	**TOTAL Salary and Fees** (bands of £5000)	*Taxable Benefits and Bonuses* (bands of £5000)	*Notional Increase / (Decrease) in Pension-Related Benefits (see note below)* (bands of £2500)	*Total Including Notional Increase in Pension-Related Benefits* (bands of £5000)	**TOTAL Salary and Fees** (bands of £5000)	*Taxable Benefits and Bonuses* (bands of £5000)	*Notional Increase / (Decrease) in Pension-Related Benefits (see note below)* (bands of £2500)	*Total Including Notional Increase in Pension-Related Benefits* (bands of £5000)
R Murley Chairman To Dec 2017	-	-	-	-	45-50	-	-	45-50
D Prior Chairman From Jan 2018 to 31 Oct 2018	35-40	-	-	35-40	20-25	-	-	20-25
J Neuberger Chairman From 25 Feb 2019	5-10	-	-	5-10	-	-	-	-
H Bush Non-Executive Director Interim Chair (1 Nov to 24 Feb)	30-35	-	-	30-35	10-15	-	-	10-15
R Makarem Non-Executive Director	15-20	-	-	15-20	15-20	-	-	15-20
K Murphy (To Dec 2018) Non-Executive Director	5-10	-	-	5-10	10-15	-	-	10-15
C Woolley Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
J Collins Non-Executive Director From Nov 2018	5-10			5-10				
J Bajwa Non-Executive Director From Sep 2018	5-10	-	-	5-10	-	-	-	-
C Gerada Non-Executive Director From Sep 2018	5-10	-	-	5-10	-	-	-	-
D.Walford Non-Executive Director To Nov 2017	-	-	-	-	5-10	-	-	5-10
D Lomas Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
A Efunshile Non-Executive Director From May 2016	10-15	-	-	10-15	10-15	-	-	10-15
M Levi Chief Executive From Jan 2017	270-275	10-15	-	280-285	270-275	-	-	270-275
N Griffiths Deputy Chief Executive to Aug 17	-		-	-	70-75		12.5-15	80-85
T Jaggard Finance Director	180-185		-	180-185	180-185		97.5-100	275-280
G Bellingan Medical Director	215-220		37.5-40	255-260	215-220		(47.5)-(45)	170-175
C House Medical Director	180-185		130-132.5	310-315	175-180		80-82.5	255-260
G Gaskin Medical Director	205-210		12.5-15	220-225	205-210		25-27.5	235-240
A Mundy Medical Director	155-160		-	*155-160*	155-160		-	*155-160*
F Panel-Coates Chief Nurse	160-165		7.5-10	165-170	160-165		40-42.5	200-205
B Morrin Workforce Director	125-130		75-77.7	*200-205*	120-125		25-27.5	*145-150*

Pension-related benefits are intended to show the notional increase or decrease in the value of directors' pensions, assuming the pension is drawn for 20 years after retirement. It is

calculated as 20 x annual pension increase + lump sum increase, less any employees' pension contributions paid in the year.

These increases are then adjusted for inflation to show the "real" increase in pension-related benefits – this may be negative where the inflation adjustment is greater than the underlying increase.

Medical directors' salaries include payment for both their director role and NHS clinical work.

In May 2018, our remuneration committee agreed that Professor Marcel Levi should receive £15,000 in performance related pay as he had met his performance targets in 2017/18. Professor Levi received the £15,000 in 12 monthly instalments in 2018/19.

Professor Levi is not participating in the NHS Pension Scheme.

Professor Levi is provided with accommodation by UCLH Charity. This is not included in the disclosures above.

Details of expenses paid to directors and governors are included in section 2.1.1 and section 2.1.2.

Senior manager pension entitlements

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

Name and title	Real increase/ (decrease) in pension at age 60 (bands of £2500) £000	Real increase/ (decrease) in pension lump sum at age 60 (bands of £2500) £000	Total accrued lump sum at age 60 at 31 March 2019 (bands of £5000) £000	Total accrued pension at 31 March 2019 (bands of £5000) £000	Cash equivalent transfer value (CETV) at 31 March 2018 £000	Real increase/ (decrease) in cash equivalent value £000	Cash equivalent transfer value (CETV) at 31 March 2019 £000
G Bellingan Medical Director	42.5-45	5-7.5	190-195	60-65	1,725	5	1,730
G Gaskin Medical Director	37.5-40	5-7.5	95-100	30-35	676	128	804
C House Medical Director	142.5-145	10-12.5	125-130	50-55	738	237	975
F Panel-Coates Chief Nurse	20-22.5	-2.5-0	105-110	45-50	670	(3)	667
B Morrin Workforce Director	92.5-95	0	0-5	50-55	498	155	653

The information above is based on that provided by the NHS Pension Agency.

Cash equivalent transfer values (CETVs) are stated as actual values, with the increase / (decrease) figure adjusted for inflation.

CETVs are shown as zero for directors aged over 60 at the end of the year, as these directors are not permitted to transfer their pensions.

Real increase / (decrease) in pension and related lump sum is the increase / (decrease) in annual pension compared to 31 March 2018, adjusted for inflation.

Total accrued pension at 31 March 2019 is the annual pension that each director has accrued, including any purchase of added years and transferred-in benefits from other employments. No additional benefit is payable in the event that a director retires early and no director is a member of a separate pension scheme in relation to this employment.

NHS Pensions is still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Fair pay multiple

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

	2018/19	**2017/18**
Band of highest paid director's total remuneration	280-285	270-275
Median pay remuneration (£)	36,692	37,179
Fair pay multiple	7.8	7.3

The remuneration of the highest paid director in 2018/19 was in the band £280k- £285k (2017/18, £270k-£275k). This was 7.8 times the median remuneration of the workforce, which was £36,692 (2017/18, 7.3 times and £37,179).

In 2018/19, no employees received remuneration in excess of the highest-paid director (2017/18, none).

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

Professor Marcel Levi
Chief executive

23 May 2019

2.3 Staff report

2.3.1 Staff costs

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

	2018/19 Year ended 31 March Total £000		2017/18 Year ended 31 March Total £000	
	Permanent staff	**Other staff**	Permanent staff	Other staff
Salaries and wages	386,212	58,330	351,971	68,750
Employers' National Insurance contributions	42,464	0	38,898	0
Apprenticeship levy	1,869	0	1,449	0
Employer contributions to NHS Pension Scheme	44,963	0	42,458	0
Pension cost - other	8	0	16	0
Total excluding agency staff	**475,516**	**58,330**	434,792	68,750
Salary cost recharges	(5,694)	0	(5,072)	0
Agency staff	0	10,158	0	7,903
Total employee costs	**469,822**	**68,488**	429,720	76,653
Less: employee costs charged to capital	11,959	0	5,628	0
Total employee costs	**457,863**	**68,488**	424,092	76,653

(See note 4 in the annual accounts)

2.3.2 Staff numbers

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

Average number of whole time equivalent (WTE) employees (including bank and agency staff):

	2018/19	2017/18
Medical and dental	1,476	1,411
Ambulance staff	5	8
Administration and estates	2,077	2,030
Healthcare assistants and other support staff	881	817
Nursing, midwifery and health visiting staff	3,346	3,174
Nursing, midwifery and health visiting learners	14	15
Scientific, therapeutic and technical staff	1,107	1,065
Healthcare science staff	394	374
Total average numbers	**9,300**	**8,894**
Of which:		
Number of employees (WTE) engaged on capital projects	203	54

Table notes:

- Table does not include employees who have honorary contracts with UCLH.
- Bank and agency WTE numbers have been allocated to the relevant occupational categories. In 2018/19 the average number of bank and agency WTEs was 1,036. (In 2017/18 the average number was 983.)
- The rise in the number of employees engaged in capital projects is related to the implementation of our electronic health record system and the ongoing development of two new clinical facilities. For further information see section 1.1.3 Strategic developments.

2.3.3 Staff gender analysis

Headcounts as at 31 March 2019	Male	Female	Total
Directors	9	7	16
Other senior managers	29	37	66
Other staff	2,651	6,580	9,231

Headcounts as at 31 March 2018	Male	Female	Total
Directors	12	4	16
Other senior managers	34	35	69
Other staff	2,612	6,262	8,874

Table notes:

- Tables include clinical staff with honorary contracts which have a cost implication for UCLH.
- Tables do not include bank and agency staff.

2.3.4 Sickness absence data

	Sickness absence rate % 2018/19	Sickness absence rate % 2017/18
Medical and dental	0.8	1.0
Administration and estates	3.9	3.7
Healthcare assistants and other support staff	6.3	5.4
Nursing, midwifery and health visiting staff/learners	3.7	3.8
Scientific, therapeutic and technical staff	3.3	2.5
Healthcare science staff	3.0	2.1
Total	**3.4**	**3.3**

2.3.5 Recruitment and retention

Recruitment

We have developed an evidence-based strategy to recruit and retain staff in an increasingly competitive UK and international labour market. Our strategy builds on our successful 2016/17 recruitment campaign which won a national award from the Chartered Institute of Personnel and Development and we continue to implement this strategy in 2018/19.

Our vacancy rates remain below the average for the capital and our workforce continues to grow. Vacancy levels decreased through the year from 10.5 per cent on 1 April 2018 to seven per cent on 31 March 2019. However, recruiting as many staff as we need remains difficult.

Across the country, specialisms such as emergency medicine, anaesthesia, theatres, critical care, neonatology and medical imaging are hard to recruit to areas. In these specialisms, we rely on recruits from outside the United Kingdom to fill key vacant positions, as well as temporary staff to fill some, short notice, rota gaps. In the longer term, national workforce transformation will be key to addressing the challenges around hard to recruit to specialisms.

The uncertainty around Brexit is likely to impact on a number of areas across health and social care; with workforce being the most significantly affected. Fourteen per cent of our workforce are nationals of mainland European Union (EU) countries and the Republic of Ireland. We have seen an increase in leavers since the referendum in June 2016. In 2018/19 we saw fewer EU starters than in previous years.

We continue to recruit internationally in order to support a pipeline of new nursing staff into the organisation and undertook two trips to the Philippines in 2018/19.

We greatly value the diverse mix of cultures, skills and experience all of our staff from overseas bring to our organisation and they are essential to the delivery of our services.

We use social media to showcase services and staff in areas where we want to recruit. This year we ran social media campaigns to attract talent and reduce our vacancy rate in hard-to-recruit areas. Our campaigns are designed and fronted by our staff. We have also used technology to expand our reach and are currently piloting assessments via Skype. We plan to increase our use of technology in the coming year.

In 2018/19, the average time it took to hire a new member of staff (excluding notice period) was 10 weeks (13.7 weeks in 2017/18).

We have also worked towards ensuring there is no discrimination in the recruitment process so that all staff, including those with protected characteristics, have an equal chance of being selected.

Retention

We continue to run career clinics to encourage existing staff to transfer to other posts within UCLH, rather than seeking promotion elsewhere. These clinics have overseen the transfer of more than 48 nurses to new roles within UCLH this year. The schemes enable nurses to move within the organisation so that they can gain experience in a different specialty at their current band.

A fully automated digital exit survey was introduced across UCLH in January 2019. This survey will help us to better understand the experience of all our staff regardless of their background or profession.

Our staff turnover rate has fallen from 13.4 per cent in March 2018 to 13.0 per cent in March 2019.

In 2018 we worked with Ipsos MORI to identify the key factors which will aid retention. The findings have informed our staff experience action plan. In November 2018 we ran a workshop with Ipsos MORI focused on the action we can take with neighbouring employers from our Sustainability and Transformation Partnership (STP).

2.3.6 Staff policies and actions

Health and safety

Our health and safety committee meets quarterly to review information on incidents and injuries and ensures learning is shared across the organisation. Incidents and injuries involving exposure to blood-borne viruses are reviewed by the infection control committee which meets quarterly.

We have a combined health and safety policy with a comprehensive handbook to support staff and managers.

We have undertaken our ninth risk assessment audit which included:

- staff, outpatient and visitor slips, trips and falls
- manual handling
- violence and aggression
- control of substances hazardous to health
- lone working
- stress

The audit checked whether risk assessments were up-to-date, had been risk rated and placed on the appropriate risk register. Detailed feedback was provided to each division.

The health and safety committee is focusing on the most significant risks to safe working as a central London trust. Reducing assaults and violence is a priority, supported by our in-house training programme.

Raising concerns (whistleblowing)

We encourage staff to raise concerns with senior managers about patient safety, criminal offences, breaches of legal obligations, miscarriages of justice, damage to the environment or the deliberate concealment of information. Our Raising Concerns policy guides this process. We provide an external Guardian Service which offers independent and confidential advice to support staff to raise issues with senior management.

Counter fraud, anti-bribery and corruption

UCLH takes a zero-tolerance approach towards fraud and bribery and will prosecute in this area wherever possible.

Our counter fraud team works to investigate and prevent fraud and bribery, and ensure that adequate procedures are in place.

We have an Anti-Fraud and Bribery policy and our counter fraud team gives advice to staff on how to be on the alert for, and report fraud, bribery and corruption as quickly as possible.

Equality and diversity

See section 2.3.14 Equality reporting (staff).

2.3.7 Staff engagement

As well as keeping staff updated about news and developments, we seek to actively engage staff and ensure their views are listened to and acted upon. We engage staff in our values through our awards programme and support health and wellbeing through a number of initiatives. Our main staff engagement mechanisms are outlined below:

Staff communication

UCLH-wide communications include:

- Team Brief: the chief executive's monthly briefing delivered by managers to their teams who are encouraged to discuss the content. It ensures that all staff get the same messages within the same time frame.

- UCLH Magazine: our quarterly magazine available for staff, patients and foundation trust members. The magazine received a highly commended award at the Corp Communications Awards 2018.

- Insight: our intranet is updated daily with articles about our staff and services. There is also a mechanism for staff to comment and engage in online conversation. We are currently redeveloping our intranet to make this accessible on mobile devices, meaning access for all staff will become easier.

- Meet the CEO sessions: these are open to all staff and held on each hospital site. The chief executive delivers a presentation followed by a question and answer session.

- Team meetings: where staff are kept informed and can discuss matters at a local level.

- Social media: Twitter, Facebook, Instagram, LinkedIn and YouTube.

- Staff surveys

- Staff suggestion scheme

Staff friends and family test

In quarters two and four we emailed all staff to ask whether they would recommend UCLH as a place to work and be treated to family and friends.

An average of 90 per cent of respondents across the two quarters said they would recommend UCLH as a place to be treated.

An average of 71 per cent said they would recommend UCLH as a place to work.

In quarter three the friends and family test questions are asked as part of the NHS staff survey.

Celebrating Excellence Awards

Our Celebrating Excellence Awards programme recognises exceptional work by staff across our hospitals. We are extending the numbers of places available to staff at our awards ceremony and have introduced two new categories:

- The first highlights our apprentices at UCLH. This will include recruited apprentices and existing staff undertaking an apprenticeship qualification.

- The second is the “EHRS champion award” for outstanding contribution to the electronic health record system (EHRS) programme. The award recognises an individual or team who have demonstrated considerable achievements in supporting the implementation of EHRS.

Staff partnership

Our partnerships with unions and representative bodies are important to us. UCLH’s management and staff representatives meet every two months to review policies.

Our Joint Partnership Forum (JPF) has used our staff suggestion scheme to design and introduce new staff initiatives.

Staff health and wellbeing

Our programmes for health and wellbeing have focused on the main causes of premature mortality and ill health, encouraging physical exercise and balanced diets, tackling smoking and addressing the risks to the mental health and resilience of our staff.

Last year UCLH was presented with the Healthy Workplace achievement award by the Mayor of London demonstrating that we are committed to providing healthy workplace initiatives.

Around 600 staff took part in our annual pedometer challenge and staff and patients were encouraged to use the stairs, rather than the hospital lifts.

The occupational health team and the 52 Club (our staff fitness centre) continue to run the award-winning 4WeekForward health and fitness programme. The programme provides four weeks of free specialist support to staff with musculoskeletal or mental health problems. The 52 Club also launched nutrition week with special speakers and workshops providing tips on healthier eating.

Improving psychological wellbeing and removing the stigma surrounding mental health issues in the workplace was a top priority for the staff psychological and welfare service. The service provides bespoke workshops to help equip managers with the skills to manage the wellbeing of staff. They teach managers about different mental health issues, how to spot early warning signs that a colleague is suffering from mental ill health and what steps to take to support them.

In autumn 2018 we launched a mental health network to create a safe space for staff to discuss practical ideas on how to raise awareness in this area and develop a supportive organisational culture. The network is run by staff, for staff, and includes talks and activities to help keep members up-to-date with mental health news. The network will also be involved with drafting a new UCLH mental health policy.

We marked World Mental Health Day with a special event. Staff from the service discussed how to spot the early signs of a mental health problem and how to help a colleague access the support they need.

We have also provided staff with free subscriptions to the mindfulness app, Headspace.

2.3.8 Education and training

See section 1.1.4 Education and training.

2.3.9 NHS staff survey: results and actions

Results

The results of the 2018 NHS staff survey show that UCLH remains a place that the great majority of staff would recommend as a place to work or be treated.

Overall UCLH remains above the national average for staff engagement, a measure closely linked to patient experience. In particular:

- 82 per cent of staff said they would be happy for a friend or relative to be treated here (83 per cent in 2017/18). The national average was 71 per cent.
- 69 per cent of staff would recommend UCLH as a place to work (71 per cent in 2017/18). The national average was 63 per cent.
- 83 per cent of staff agreed that the care of patients is UCLH's top priority (83 per cent in 2017/18). The national average was 77 per cent

The survey response rate was as follows:

	2018		**2017**		
	UCLH	National average	UCLH	National average	UCLH % change
Response rate	37%	44%	40.5%	44%	-3.5%

A total of 3,113 staff (37 per cent) completed the 2018 survey, compared to 3,307 staff (40.5 per cent) in 2017. We believe some of this decrease occurred because we were running additional staff surveys as part of our electronic health record system (EHRS) programme.

The results from the questions were grouped into ten themes. Each of the themes was scored out of ten. Our scores, and the average scores of all acute trusts, were as follows:

	2018		2017		2016	
	UCLH	Acute trust average	UCLH	Acute trust average	UCLH	Acute trust average
Equality, diversity and inclusion	8.3	9.1	8.6	9.1	8.7	9.2
Health and wellbeing	5.6	5.9	6.0	6.0	6.0	6.1
Immediate managers	6.7	6.7	6.8	6.7	6.8	6.7
Morale	5.9	6.1	N/A	N/A	N/A	N/A
Quality of appraisals	5.9	5.4	6.2	5.3	6.0	5.3
Quality of care	7.5	7.4	7.6	7.5	7.6	7.6
Safe environment – bullying and harassment	7.3	7.9	7.5	8.0	7.5	8.0
Safe environment – violence	9.5	9.4	9.5	9.4	9.5	9.4
Safety culture	6.7	6.6	6.8	6.6	6.8	6.6
Staff engagement	7.2	7.0	7.2	7.0	7.2	7.0

Actions

We recognise that some areas of concern in the staff survey results have seen little improvement in the past year.

We know that a large proportion of staff concerns, whether raised through formal or informal routes, relate to a lack of courtesy among colleagues and teams.

In 2019/20, we will focus on creating a more supportive culture which reinforces our organisational values of safety, kindness, teamwork and improving. We will pay particular attention to areas where staff are reporting having a relatively poor experience of working at UCLH.

We will do the following:

- launch five key pledges that demonstrate our commitment to supporting staff and which will provide a framework for developing a staff experience strategy

- strengthen our leadership development programme to encourage modelling of behaviour in line with our values

- undertake a detailed review of areas with relatively poor staff experience to identify the support needed to make improvements. The workforce director and the relevant director of each area will lead this.

- focus on delivering the actions of our equality and diversity plan to improve the experience of staff with protected characteristics under the Equality Act 2010.

We will monitor both awareness and impact of these actions throughout the coming year. This will be done through a variety of methods, including brief all staff surveys, focus groups and qualitative feedback.

2.3.10 Trade unions

The following four tables are published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017.

Table 1: Number of relevant trade union officials

	2018/19	**2017/18**
Total number of employees who were relevant trade union officials	35	34
Total WTE employees who were relevant trade union officials	34.69	33.8

Table 2: Percentage of time spent of facility time

Percentage of working hours spent on facility time	**Number of employees 2018/19**	**Number of employees 2017/18**
0%	0	0
1-50%	33	32
51%-99%	0	1
100%	2	1

Table 3: Percentage of total pay bill spent on facility time

	2018/19	2017/18
Total cost of facility time	£129,768	£80,442
Total pay bill*	£475,508,000	£434,777,000
Percentage of total pay bill spent on facility time	0.03%	0.02%

* Excluding bank and agency costs

Table 4: Percentage of time spent on trade union activities

	2018/19	2017/18
Total hours spent on paid trade union activities by relevant trade union officials	3,858	2,974
Total paid facility time hours	3,858	2,974
Percentage of total paid facility time spent on trade union activities	100%	100%

2.3.11 Expenditure on consultancy

In 2018/19 expenditure on consultancy was £4.3m, compared to £3.9m in 2017/18.

2.3.12 Off-payroll engagements

There were no off-payroll engagements as of 31 March 2019 for more than £245 per day and that lasted longer than six months.

There were no new off-payroll engagements, or any that reached six months in duration between 1 April 2018 and 31 March 2019, for more than £245 per day and that lasted longer than six months.

The following table details 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 officials with significant financial responsibility during the financial year	0
Number of individuals that have been deemed ‘Board members and/or senior officials with significant financial responsibility’ during the financial year.	7

2.3.13 Exit packages

In 2018/19 UCLH agreed the following exit packages:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	0	5	5
£10,000 – £25,000	0	0	0
£25,001 – £50,000	0	1	1
£50,001 – £100,000	0	0	0
Total by type	**0**	**6**	**6**
Total resource cost	**£0**	**£64,000**	**£64,000**

In 2017/18 UCLH agreed the following exit packages:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	0	8	8
£10,000 – £25,000	2	1	3
£25,001 – £50,000	0	0	0
£50,001 – £100,000	1	0	1
Total by type	**3**	**9**	**12**
Total resource cost	**£102,000**	**£64,000**	**£166,000**

2.3.14 Equality reporting (staff)

We are committed to the principles of equality and fairness for our staff and have made good progress in the past year in promoting diversity, equality and inclusion.

The characteristics of our workforce are broadly consistent with our local communities in terms of religion and ethnicity. We have more female employees and staff from black, asian and minority ethnic (BAME) backgrounds compared to the local population.

Following a campaign to ask staff to update their personal information held on our electronic staff record system, we now have more accurate data about the characteristics of our workforce.

Information about the importance of equality, diversity and inclusion is included in staff induction and we regularly audit data on new starters.

The Starting at UCLH policy sets out how we give full and fair consideration to job applications made by disabled people. UCLH is a Disability Confident Employer and guarantees that disabled candidates that meet the minimum criteria for a position will be interviewed. We regularly analyse the data relating to applications, shortlisting and appointments as a way of monitoring whether our recruitment processes are fair and equitable.

We make reasonable adjustments to working arrangements for disabled staff and those who become disabled. We provide suitable opportunities for training, career development and promotion, in line with our Training, Development and Study Leave policy.

We publish the Workforce Race Equality Scheme (WRES) annually, as required by NHS England. We publish quarterly updates on key indicators to managers and the Board so that we can identify emerging trends. There is a detailed action plan monitored by the diversity and equality steering group and the WRES is included in the annual equality report.

Our priorities in 2018/19 were to:

- Introduce new systems and processes to ensure that BAME staff are not more likely to be the subject of formal disciplinary processes than their white colleagues. This includes triage and enhanced mediation support.

- Ensure that recruiting managers have access to training materials so that they are aware of the impact of unconscious bias.

- Continue to support the development of our staff networks: BAME, Women in Leadership, and Lesbian, Gay, Bisexual and Transgender (LGBT).

- Continue to improve the quality of information held on our staff to gain a better understanding of the needs of staff with protected characteristics and consider what we can do to improve their experience of working at UCLH.

- Introduce ways of further supporting staff who are experiencing bullying, harassment or abuse.

- Improve learning and development opportunities for staff with protected characteristics.

Almost 46 per cent of our staff are from a BAME background, yet this representation is not spread equally across all professions or grades. Clinical and non-clinical staff in Agenda for Change (AfC) posts at band five and below are predominantly BAME. The proportion of BAME staff in band six posts and above, however, reduces as you progress up our banding structure. For medical and dental staff, 40 per cent of doctors-in-training have a BAME background, whereas 31 per cent of consultants are BAME.

To increase the representation of BAME staff at higher bands in the organisation we are recruiting an administrative support officer to work with the BAME network to focus on creating more training and development opportunities for these staff.

UCLH published its second gender pay report in March 2019. The report is available on our website via the following link: www.uclh.nhs.uk/genderpayreport

We are committed to the principles of equality and fairness for our patients and work with different communities to deliver better patient care that is inclusive, accessible and fair. See section 2.1.9 Equality reporting (patients).

2.4 Code of Governance disclosures

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

Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.

Code reference	**Section**
A.1.1.	2.1.1 UCLH Board and committees 2.1.2 Governors and members
A.1.2	2.1.1 UCLH Board and committees 2.1.2 Governors and members
A.5.3	2.1.2 Governors and members
Additional requirement	2.1.1 UCLH Board and committees 2.1.2 Governors and members
B.1.1	2.1.1 UCLH Board and committees
B.1.4	2.1.1 UCLH Board and committees
Additional requirement	2.1.1 UCLH Board and committees 2.1.2 Governors and members
B.2.10	2.1.1 UCLH Board and committees 2.1.2 Governors and members
Additional requirement	2.1.2 Governors and members We used one external search consultancy and open competition for the role of chair. We used another external search consultancy and open competition for the appointment of four non-executive directors.
B.3.1	2.1.1 UCLH Board and committees
B.5.6	2.1.2 Governors and members
Additional requirement	Not applicable
B.6.1	2.1.1 UCLH Board and committees
B.6.2	Not applicable
C.1.1	2.6 Statement of accounting officer's responsibilities
C.2.1	1.1.6 Key risks to delivering our strategic objectives 2018/19 2.7 Annual governance statement
C.2.2	2.1.1 UCLH Board and committees

Code reference	Section
C.3.5	2.1.1 UCLH Board and committees Not applicable, the Council accepted audit committee's recommendation
C.3.9	2.1.1 UCLH Board and committees
D.1.3	2.2 Remuneration report 2.1.1 UCLH Board and committees
E.1.4	2.1.1 UCLH Board and committees 2.1.2 Governors and members
E.1.5	2.1.2 Governors and members
E.1.6	2.1.2 Governors and members
Additional requirement	2.1.2 Governors and members
Additional requirement	2.1.1 UCLH Board and committees 2.1.2 Governors and members
A.4.1	Plans to appoint a senior independent director (SID) in 2018/19 were postponed following the resignation of Lord Prior as chair. This will be revisited in 2019/20.
B.1.2	The Board considers all its non-executive directors to be independent in character and judgement. They are also all independent of management, with the exception of Professor David Lomas, vice provost of UCL, who holds an honorary contract with UCLH.
B.6.3	See code reference A.4.1 above. The Board has not yet appointed a SID. The chair's annual evaluation is undertaken jointly by a governor (chair of the Council's nomination and remuneration committee) and the vice chair (a non-executive director).
D.2.3	UCLH partially meets the provision in D.2.3 relating to the market-testing of remuneration levels for non-executive directors and the chair. UCLH participates in NHS Providers remuneration surveys and other industry benchmarking exercises. However, it would approach advisors were it to consider a material change to remuneration.

2.5 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

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

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

Segmentation

We are currently in segment 2. This reflects our good rating from the Care Quality Commissions (CQC).

We were not placed in segment one because we did not achieve the emergency department four-hour waiting time standard or the 62-day referral to treatment cancer waiting time standard.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score for finance and use of resources. This is used by the regulator to determine the level of support the provider requires. Our overall score of a 1, in line with 2017/18, places us in the lowest risk category from a regulatory perspective with no, or limited, support needs.

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

2.6 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of University College London Hospitals NHS Foundation Trust.

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

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

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

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

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

- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose, with reasonable accuracy at any time, the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Professor Marcel Levi
Chief executive

23 May 2019

2.7 Annual governance statement

Scope of responsibility

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

The Board of Directors (Board) is accountable for internal control. I have overall accountability for risk management at UCLH. The control of risk is defined in the management roles of the executive directors, particularly the corporate medical director who leads on clinical risk and the medical directors of the medicine, surgery and cancer, and specialist hospitals boards, who have responsibility for the delivery of operational services.

Levels of accountability and responsibility are set out in the UCLH Risk Management Policy and Procedure. The risk register and risk process is overseen by the risk coordination board (RCB), an executive subcommittee chaired by the director of planning and performance, reporting to the senior directors' team (SDT).

To ensure that risk management is not seen only as an issue to be addressed within UCLH, working arrangements are in place with stakeholders and partner organisations, including with Clinical Commissioning Groups (CCGs) and NHS England (together our commissioners), University College London and other key partner organisations to provide a comprehensive range of clinical and non-clinical support services. These cover both operational and strategic issues such as service planning, performance management, research, education and clinical governance. The Risk Management Policy and Procedure defines the process for capturing risks both locally and strategically. It also defines the Trust's risk appetite.

A board assurance framework (BAF) has been used at UCLH for eight years. The central purpose is to set out the strategic themes of UCLH for the year, identify principal risks against them, the controls and any gaps in control, the assurances and gaps in assurances, and the action plans to remedy such gaps. The BAF is reviewed quarterly by the RCB, SDT and the Board.

Processes for auditing and monitoring clinical activity are in place in all the clinical divisions. Clinical processes are updated when national guidance is published or in response to adverse events and national safety notices, such as via the Central Alerting System (CAS). Sub-committees of the quality and safety committee (QSC) monitor implementation of the National Institute for Health and Care Excellence (NICE) guidance and recommendations by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the corporate clinical audit programme. Standard clinical data sets are established, including areas of performance such as emergency readmissions. These are assessed on a monthly basis by the QSC via the performance pack.

The audit committee reviews risk and control-related disclosure statements prior to endorsement by the Board, and the effectiveness of the management of the principal strategic and top operational risks identified by UCLH.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of UCLH; 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 at UCLH for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

The system of internal control is based upon a number of individual controls – for example, policies and procedures covering important business activities, how staff are appointed and managed, the Standing Orders, Standing Financial Instructions and Scheme of Delegation that are used to govern UCLH. In addition there are checks and balances inherent in internal and external audit reviews, SDT and UCLH Board oversight.

Capacity to handle risk

The SDT brings together the corporate, financial, workforce, clinical, information and research governance risk agendas. The BAF ensures that there is clarity over the risks that may impact UCLH's ability to deliver its strategic themes together with any gaps in control or assurance.

There are internal processes to ensure that incidents which fit the national criteria for serious incidents are reported on the Department of Health and Social Care's Strategic Executive Information System (STEIS). The QSC has oversight of serious incidents and receives a monthly report on serious incidents declared and reports completed that month. A quarterly report on serious incidents is provided to the QSC, a sub-committee of the Board, and a monthly update and quarterly report to commissioners. A report is also provided to governors three times a year.

Board members receive training in risk management awareness and an overview of the risk systems. Staff receive online training in risk at induction. The risk manager also provides one-to-one and group training, as required. Guidance on risk management is available on the UCLH intranet. Good practice is shared through the RCB.

The risk and control framework

The Risk Management Policy and Procedure is available to all staff on the UCLH intranet. UCLH uses risk management software as a repository for risks. This assists in the production of risk reports and helps staff manage local risk registers. Risk reports, including the top risks, are reviewed quarterly by the RCB and SDT with oversight from the audit committee.

UCLH reviews the most significant risks and the associated risk management plans based on the highest graded risks on the risk register. The RCB reports to the SDT after each meeting. The audit committee and the Board consider a BAF report and risk report on a quarterly basis.

The Risk Management Policy and Procedure defines what risks need to be escalated to the next management level, as well as defining the level of risk which must be referred to the

RCB and the UCLH Board. Risks are classified as low, moderate, high and very high, based on a consequence and likelihood matrix approved by the Board. The risk appetite is such that any very high risks are managed at clinical board level or by the Board and high risks are managed at divisional level.

The QSC is responsible for ensuring that effective arrangements are in place for the oversight and monitoring of all aspects of clinical quality and safety, including identifying potential risks to the quality of clinical care. The Board relies on the committee to provide advice on clinical quality, patient safety and risk, and for assurance on areas of clinical governance and audit. It focuses on promoting a culture of openness and organisational learning. On behalf of the Board, it reviews compliance and receives assurance in meeting regulatory standards set by the Care Quality Commission (CQC).

In compliance with the regulations of the Health and Social Care Act, UCLH has registered twelve locations and nine registerable activities, approved by the Board.

Internal audit and counter fraud activities

The results of internal audit reviews are reported to the audit committee which takes a close interest in ensuring system weaknesses are addressed. Improved procedures are in place to monitor the implementation of control improvements and to undertake follow up reviews where systems were deemed less than adequate. An internal audit tracking system is in place which records progress in implementing the agreed recommendations. Progress in implementing corrective action is reported to the audit committee, and the SDT also receives regular reports on outstanding high and medium rated actions. The counter fraud programme is led by the finance director and monitored by audit committee.

During 2018-19, fifteen internal audit reviews were completed, with three receiving partial assurance ratings. Two high risk recommendations were raised during the year, which the Trust is actively working to implement. Overall, the head of internal audit opinion was that the adequacy and effectiveness of the organisation's framework of governance, risk management and control provided significant assurance with minor improvement opportunities.

Information governance

UCLH has a records and information governance group (RIGG) which is chaired by the Caldicott Guardian. This group reports to the digital services delivery board (DSDB). The DSDB reports to the senior directors' team (SDT) and is chaired by the director of digital services who is the senior information risk officer (SIRO) for UCLH.

The Data Security and Protection Toolkit (DSPT) has replaced the Information Governance Toolkit. The DSPT is based on the National Data Guardian's ten data security standards and consists of forty assertions which the Trust needs to be compliant with. The RIGG and DSDB oversee our DSPT annual assessment and action plan. The HSCN Connection Agreement replaced the N3 Information Governance Statement of Compliance (IGSoC).

The toolkit includes a requirement to undertake an annual "data mapping" exercise to assess all routine data flows within UCLH and between UCLH and any third party. UCLH is making good progress on improving its overall DSPT attainment.

The DSPT submission for 2018/19 will be shown as 'Standards not fully met (Plan Agreed)'. The toolkit was submitted with an improvement plan for the six assertions that were not fully met.

Data security risks are managed via an information governance framework, which comprises an Information Governance Policy, related policies and guidance and the RIGG.
In particular, the Information Risk Policy sets out a structured approach to information risk management which is integrated with our broader risk management arrangements. This includes the appointment of the SIRO, information asset owners and information asset administrators.

Information risk identification is supported by the maintenance of an information asset register and regular information mapping exercises. Any significant risks identified from these processes are included in our risk register and will be subject to formal management attention.

UCLH operates in a complex environment and exchanges data with a number of organisations and we continue to prioritise activities to reduce the risk of data loss or accidental disclosure of personal data.

Information governance policy and guidance is continually reviewed and training and awareness raising programmes target all our staff. Information governance training includes an assessment of understanding of key aspects of policy and assessment scores indicate the success of awareness raising activities.

Strengthened technical controls will result in a reduction of risk of specific types of data loss. Any breach that is likely to result in a high risk to individuals' rights and freedoms should be reported via the Data Security and Protection incident reporting tool. Similarly, under the Security of Network and Information Systems Regulations 2018 any network and information systems incident which has a 'significant impact' on the continuity of our essential service should be reported via the DSP incident reporting tool. For 2018/19 UCLH did not report any incidents via the tool.

Major risks

UCLH has described the principal strategic risks that it faces in the annual report. The most serious strategic risks relate predominantly to financial sustainability, in particular the risk that unachievable efficiency targets or control totals are imposed on UCLH and are greater than can be achieved through our cost improvement programmes. There is the further risk that the tariff will not appropriately compensate UCLH for the complex, specialist work that is undertaken and the risk of non-payment for activity by commissioners.

The main operational risks currently are:

- Emergency Department flow – risk of insufficient bed capacity and operational resilience across the full emergency pathway (at UCLH and in the wider community) to meet the four-hour emergency department target. Despite the pressures UCLH has performed reasonably well compared to other trusts. This will however continue to be an area where we will invest considerable improvement resource.

- Providing cancer treatments within 62 days of referral – risk of not meeting the 62-day cancer waiting times standard. This is due to a combination of factors: higher levels of complexity in the patients seen at UCLH, compared to the national average; impact of patients taking time to make decisions about treatment options on pathways where there is not as much urgency around treatment starting; further improvements are needed in how we track patient pathways so that we can quickly identify patients at risk of not getting their treatment in 62 days; referrals of patients by other providers too late in the pathway for the standard to be met. UCLH has an

improvement plan which tracks the key actions that will shorten the waiting time for treatment for cancer patients.

For further detail of how UCLH is managing these challenges, please see section 1.2.3 Detailed review of our performance.

All the above are current risks to UCLH, but are also expected to continue into the future. The risks associated with financial pressures in the NHS are expected to increase. In particular, there is a risk that planned developments, including new hospital buildings and investment in a new electronic health records system to support UCLH's plan to improve efficiency, have a short to medium-term financial impact. This could risk the Trust's achievement of its control total and other financial targets.

EU exit preparations

We have made preparations through 2018/19 for the potential impact of the UK's exit from the European Union (EU). This includes preparing for the possibility of the UK exiting without a deal.

We are following the recommendations issued by the Department of Health and Social Care in its EU Exit Operational Guidance and are focusing on the following seven areas of activity:

- supply of medicines and vaccines
- supply of medical devices and clinical consumables
- supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials
- data sharing, processing and access.

We have created an EU Exit Operational Readiness Task Force. Our chief nurse, who is our senior responsible officer (SRO) for emergency planning and resilience, and our chief executive, jointly chair this group. The task force reports to senior director's team on a regular basis.

Our board assurance framework and corporate risk register include various risks relating to the UK's exit from the EU, including on our workforce. Fourteen per cent of our workforce are nationals of mainland EU countries and the Republic of Ireland.

We are closely monitoring trends in starters and leavers data to assess any impact from Brexit and/or tighter labour supply in national and international contexts. We have seen an increase in leavers since the referendum in June 2016. In 2018/19 we saw fewer EU starters than in previous years.

Our workforce framework details action to sustain recruitment and aid retention. A supporting retention and recruitment group oversees action.

In 2018/19 our chief executive directly communicated with staff born in mainland EU to assure them of our support during any Brexit process. We have provided free legal support to colleagues wanting to remain in the UK.

We continue to monitor all risks relating to Brexit through our governance and risk frameworks, as well as working closely with NHS England and our suppliers as part of our preparation process.

Foundation trust governance requirements

The Board of Directors sets the vision, values and strategic direction of UCLH and is collectively responsible for the performance of the Trust. The Board agrees its strategy and objectives annually, which are set out in the annual report. The Council of Governors receives regular updates on clinical and financial performance and reports relating to service delivery. Governors input into the annual forward plan and meet separately with the non-executive directors four times during the year. This enables the governors to discharge their duties.

The audit committee oversees and monitors governance including the effectiveness of the risk management system. Internal audit (KPMG) and external audit (Deloitte) work closely with this committee and undertake reviews and provide assurances on the systems of control operating within UCLH.

The finance and investment, QSC and remuneration committees each chaired by a non-executive director provide oversight of UCLH's performance in these areas. Reports providing the assurance are submitted to the Board.

The Board also reviews the risk register and BAF (previously described above) and it receives a report from the SDT, through the chief executive.

The SDT meets regularly to review the performance of its clinical and corporate boards against financial, workforce and clinical indicators. This information forms part of a performance information pack which is reviewed by the Board monthly.

UCLH has a clinical leadership model delivered through four medical directors and its chief nurse. Three of the medical directors manage the operational service through three clinical boards and 17 divisions supported by corporate functions, such as finance and workforce.

UCLH has a well-established performance management framework that ensures that key indicators across a range of the business are scrutinised on a monthly basis, with key exceptions analysed further at clinical team, clinical board and UCLH Board level as appropriate.

Each of the key issues (governance measures, quality, activity levels and efficiency) is discussed at specific sub-board meetings and form sections within the Board performance report.

The Board receives the Board performance pack at its meetings. The QSC also receives a monthly performance report focused on quality issues.

Performance metrics are reviewed on an annual basis to ensure that all national and local priority indicators are included.

The Board can self-certify the validity of its corporate governance statement.

The process for reviewing the effectiveness of the system of internal control has been reviewed by:

- The Board, which has considered the risk report and the management of risks to the delivery of the objectives set out in the BAF
- The audit committee, which has reviewed governance and risk management policies and monitored the implementation of these

- The QSC, which has reviewed compliance against the CQC standards, reviewed clinical audit and clinical governance arrangements
- A number of compliance self-assessments, including from the finance director. This provides assurance on financial performance and the opinions and reports of both internal and external audit.

Stakeholder involvement in risk management

UCLH actively works with key partner organisations across the local health economy. Wherever possible, and where appropriate, it works closely with the partner organisations to identify and mitigate risks that might impact upon them. These include:

- UCL Partners
- The UCLH Cancer Collaborative
- Our joint venture partners
- Our partners in the Sustainability and Transformation Partnership (STP)

UCLH also has well established arrangements in place for engaging with a diverse public, patient and stakeholder community in a number of ways as follows:

- Council of Governors: governor representatives on the nursing and midwifery board, the quality and safety committee
- Governors: participation in walkarounds and Patient-Led Assessment of the Care Environment (PLACE) inspections, clinical excellence award panels
- Public and patients: Annual Members' Meeting; Members' Meets; annual research open event; patient focus groups; residents meetings about our capital developments; patient surveys
- Members: participation in PLACE inspections and on the CQRG
- Overview and scrutiny committees
- Healthwatch
- National and local patient surveys; exhibitions and mail outs; Patient Advisory Liaison Service (PALS) and UCLH Magazine
- Staff: annual staff survey, Meet the CEO sessions, joint staff forum, executive and non-executive walkarounds
- Health Partners: CQRG; integrated care board; GP practice relationship visits and GP newsletter; GP engagement events and seminars, joint strategic and service planning meetings.

Other control measures

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

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

Control measures are in place to ensure that the Trust's obligations under equality, diversity and human rights legislation are complied with. Equality impact assessments are carried out for all new service developments and when reviewing policies.

Risk assessments are undertaken and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects. This ensures that our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Economy, efficiency and effectiveness of the use of resources

Monthly finance and performance reports are presented to the finance and investment committee, SDT and to the Board. UCLH has reported a financial position significantly better than plan in 2018/19, as a result of a number of non-recurrent benefits combined with central matched funding for over-performance against plan.

Internal audit reports consider value for money and Deloitte is required as part of their annual audit to satisfy themselves that UCLH has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion UCLH has not.

All cost improvement plans (CIP) over £100k in value or having an impact on the existing staffing establishment, irrespective of their value, are required to have a quality impact assessment (QIA) undertaken which assesses the potential impact of the plans against four criteria:

- Patient experience
- Patient safety
- Clinical effectiveness
- Performance / inspection / audit / CQUINS

The QIA process uses the risk management methodology in place at UCLH to consider and rank the impact of proposed changes. Once satisfied that all risks have been appropriately considered, and where required, mitigation measures put in place, authorisation to proceed with the CIP is required from the relevant board's divisional manager, deputy chief nurse and medical director.

Quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

There are a number of assurances and controls in place to ensure the quality of data within the quality report, which includes:

- Clearly defined corporate indicators for data quality
- Data quality indicators and reports monitored, validated and provided to clinical divisions
- Guidance on data quality in the Data Capture Policy and Access Policy
- Performance is monitored at senior directors' team meeting, elective access board and QSC
- Clinical Boards monitor and manage performance
- Clinical and quality data is reported to the Board and scrutinised and challenged at Board sub-committees, including an annual review of controls and assurances for the

chief executive's performance report metrics. The annual data quality assurance report to the audit committee includes a kite mark dial assessment for each performance indicator. Each year we have a programme of actions that we implement to improve our data quality

- Data quality is audited internally and externally
- Data quality is scrutinised routinely by commissioners
- External assurance statements on the Quality report are provided by our local commissioners, overview and scrutiny committee (OSC) and our local Healthwatch, as required by Quality Account Regulations. The UCLH Council of Governors also provide a statement

The Board has regularly reviewed the Trust's performance on referral to treatment (RTT), diagnostics, emergency department and cancer access standards. It has also discussed the findings of previous internal and external audit reports and the plans in response to them.

The audit committee reviews, on behalf of the Board, data quality issues to give the Board assurance that performance can be understood and managed. It also recognises the need for data and its sources to be constantly reviewed and the ongoing improvements that are needed, for example those set out above.

The elective access board (EAB) reports to the senior directors team (SDT) on a monthly basis and oversees improvements to elective waiting time, data quality for RTT, diagnostics and cancer.

Key areas of focus include:

- Weekly monitoring of data quality indicator trends for RTT. These are circulated to divisions on a weekly basis with priority areas of focus highlighted for action.
- Review of a bi-monthly internal sample audit, which alternates between RTT and diagnostics. Individual and aggregate findings are shared with divisional managers and frontline staff.
- Bi-monthly assessment of the health of PTL management, carried out by the elective access team.
- Tracking delivery of our RTT and diagnostics training plan. The programme was formally launched in September 2016 to ensure staff have the knowledge and capability to record pathways correctly at source and thus reduce the risk of data quality errors. eLearning modules are mandatory for all staff involved in the administration of pathways and require annual refresher courses. The current phase is to progress clinic outcome form training to improve completion and accuracy rates among clinicians.

Our Quality report external audit has shown that we need to do more work to improve how we document and provide assurance on waiting times in ED. We have improved validation processes and introduced monthly audits of how staff are documenting waiting times. These have demonstrated no systematic inaccuracies in the waiting times that we report for individual patients.

External audits have shown that we do not consistently document evidence for the ED waiting times that we report.

We continue to raise awareness about the need for accurate record keeping and validation. Full assurance on the accuracy of our recorded waiting times will be provided with the implementation of a new electronic health record system (EHRS), from April 2019 onwards.

The foundation trust is fully compliant with the registration requirements of the CQC.

The CQC inspected our services from July to September 2018 and published their report in December 2018. We were rated good overall. We received a requires improvement rating for safety but were rated good for the remaining areas of effective, caring, responsive and well led. The CQC report identifies actions that we 'must do' and actions that we 'should do'. We have addressed most of the 'must do' actions and are actively working on the 'should do' actions. See section 3 Quality report for more information.

Review of effectiveness

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

UCLH reviews the effectiveness of the system of internal control through executive directors and managers within the organisation, who have responsibility for the development and maintenance of the system of internal control and the BAF.

The responsibility for compliance with the CQC standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The assessment of compliance and the work of internal audit through the year have assisted the Trust in gaining assurance on its system of internal control.

The results of external audit's work on the UCLH annual accounts and quality report are a key assurance together with the results of patient and staff surveys.

I have been advised on effectiveness of the system of internal control through reports produced for the quality and safety committee, by the corporate medical director and the audit committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Board has played a key role in reviewing risks to the delivery of our performance objectives through monthly monitoring and discussion of the performance dashboard which reports performance in the key areas of finance, activity, national targets, patient safety and quality and workforce. This enables the SDT and the Board to focus on key issues as they arise and address them. The Board requests specific in-depth reports on areas of under-performance as required.

The audit committee has overseen the effectiveness of the Trust's risk management arrangements and has taken part in a review of its role and responsibilities. The audit committee is supported in this oversight role by the work of the QSC and the clinical audit and quality improvement committee which reports to the QSC.

The head of internal audit opinion has given a reasonable assurance that there is adequate and effective management and internal control processes to manage the achievement of the organisation's objectives.

Significant control issues

There were twelve never events this year. Six were wrong site surgery, four were retained foreign object post procedure and two were unintentional connection of a patient requiring oxygen to an air flowmeter.

All of the incidents are subject to detailed investigations and the actions and assurances monitored through the clinical boards, quality and safety committee and reported to the commissioners who approve the action plans. Learning so far has identified the need to follow procedures and the importance of human factors in understanding why staff sometimes vary from procedures. See section 3 Quality report for more information.

Conclusion

Overall UCLH has a strong control environment, with minor improvement opportunities identified during the year as concluded in the head of internal audit opinion.

However, significant internal control issues were identified in the year relating to the never events outlined in the previous section and summarised below:

- six incidents of wrong site surgery
- four retained foreign objects post procedure
- two unintentional connections to air flowmeters

Section 3 Quality report gives additional detail on these incidents and subsequent investigations. No other significant control issues were identified during the year.

Professor Marcel Levi
Chief executive

23 May 2019

Signature to the accountability report:

Professor Marcel Levi
Chief executive

23 May 2019

3 Quality report

Statement on quality from the chief executive

Our vision is to deliver top-quality patient care, excellent education and world-class research and this has continued to be our focus during 2018/19.

I am proud to present our quality account for 2018/19 which shows how we performed against our priorities during 2018/19, sets out our priorities for the coming year, and gives an overview of our key performance indicators and assurance statements.

The Care Quality Commission (CQC) inspected our services from July to September 2018 and published their report in December 2018. We were pleased to be rated as good overall and to see some areas of excellence also recognised and highlighted. We have already made progress on the areas identified for improvement. Our progress and remaining challenges are covered in more detail in section 3.2.

Whilst we try to ensure our patients have little cause to complain, those that do we value as these complaints create opportunities to learn and improve and I am pleased to share that an area of concern identified last year, relating to our transport service, is beginning to show improvement. Other examples of learning from complaints are outlined in the report. We have started work to improve our timely response to complaints which hopefully will show results in the next few months.

Looking at our performance against the year's improvement priorities, we have made progress in all areas although we were very disappointed that we had 12 Never Events during the year. Our report covers the actions we have taken so far and our plans for 2019/20 to improve further safety in these important areas.

We have continued to learn from serious incidents and from deaths. Our systems for reviewing deaths are now well established and we have increased the numbers of deaths reviewed and will continue to build on the learning and improvement.

An important part of learning is understanding the impact human factors such as communication, teamwork and situational awareness (being aware of what is going on) can have on team performance. I am pleased that we delivered human factors awareness training days this year and trained over 100 members of staff both clinical and non-clinical.

We continued with our enhancing safety visits into areas undertaking surgery and invasive procedures and supplemented them with workshops on human factors. These workshops aim to support individuals to understand how to recognise and manage potential risks to patients during surgery and invasive procedures. We launched e-learning on the five steps to patient safety for surgery.

Our performance in using vital signs to identify when we should escalate concerns about patients remains good and we have continued to improve in our treatment and review of patients with sepsis. We met the targets for identification and treatment for patients in our emergency department and inpatients, except for timely treatment in inpatients despite improvement over the year. We have begun to get a better grip on factors contributing to acute kidney injury and have been able to plan our priorities for next year.

Progress towards a more robust system for following up imaging results was paused due to the implementation of a new electronic health record system (EHRS) and the switch from our current system.

In 2018/19, our aims were to maintain our high overall experience ratings as measured by the Friends and Family Test (FFT) and to improve on specific areas in inpatient and outpatient care.

I was pleased to see the improvement in our patient recommended score for the emergency department reflecting the real time experience despite the increase challenges all emergency care areas are experiencing. We are delighted we are beginning to see an improvement in recommendation scores for transport. Our outpatient and inpatient targets have remained stable. We remain committed to using every opportunity to offer the experience we would want for those we care about.

Our overall performance, as shown in our real-time survey results, for outpatient waiting has remained stable against the previous year, as a result of the work undertaken in local areas.

We have seen a mixed level of progress against the specific areas. The Coordination Centre and the management of patient flow has improved yet we have some way to go to see this having an impact on our patients, who continue to report that sometimes they are unclear about what will happen when they go home.

We have continued to improve the support patients receive at meal times and have improved our provision of easy-to-understand written information for patients with cancer.

Over the last two years we have been developing a new electronic health record system (EHRS) for UCLH. Our new system went live on 31 March 2019.

Moving to EHRS is really exciting: it replaces well over one hundred separate clinical systems and will mean that clinicians at UCLH will have access to a complete patient record in one place with a detailed view of patient history, treatments, test results with alerts, and decision support. EHRS also includes tools for scheduling, reporting and communicating with patients and healthcare professionals, helping us to streamline patient care, reduce duplication and improve collaboration.

Implementing EHRS was a huge task which has involved training thousands of staff and spending several months preparing in detail for the go-live day. EHRS will impact on every way we work and provide care and our top priority in the next year will be patient safety and ensuring patients get the care they need. This is also an opportunity to look at how we do things and the data we collect and to use the improvements made in EHRS to improve further patient safety.

This is a huge change for the organisation and this will mean that we will need a period of time to get used to the new system. For this reason we have been circumspect on what we have said we will deliver in 2019/20 with some of our time being spent on understanding what risks we need to address, what benefits the new EHRS can bring, and how we can measure these.

The quality report has been prepared with our clinical teams and people who are closest to the service being reported upon. Reporting on quality and performance necessarily involves judgement and interpretation. But to ensure that the report paints a fair picture it has been scrutinised by all stakeholders and by the board including our non-executive directors.

To the best of my knowledge, and taking into account the processes that I know to be in place for internal and external scrutiny, I believe that this report gives an accurate account of quality at UCLH, recognising the matters identified in the report in respect of the 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' indicator and the 'A&E maximum waiting time for four hours' indicator as described in section 3.5.2.

I hope it will be read widely by our staff, our patients and our partners.

Professor Marcel Levi
Chief executive

23 May 2019

3.1 About this report

Every year all NHS hospitals in England must write a report for the public about the quality of their services. This is called the quality report. A quality report makes University College London Hospitals (UCLH) more accountable to you and drives improvement in the quality of our services.

Quality in healthcare is made up of three dimensions:

- Patient safety - keeping patients safe from harm
- Clinical effectiveness - how successful is the care we provide
- Patient experience - how patients experience the care they receive

This report tells you how well we did against the quality priorities and goals we set ourselves for 2018/19 (this year). It sets out the priorities we have agreed for 2019/20 (next year), and how we plan to achieve them.

It also contains an overview of our quality performance based on mandated and locally chosen indicators. Certain elements of the annual quality report are mandatory and these are included in section 3.6.

3.2 Learning from feedback

3.2.1 Care Quality Commission (CQC) Inspection

We underwent an inspection of our services by the CQC from July to September 2018. The CQC inspected 11 services overall. At University College Hospital (UCH) and Elizabeth Garrett Anderson Wing the CQC inspected urgent and emergency care, medical care, outpatients, maternity and gynaecology services. At the National Hospital for Neurology and Neurosurgery (NHNN) they inspected surgery, medical care, outpatients and critical care services and at the Sir William Gowers Centre (SWGC), they inspected medical care and outpatient services. Details of the full inspection report can be found here: https://www.cqc.org.uk/provider/RRV

We were rated good overall. We received a requires improvement rating for safety but were rated good for the remaining areas of effective, caring, responsive and well led. Individually University College Hospital and the Elizabeth Garrett Anderson Wing were rated as requires improvement overall but we were pleased to receive an overall good rating for both the National Hospital for Neurology and Neurosurgery (NHNN) and Sir William Gowers Centre (SWGC).

NHS Improvement rated UCLH as good when assessing how effectively the organisation uses its resources to provide high quality, efficient and sustainable care for patients.
All of the ratings above were combined with the ratings of services from the CQC inspection in 2016, to give an overall rating of good for 2018.

Areas of praise within the report included how staff treat patients with compassion, patience and respect. The inspectors said feedback from patients about their care was consistently positive. Good teamwork among staff at all levels was noted and a sense of common purpose based on shared values and with staff working collaboratively to deliver effective, patient-centred care. Staff said they were proud to work at UCLH. There was a positive and friendly culture, and staff said that they were well supported by their colleagues. The report noted that leaders at every level were visible and approachable and we had a clear vision and strategy with action plans to achieve this. Trust leaders were knowledgeable about service performance, and priorities, as well as challenges and risks, and safe innovation and team success were celebrated. Services were planned and provided in a way that met and supported the needs of local people, including those with complex or additional needs, and that we worked closely with the commissioners, clinical networks, patients and other stakeholders.

They observed that there was a culture of incident reporting and staff said they felt confident in reporting incidents and learning was shared with staff to make improvements. They noted that we had systematic and established systems in place for reporting, investigating and acting on incidents and serious adverse events. When things went wrong, staff apologised and gave patients honest information and suitable support.

Inspectors also praised the strong culture of improvement, research and innovation at UCLH and cited many examples of research being used to improve patient care. There were a number of areas of outstanding practice including our fetal surgery service for spina bifida which is the first of its kind in the UK, and our specialist service for women at high risk of developing ovarian cancer.

The CQC also commended the breadth of research and clinical trials both within our specialist epilepsy service at the SWGC and at the NHNN.

There are numerous research projects taking place at the NHNN with a high proportion of patients involved in clinical trials, which are recognised as having a positive impact on patient care and treatment. For example, clinicians at the NHNN are exploring the use of neuroimaging to facilitate the effect of deep brain stimulation to improve motor symptoms of Parkinson's disease. The mechanical thrombectomy service within stroke services, which removes the clot blocking the artery within the brain, restoring blood flow and minimising brain tissue damage, has demonstrated improved survival rates and positive outcomes for patients.

The CQC report identifies actions that we 'must do' and actions that we 'should do'. We have addressed most of the 'must do' actions. As the report was only published in December 2018 we are still implementing some of the improvements. The actions and improvements for the 'must do' actions and some of the 66 'should do' actions are outlined below.

'Must do actions'	**Update**
Ensure people using services within the endoscopy unit are treated with dignity and respect by switching off the monitoring screens within the endoscopy unit.	The monitors have been switched off and decommissioned.
Ensure staff at the SWGC have the appropriate level of child safeguarding training.	Current staff have been trained and all band six and band seven nursing staff at SWGC will have level three training as part of their standard training programme. The matron will ensure that there are at least three staff members with safeguarding training in the centre's nursing establishment on an ongoing basis.
Ensure that the Trust restraint policy follows best practice guidance.	We have reviewed our policy to ensure that it meets best practice guidance. The assessment tool and record are included in the Electronic Health Record System (EHRS).
Ensure there is a rapid tranquilisation policy which follows national guidance.	We are adapting the local mental health trust protocol for rapid tranquillisation for UCLH.
Ensure that there are sufficient numbers of suitably qualified and experienced medical staff within the Intensive Therapy Unit (ITU) at the NHNN in line with national standards.	We are improving staffing in line with the 'Guidelines for the Provision of Intensive Care Services' (Faculty of Intensive Medicine 2015).

Our other key areas of focus from the 'should do' action plan are to:

- Ensure that medicines are managed appropriately and medicine storage temperatures are monitored, recorded and managed in line with Trust requirements for the safe storage of medicines.
- Ensure high standards of infection control practices are consistent across the Trust.
- Ensure mandatory training, including safeguarding training, for medical staff meets the Trust target of 90 per cent.

- Continue to address the challenges in meeting the target that 95 per cent of patients should spend less than four hours in our emergency department.
- Continue to work on meeting the standard that patients referred by a GP with suspected cancer should be treated within 62 days.

3.2.2 Learning from complaints

Patients and carers can raise a concern in a number of ways. One way is via the Patient Advice and Liaison Service (PALS). They will try to resolve any issues. If this is not successful, or the concern is too complex, PALS will pass this on to the complaints department. The other way patients can raise concerns is by directly contacting the complaints team. The complaint will be passed on to the relevant division to respond. Once received, individual divisions work closely with the complaints team to resolve those concerns which do not require a full formal investigation. A formal complaint is one in which the complainant asks for an investigation and written response.

We encourage and welcome complaints about the quality of care being provided to patients as a means of continually assessing and improving our services. Through the lessons learned, complaints are seen as an important part of helping us to improve the quality of patient experience, safety and effectiveness whilst also providing evidence to our patients and the public of the action UCLH has taken to learn (see learning from complaints section below).

Formal complaints data are shared internally with subject matter expert leads and committees such as the medication safety committee, nutrition and hydration steering group and end of life care steering group amongst others so that Trust wide monitoring of these issues can take place and appropriate improvement actions can be identified and monitored. Issues from complaints are also discussed at local departmental and divisional meetings and actions taken where appropriate to ensure learning takes place.

Monthly figures on formal complaints are shared and monitored via performance reports and the patient experience quarterly report uses data from complaints, Patient Advice and Liaison Service (PALS), feedback, surveys and Friends and Family Test (FFT) results.

Quarterly divisional and Board reports are produced for the patient experience and engagement committee (PEEC) and the quality and safety committee to identify any trends or themes. Lessons learnt are shared through the quality and safety bulletin, divisional governance groups and site experience groups. Site experience groups have been established in a number of locations, such as Queen Square (NHNN and Royal London Hospital for Integrated Medicine (RLHIM)) and the UCH Macmillan Cancer Centre, and are in the process of being set up in other areas. The purpose of the groups is to regularly conduct reviews of local feedback, as well as analysing PALS and complaints data, with a view to resolving issues. The work of these groups is shared with and monitored through the PEEC.

Formal complaints and their responses are personally reviewed and signed off by the chief executive (or his acting deputy) and are also seen by several members of the Trust Board, including the medical directors and chief nurse.

During 2018/2019 UCLH received 891 formal complaints, a rise of approximately 0.4 per cent compared to the same period in 2017/18 when 887 complaints were received.

Some examples of how we have made changes as a result of learning from complaints are as follows:

Transport complaints

In 2017/18 complaints about transport were responsible for 16 per cent of our complaints overall. Complaints were primarily due to long waiting times and non-arrival of booked transport. Following a revised contract, and as part of its commitment to improving the experience for users of the service, the provider agreed key performance indicators related to patient experience and complaints which the Trust has been monitoring. A recovery plan was put in place with a transport quality improvement group monitoring a range of metrics including complaints and patient feedback.

The proportion of complaints raised about non-emergency patient transport fell from 14 per cent in 2017/2018 to seven per cent in 2018/2019 suggesting that the initiatives put in place are improving the service. The initiatives included working to reduce the number of 'on the day' discharges and increasing the number of stretcher vehicles which has helped to cope with demand and reduce long waits.

This correlates with our patient experience FFT data which shows improvement in scores - see section 3.3.3.1. However, we recognise that there is still room for further improvement.

Women's Health complaints

A patient's IVF treatment was postponed as a result of delayed notification of a positive chlamydia test. This should have been flagged up as an unexpected and significant result. The microbiology department have tightened their systems for identifying and informing clinicians of such results. We have also reminded clinicians of the importance of providing a contact number on every request form so that it is easy to contact them with unexpected and significant results. Timelier notification of abnormal test results will be easier to achieve following the introduction of the new EHRS which makes it easier and more efficient.

Administration and communication complaints

Communication issues are a common theme in the complaints raised by our service users. A review of issues from complaints identified areas for improvement which have been taken forward as part of the Access and Patient Administration Programme (APA).

Appointment letters have been reviewed and a 60 per cent improvement has been made to the turnaround times of clinic outcomes letters. Over 900 staff have attended a new foundation training course in administration and communication skills and a further 450 staff have received advanced training in these areas. We are also expecting a further improvement in 2018/19 for letters produced following clinics, with greater use of digital dictation. Our implementation of the EHRS will improve communication between medical teams, GPs and patients.

For more information on our complaints for 2017/18 please see the annual complaints report available on our website at https://www.uclh.nhs.uk/complaints. The annual complaints report for 2018/19 will be published in September 2019.

3.3 Progress against 2018/19 priorities

This section of our quality report provides a look back over the 2018/19 quality priorities at UCLH. We put in place action plans and developed measures for each of the priorities and our performance has been monitored throughout the year by our clinical teams and hospital committees.

3.3.1 Priority 1: Patient Safety

3.3.1.1 Five steps to surgical safety: reduce avoidable harm from surgery and invasive procedures

Our aims are to make areas carrying out invasive procedures safer through better use of the *Five Steps to Safer Surgery (5SSS)* and to build a safer culture by improving teamwork and communication. Every team member can then feel confident to speak up and raise concerns.

The 5SSS are a series of time critical safety checks which should be performed for every patient undergoing a surgical or invasive procedure. The WHO (World Health Organisation) surgical safety checklist consists of the sign in, time out, and sign out components of the 5SSS. The five checks are:

- **Team brief** – the team members to identify themselves and their individual roles, discuss what procedures are planned, what is required and what problems may be anticipated to ensure that any issues may be dealt with early
- **Sign in** – includes confirmation of correct patient identity and procedure prior to anaesthesia or sedation
- **Time out** – the theatre team make final checks prior to the procedure commencing
- **Sign out** – to check that all information has been recorded, equipment, swabs and specimens are accounted for and to ensure there is an ongoing plan for patient care
- **Team debrief** – to discuss what went well, what needs attention and any learning

We perform enhancing safety visits (ESVs) with the aim of providing a collaborative way of fostering a culture of safety in our theatres and procedural areas, through measurement and improvement of the use of the 5SSS. These involve members of staff visiting an area that undertakes surgery or interventional procedures and observing how the 5SSS are being carried out. These tend to be unannounced in order to observe normal practice. We talk to staff, collect quality measures and feed back to them what they are doing well and what could be improved. We utilise our findings and create action plans with the teams visited, which are reviewed on a quarterly basis.

Our methods, described above, are transferrable and we were glad to have an opportunity to share them with another NHS Trust in 2018/19. We will continue to share our learning in 2019/20.

What we said we would do	What we have done
Undertake 18 ESVs to improve safety across surgery and invasive procedures and for six of these to be led by individuals of varying professions outside of the core team.	18 ESVs took place across 33 specialities with 30 different members of staff participating, including educators, surgeons, anaesthetists, a human factors consultant, theatre practitioners, patient safety leads and theatre pharmacists. Sixty three patient procedures were observed. These visits are increasingly embedded in the culture in many surgical and invasive procedure areas. Three visits were led by staff outside of the core team.
Launch the e-learning on 5SSS and set a target for measuring uptake.	An e-learning module on the 5SSS was created and launched in December 2018. This learning package includes videos, interactive learning processes and knowledge checking throughout to provide a robust learning experience. Monitoring of completion requires a certain system set up and this was not possible this year as the resources of the central training team were focused on preparation for the introduction of our EHRS.
Undertake at least six two-hour workshops across the Trust to raise staff awareness of factors such as systems, environment and behavioural influences and how to overcome them in working practice, alongside the e-learning on the 5SSS.	These workshops aim to support individuals to understand how to recognise and manage potential risks to patients during surgery and invasive procedures. They include raising awareness of the impact of human factors (e.g. communication, teamwork, situational awareness) can have on team performance when carrying out the 5SSS. We have completed four workshops for 85 members of staff across UCH, UCH at Westmoreland Street (WMS) and NHNN main theatres and endoscopy. The feedback was positive and participants gained new knowledge that they can use in practice. Enhancing safety visits confirmed that the learning from these workshops had been put into practice. Although we did not achieve our target of six workshops, we did provide additional condensed training for staff utilising the material from these workshops on five other occasions.

Use observations, incident reports and near misses ('good catches') to inform our learning and form the basis of our education requirements.	Good practice and near misses have been shared across a variety of clinical specialities, utilising material from incident reports and observations from enhancing safety visits. There is now a standing agenda item on learning on this topic at the reducing surgical harm steering group. We have utilised learning points from a Never Event* investigation to support staff at NHNN in improving their process of conducting nerve root injections. Our training for the endoscopy team was designed around the early learning from an incident that had occurred in that department.
Have implemented actions agreed from our review of issues highlighted in our 2017 culture survey across theatres and anaesthetics.	Our analysis of the culture survey results highlighted five themes for improvement, which included; vision and values, goals, performance, support and compassion, learning and innovation and teamwork. Examples of achievements in these areas are highlighted below: **Vision and values:** A new team brief time has been introduced at NHNN to facilitate handover and prioritise the most urgent cases. Theatre coordinators ensure team leaders are allocated per theatre who are responsible for ensuring that the team brief is carried out and that staff breaks are taken into consideration when planning the list. **Goals and performance:** A surgical huddle has been introduced at UCH main site, which has led to improved communication and a reduction in cancellations. **Support and compassion:** Staff are offered access to the senior management team on a weekly basis to enable staff to raise any concerns or ideas for improvement. Staff were part of the consultation on a staff room re-design at the UCH main site. **Learning and innovation:** Sites have promoted reporting and learning from incidents in a number of ways, including use of a laminated template of how to report an incident. WMS have used the 'Lean Six Sigma' approach to improve access to equipment. **Teamwork:** Recovery co-ordinators have been introduced who work with theatre co-ordinators to improve teamwork and communication. There has been an improvement in debriefing taking place to action any issues that arise.
Share learning across UCLH through publication of three 'At the Sharp End' surgical safety bulletins.	We have published three At The Sharp End surgical safety bulletins.

Continue to share our approach and learning with at least one other NHS Trust by offering training and resources.	We have shared our approach and learning with one other Trust, where we carried out a peer review in the form of an enhancing safety visit.
Work with the EHRS team to design the safety check list.	We worked with the EHRS team to develop our approach to the 5SSS and live tested a number of prototypes in a theatre environment, to ensure the WHO checklist was fit for purpose before 'go live'.

**Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available*

Due to the increase in numbers of ESVs we have been able to identify themes from the data we capture, which have been shared at appropriate fora in order to formulate action plans for the wider surgical safety approach. For example, we identified that improvements were required to promote debriefs across the Trust. We therefore provided education sessions, staff attended workshops to create posters on what they felt 'good' looks like and how to achieve this, and debriefs were a feature in our At the Sharp End surgical safety bulletin. Please see appendix one.

The innovative approach of training staff and students to fully utilise the WHO safety checklist through simulation training at the Eastman Dental Hospital, which we described in last year's quality report, has resulted in two national level awards. These include 'Winner of the Oral Presentation Prize' at the Association of British Academic Oral and Maxillofacial Surgeons annual conference for their 'Human Factors Simulation *in situ* training approach in Oral Surgery' and 'Winners of the Patient Safety Prize' at the Association of Surgeons in Training /Royal College of Surgeons England for their work on the WHO checklist training sessions.

We have been proactive in our approach to Patient Safety Alerts (PSA), as demonstrated by our response to the PSA outlining requirements for confirming removal or flushing of lines and cannulae after procedures. Immediate action, monitoring and assurance were put in place, supported by our reducing surgical harm steering group. Compliance has been measured monthly and improvements have been demonstrated, providing assurance of enhanced patient safety.

It was very disappointing that we had twelve Never Events this year of which ten were surgery and invasive procedures related. We are committed to ensuring that we create safe systems and processes in order to protect our staff and patients from Never Events occurring. We will ensure we support staff across the organisation to implement learning from these events, as set out in the action plans, and provide assurances that this has been completed. Please see section 3.3.1.4 for further information.

Our stakeholders have confirmed that they want to see us continuing to focus on reducing avoidable harm in surgery and invasive procedures. Therefore this will remain a safety priority for 2019/20. For more information see section 3.4.1.1.

3.3.1.2 Reduce harm from failure to recognise and respond appropriately to deterioration

Unrecognised deterioration is where a patient's health becomes worse and this is not picked up and acted on quickly. We identified the need to predict deterioration as well as focus on

timely recognition, escalation and management of deterioration. Evidence shows that sepsis and acute kidney injury (AKI) are the leading causes for deterioration nationally, therefore, we continued to focus our improvement work on these areas.

Over the past year we have focused on the following to reduce harm from unrecognised deterioration:

- Prediction of deterioration*
- Recognition of deterioration
- Escalation of a deteriorating patient
- Management of a deteriorating patient

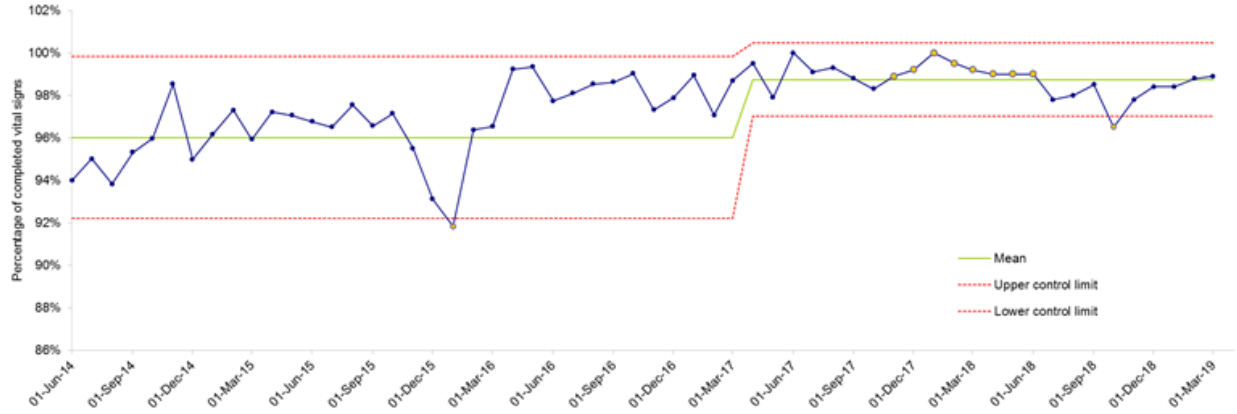
**By prediction of deterioration we mean using clinical intuition to identify deterioration which may not be identified using tools such as the national early warning score (NEWS)*

What we said we would do	What we have done
Prediction of deterioration* Agree a standardised template for safety huddles and assess its use via the Improving Care Rounds (ICRs) and matron quality rounds.	A huddle takes place across each ward during the day shift where staff are encouraged to share concerns about patients. We discovered that there is variation in the content discussed and who attends. This is due to the variability of the patients that are on the wards. We therefore determined that a standardised template was not appropriate.
Use the emergency department (ED) safety checklist for all high risk patients (those in the resuscitation and majors areas of ED) and monitor its use via audit.	A weekly documentation audit in ED commenced in quarter two and showed 39 per cent compliance. We have seen a steady improvement each quarter and achieved 64 per cent in quarter four. March showed 78 per cent compliance, demonstrating that we are continuing to improve.
Recognition of deterioration Maintain our average hospital-wide vital signs compliance of 96 per cent, based on a sample of one in ten patients on every ward, every month.	We have consistently exceeded our target for accurate vital signs and NEWS compliance. Please see chart Q1.
Produce a UCLH fluid balance policy to support the implementation of an agreed updated fluid balance chart and review its use via audit.	The fluid balance policy, which includes the fluid balance chart has been approved and will be implemented via the EHRS. We did not undertake audits as our focus was on ensuring that it was integrated into the EHRS and we recognised the audit methodology would change significantly next year.
Escalation of a deteriorating patient Improve the use of ISBARD (Introduction, Situation, Background, Assessment, Recommendation, and Decision), a structured communication tool from 64 per cent to 70 per cent in escalations to Patient Emergency Response and Resuscitation Team (PERRT).	We have continued to improve our use of ISBARD in escalations to PERRT and achieved 78 per cent. Please see chart Q2.

Educate staff on the risks of deterioration for patients with low NEWS scores by including a clinical case study in the mandatory two yearly basic life support training. This will be further supported by sharing learning via the quality and safety bulletins and safety huddles.	The sepsis improvement nurse educates staff widely on the risks of patients with low NEWS scores. She provides Trust wide teaching to a variety of disciplines on a daily basis and has included a case study of a patient with a low NEWS score who deteriorated. A case study has been prepared for use in the mandatory two yearly basic life support e-learning but due to the introduction of our EHRS and the training associated with this, modification to existing training was put on hold.
Management of a deteriorating patient Improve compliance with provision of antibiotics within one hour of diagnosis for all sepsis patients from our 2017/18 quarter four results of 76 per cent to the 2018/19 quarter four target of 90 per cent.	We were disappointed not to meet our quarter four target of 90 per cent of patients with sepsis receiving antibiotics within one hour of diagnosis but did achieve an improvement from 76 per cent last year to 86.1 per cent. The target for giving antibiotics to inpatients within an hour was 90 per cent and we achieved 72.7 per cent. We achieved the target within ED, with 90.4 per cent of patients receiving antibiotics within one hour of diagnosis.
Undertake a clinical review of antibiotics within 72 hours of giving the first dose in 90 per cent of patients with sepsis to determine if it has been reviewed by an appropriate clinician, outcome of the review is documented and where appropriate an IV to oral switch has been made or decision to continue IV is clearly documented.	We have undertaken a clinical review within 72 hours of giving the first dose of antibiotics in 100 per cent of patients with sepsis to determine appropriate treatment course and clear documentation of treatment rationale.
Undertake a Trust wide audit identifying the incidence and distribution of patients with AKI and the outcomes for these patients. Assess staff awareness, knowledge and competencies and map out key processes in the recognition, escalation and management of patients with AKI.	We have completed a baseline audit against London Acute Kidney Injury Network standards in 67 case records across the organisation. This has identified the need for improved recognition and response to patients identified with AKI and we will focus on this in the coming year.
EHRS We will be proactive in our approach to the Trust moving onto an EHRS. Our current vital signs recording system NEWS will be updated to NEWS2. We will also ensure that AKI and sepsis care bundles are built into the system to improve patient outcomes.	We have built NEWS2 into the EHRS. We have also run a Trust wide education programme to ensure staff are prepared for the change in process and system approach to vital signs monitoring. We have built best practice advisories (BPAs) within our EHRS, which provide alerts to staff, to support recognition, escalation and decision making in response to deteriorating patients. We have built deterioration and sepsis order sets to support staff to deliver optimal care if a patient deteriorates.

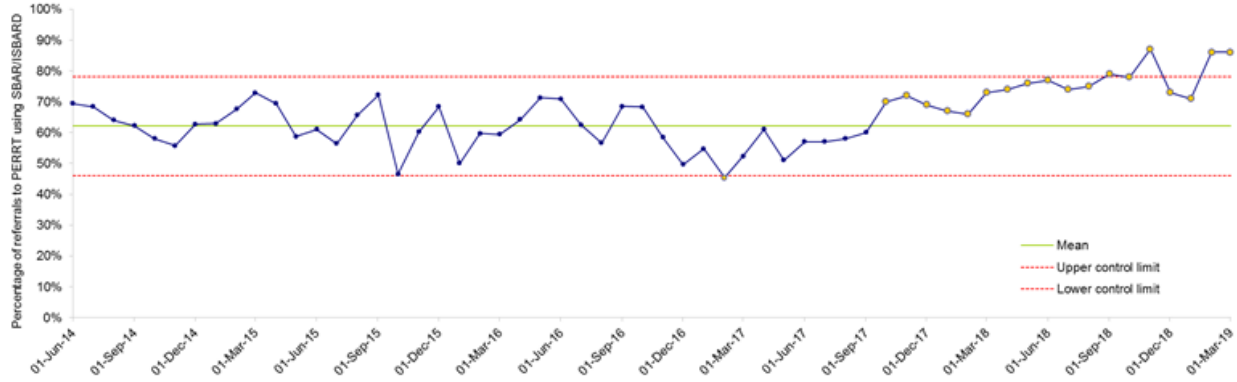
Mortality reviews We will review all deaths relating to sepsis and AKI to identify and share further learning Trust wide.	We began to review deaths relating to sepsis and AKI as we became more familiar with the mortality review process and as more clinicians became trained. We were able to review 28 deaths this year and will continue next year through our learning from deaths work. We shared the learning through a mortality surveillance newsletter as part of our quality and safety bulletin. See section 3.3.2.1 on responding and learning when patients die.

Chart Q1 Statistical Process Control Chart demonstrating vital signs completion across inpatient wards June 2014 – March 2019



Data taken from Essence of Care Audits June 2014 – March 2019

Chart Q2 Statistical Process Control Chart demonstrating ISBARD use on referral to PERRT June 2014 – March 2019



Data taken from Medicus PERRT Database June 2014 – March 2019

Two sepsis masterclasses were held for staff at UCLH with 170 attendees as well as a further 1000 staff being trained locally by our sepsis improvement nurse.

We have contributed to the UCL Partners (UCLP) deterioration network and shared our approach on NEWS2 and the introduction of our structured communication tool, ISBARD in order to share improvement work across the local network and further afield.

Our stakeholders have confirmed that they want to see us continuing to focus on reducing avoidable harm from unrecognised deterioration, therefore this will remain a safety priority for 2019/20 – see section 3.4.1.2.

3.3.1.3 Reduce the harm from failure to follow up on radiology results

It is important that there are systems in place for communicating and following up on radiology results and that associated 'safety net' procedures are in place and are robust.

What we said we would do	What we have done
There will be a Trust policy in place that describes the responsibility and process for imaging and for every specialty to ensure that all radiology reports requested are read and acted on appropriately.	A policy was completed which described the responsibility and process for imaging for every specialty. However it became apparent that our new EHRS would fundamentally change this and so the work was paused.
All specialties will have a standard operating procedure (SOP) for acknowledging and acting on results. They will also audit these procedures to check that they are effective.	The policy contains a standard operating procedure (SOP) for acknowledging and acting on results. However, it was not clear how this would work with the new EHRS and specialities were not asked to adopt these.
The radiology department will improve compliance in flagging urgent and unexpected results from 52 per cent (February 2018 audit) to 90 per cent.	The latest audit in November 2018 confirms an upward trend and that 97 per cent of all urgent and unexpected results were flagged.
A new Radiology Information System (RIS)/Picture Archive and Communication System (PACS) system 'Soliton' is being installed and interim technical options for addressing this priority will be explored.	It was decided that the imaging functionality within the new EHRS (Radiant) was the preferred way forward and so options within Soliton were not followed up.
We will move to a new EHRS system on 31 March 2019 and will be working on establishing systems including an imaging results acknowledgment system.	We met with the EHRS build team to ensure that there is a process for highlighting and acting on imaging results in EHRS and will monitor this next year.

3.3.1.4 Continue Trust wide learning

We wanted to continue our focus on learning and in particular from serious incidents which include Never Events. We said we would do this by the following:

What we said we would do	What we have done
Further improve the proportion of incidents reported as near misses; and to encourage these to be more thoroughly investigated.	During 2018/19 we have continued to monitor near miss incidents reporting and raise awareness of these through the Trust quality and safety bulletins and the patient safety committee. We did not improve the proportion of incidents reported as near misses but benchmarking with colleagues showed similar rates across all Trusts. We have however encouraged learning through near misses by reporting on stories in the quality

What we said we would do	What we have done
	and safety bulletin and through discussion at the patient safety committee.
Monitor and publish 'near miss' reporting rates and continue to publish monthly quality and safety bulletins with a focus on learning from near misses.	Near miss reporting rates continue to be published in the quarterly incident analysis report. All quality and safety bulletins published in 2018/19 have included stories on near miss incidents.
Identify root causes and contributory factors for 15 completed serious incident investigations reported in 2018/19. The data will then be analysed to see if there are common or linked issues which provide additional learning over and above that arising from individual cases.	This proved difficult in practice as there was not enough consistency in the way root causes and contributory factors were categorised. However a formal review of root causes and contributory factors for completed Never Event reports is in progress. See section 3.4.1.5.
Pilot a one day workshop on human factors awareness and aim to provide training for at least 100 people across the Trust. This will include clinical and non-clinical staff.	In July we delivered the human factors pilot training day and have subsequently trained 90 members of staff, giving a total of 107 people trained, both clinical and non-clinical. We have extended our approach to 'train the trainers' with eight members of UCLH staff receiving human factors training at UCLP. The staff members will now be involved in the delivery of the training at UCLH during 2019/20.
Measure the benefits of the human factors workshops using an established measurement tool.	Feedback from the human factors awareness training day (using an adapted tool) has been positive and the course content adjusted in the light of the feedback. The measurement tool is being reviewed so that we can look at pre-and post-course knowledge and see what the impact has been.
Incorporate human factors into a range of already established training.	There are more than 30 established training programmes which incorporate human factors. In addition we have included human factors in our training provided to clinicians on how to undertake mortality reviews and in communications workshops on safer surgery.
Introduce training for serious incident investigators which will incorporate a focus on human factors in the investigative process and actions plans.	Serious incident investigation training was provided to 16 members of UCLH staff in December 2018. As serious incident investigation training was last delivered a number of years ago we decided that the need at this time was for a more basic course focusing mainly on investigation techniques. Training specifically on embedding human factors into serious incident investigations will now be provided later next year. See section 3.4.1.5.

What we said we would do	What we have done
Continue the Trust patient safety committee (PSC) and evaluate the committee's success in promoting Trust wide learning by obtaining feedback from PSC members and staff via the improving care walk rounds and matron quality rounds.	The Trust PSC has met as planned and drawn out key learning from serious and near miss incidents. Learning from the PSC is shared with the QSC and via the medical directors with the divisional teams. Review of the committee showed that the PSC is beneficial in the detection of issues and safety risks and in their impact on patient safety – and in highlighting these for wider circulation and for discussion at local governance meetings. A check via the improving care walk rounds and matron quality rounds on whether local learning has occurred has started and will be used more extensively next year.
Audit divisional governance meeting minutes to check for evidence of learning from serious incidents.	An audit of governance minutes was undertaken which demonstrated that in 87 per cent of minutes reviewed there was evidence of learning or discussion concerning incidents or serious incidents. The CQC also noted in their report that minutes of governance meetings and newsletters showed that serious incidents, complaints and quality audit updates were discussed and shared with staff. These included actions taken to reduce recurrence and improve service provision.

Despite the focus on learning we were disappointed that there were 12 Never Events reported as follows:

- a retained vaginal swab following a forceps delivery
- a retained foreign body post procedure (a drill part)
- a wrong site surgery (a nerve block) on a patient undergoing spinal surgery
- a retained vaginal tampon following delivery of baby
- a wrong site surgery (a nerve block) for interventional pain management
- a retained swab / dressing following nasal surgery
- wrong site surgery (tooth)
- wrong site surgery (finger)
- unintentional connection of patient oxygen tubing to air flow
- wrong site surgery (skull)
- unintentional connection of patient oxygen tubing to air flow
- wrong site surgery (elbow)

We have taken some actions already for those investigations which are complete.

A retained vaginal swab following a forceps delivery

Following the use of forceps during delivery an episiotomy (a surgical incision of the perineum – the area between the vagina and the anus) and perineal repair were performed and a swab was inserted to stem blood flow.

An accurate swab count was not carried out nor documented in the clinical records as per the perineal suturing guideline and the doctor did not counter-sign the perineal repair pro forma. There was a change in the team at a safety critical point following the baby's delivery,

a congested delivery room, competing task priorities and time pressure. This meant that there was a loss of team situational awareness (knowing what is going on around you) of the swab count. Completing the perineal repair pro forma was perceived by the doctors as a 'documentation task', not a check where two healthcare professionals confirm the swab count was correct. National and local UCLH postnatal guidelines do not prompt staff to consider a retained vaginal swab as a possible cause of discomfort and pain following childbirth.

Learning from this investigation has been included in team training and education, and induction programmes for midwives and doctors. The trust postnatal care guidelines are currently being updated and the learning has been passed to NICE to enable them to consider this in national guidelines

Wrong site surgery (wrong level root injection)

Two Never Events were reported where the wrong level of the spine was injected. The one reported in September 2018 made the staff realise that a similar event had been reported in June 2018 but not recognised as a Never Event at the time. A number of factors led to the incorrect spinal level being identified and consequently injected in both cases. One of these was that there was no 'stop before you inject' process which includes checking relevant imaging, which would have confirmed the correct level to be injected. There was also not a team based approach to the five steps in particular the sign out which might have identified sooner that the error had occurred.

An enhancing safety visit took place in November 2018 and during this it was observed that the following changes to process had been made:

- The team demonstrated embedding of the Stop Before You Inject Process including the process of checking all relevant imaging.
- Sign Outs observed were completed as a collaborative team approach between the radiographers and radiologists (previously done by one person due to multitasking of other members of the team).

Learning on the definition and description of Never Events and the process of reporting on these was also covered in the departmental governance meeting.

We will continue to focus next year on what we can learn from our Never Events. See section 3.4.1.5.

3.3.2 Priority 2: Clinical Effectiveness

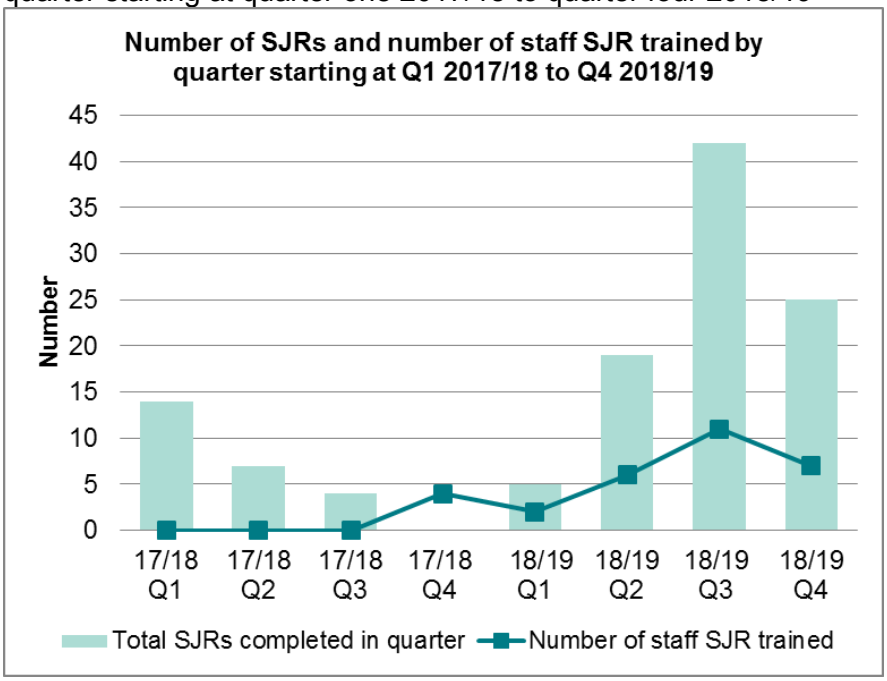
3.3.2.1 Responding and learning when patients die

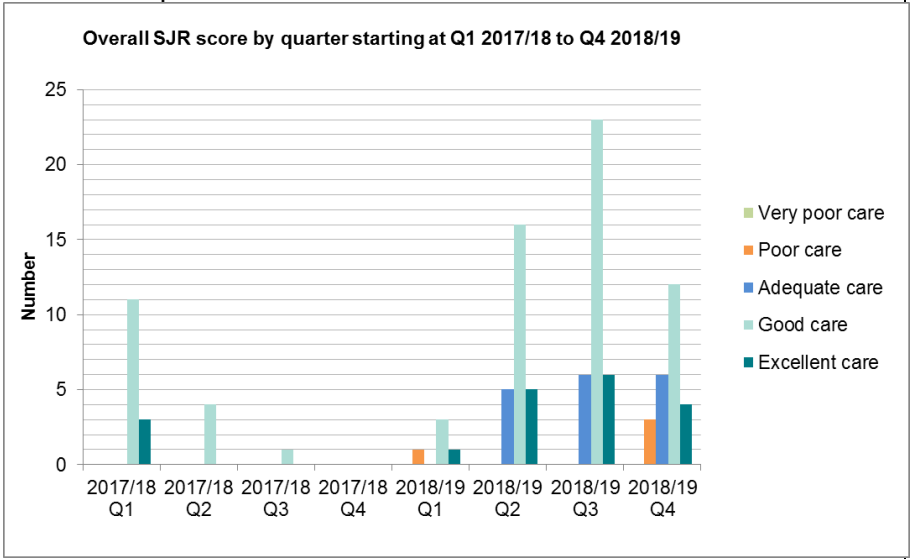
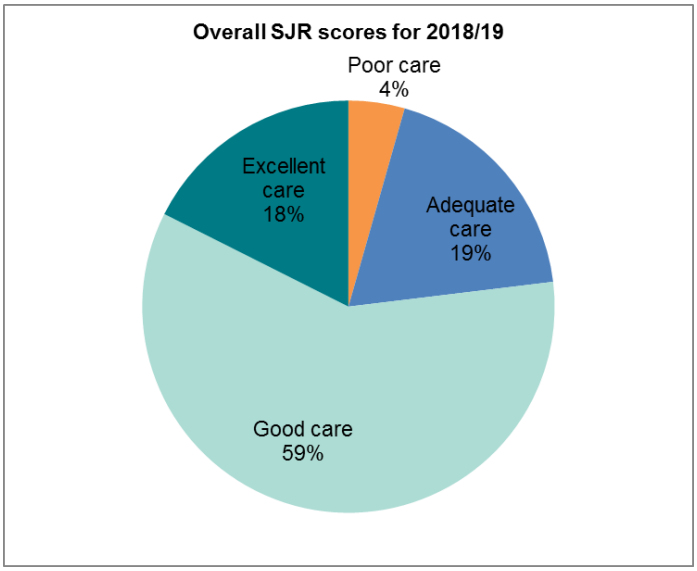
Even though our mortality rate remains consistently within the five lowest trusts in England, we chose to keep this priority again in 2018/19 because there is more to be learned from patient deaths. Following the 2017 *National Guidance on Learning from Deaths*, we began to establish our systems of formally reviewing deaths. Last year we began a review of deaths using the Royal College of Physicians structured judgement review (SJR) template and approach, in addition to our already well established processes such as serious incident investigations. An SJR requires trained reviewers to look at medical records in a critical manner to comment on specific predefined phases of clinical care. The SJR provides two types of data: quantitative in the form of a score of one to five where one is very poor and

five is excellent care in six phases of care. The qualitative data is in the form of explicit statements about the care received.

Our policy defines which deaths we review in line with the national guidance. In total we investigated 123 deaths which occurred in 2018/19 by either our already well established systems or the new SJR processes. This represents 72 per cent of the deaths which met the criteria for review in 2018/19. Of these we undertook an SJR for 52 per cent of the deaths which met the criteria for SJRs. We will continue to review all of the deaths meeting the criteria for 2018/19 as well as the deaths for 2019/20.

We have provided quarterly reports to our Trust Board on our reviews and learning and have continued to build on this process.

What we said we would do	What we have done
We will increase the number of SJRs undertaken	Last year we undertook 25 SJRs. This year an additional 26 reviewers were trained and over 90 SJRs were completed. **Chart Q3** Number of SJRs and number of staff SJR trained by quarter starting at quarter one 2017/18 to quarter four 2018/19  Data source: Mortality Surveillance Group

What we said we would do	What we have done
Our quarterly public report will reflect more learning and thematic analysis as we increase the number of reviews we carry out.	Our quarterly reports continue to the public Board and we have been able to highlight learning from complaints, serious incidents and SJRs. Please see section 3.5.4 for more information or the reports available on our website: (https://www.uclh.nhs.uk/board).The graph below shows the number of SJRs completed over the year by score by quarter. **Chart Q4** Overall SJR score by quarter starting at quarter one 2017/18 to quarter four 2018/19  *Data source: Mortality Surveillance Group* **Chart Q5** Overall SJR scores for 2018/19  *Data source: Mortality Surveillance Group* In 77 per cent of all SJRs completed relating to deaths this year, the overall assessment was that the patient received good or excellent care.

What we said we would do	What we have done
We will begin to assess the impact of the actions taken as a result of reviews and investigations and report these in our quarterly reports.	Please see quarterly reports available on the Trust website in the Board paper section and section 3.5.4 of this report for more information.

3.3.3 Priority 3: Patient experience

This year changes were made to the governance structure for patient experience – a new committee, the patient experience and engagement committee (PEEC) was created which reports into the quality and safety committee (QSC). It has representatives from all sites in the Trust, corporate support services (such as PALS, complaints and estates and facilities teams) as well as patient members. The changes have enabled us to ensure that patient experience is a priority at all levels across the Trust.

The patient experience team supports this structure with detailed quarterly reports showing performance against priorities and highlights from patient feedback. This includes feedback gathered during our regular listening events and other involvement activities. These reports are used to help us set our priorities each year.

Patient experience encompasses patient engagement, involvement and feedback. We use a number of survey sources to measure patient experience. The CQC's annual National Inpatient Survey shows how we compare to all other NHS trusts but is only available later in the year. The Picker Institute carries out the inpatient survey on behalf of the CQC for some trusts which allows us to compare ourselves with other trusts (77 trusts out of 148 surveyed in 2018). In addition, Quality Health runs the annual National Cancer Survey. This year our response rate for our inpatient survey was 38 per cent (nationally 43 per cent) and for our cancer survey was 49 per cent (nationally 63 per cent).

The Picker Institute has changed the scoring methodology for all surveys they carry out this year – please see the glossary for further information.

We also have an internal patient feedback system, which provides real time patient feedback which includes the FFT and a range of other questions which help us track our performance continuously through the year. Improvement against feedback is monitored at local level and used to monitor progress against our priorities as described below.

In 2018/19, our aims were to maintain our high overall experience ratings as measured by the FFT (table Q6) and to improve on specific areas detailed in tables Q7-Q11.

3.3.3.1 Improving overall patient experience scores as measured by the Friends and Family Test (FFT)

The FFT gives an overall picture of patient experience, asking patients 'how likely are you to recommend UCLH to friends and family if they needed similar care or treatment?'. The results are the percentage of patients who say 'extremely likely' or 'likely'. We have focused on four areas that give us a broad picture of patient experience across our hospitals –

inpatient and day case patients, outpatients, ED patients and users of our transport service. As required nationally, scores for inpatient and day case patients are combined.

Small year-to-year fluctuations are to be expected in FFT scores, reflecting not just changes in patient responses but also the number of responses and the method of collection. We have continued to monitor the responses we receive via the automated methods of collecting data, through text and voice calls sent to the majority of our patients shortly after leaving hospital. We made changes this year to the wording of the message sent to encourage more patients to reply. This prompted a rise in responses in the months following the change. In ED, this rose by three per cent (from 17 per cent to 20 per cent) from July. For outpatients there was a one per cent improvement (to ten per cent) and day cases a two per cent rise in response rates (up to 20 per cent) from December 2018.

Table Q6 2018/19 Progress against FFT Priorities

Friends and Family Test area	Patients recommending UCLH 2017/18	Target for 2018/19	Patients recommending UCLH 2018/19	Performance compared with previous year
Inpatients and day case	94%	95%	94%	The same
Outpatients	92%	94%	92%	The same
Emergency department	83%	85%	85%	Better
Transport	69%*	85%	88%**	Better

** This figure was incorrectly stated as 65 per cent in last year's quality report due to an administrative error*
***Transport data not collected between May and October 2018*
FFT Data taken from NHS England

We are pleased to see the small improvement in the patient recommended score for ED, meeting our target for the year. We have not met our outpatient and inpatient targets however, these have remained stable.

For inpatients, response rates and scores were broken down by ward and shared with divisions for local action. We also ran a refresher session for staff to show how to access and interpret the data. This has enabled staff to better engage with their own local data, with a view to more easily identifying areas for improvement.

Feedback in paediatric ED is collected on paper as we cannot assume we have a phone number for the child. In February 2019, as responses were low, we carried out a review of the waiting areas and looked at ways to improve how feedback is collected. We ran a training session with staff to encourage them to collect the feedback. Staff have since been focused on making sure the opportunity to give feedback is available to every patient/ carer/ parent and improvements in response rates and scores have already been seen.

Although our transport FFT data has shown an improvement in recommendation scores, there are still concerns being raised in the comments we receive regarding the quality and reliability of the transport provided. This is consistent with complaints about the transport service. Further information about transport complaints received can be found in complaints section 3.2.2.

In 2018, we chose to collect feedback about our transport service from some of our most vulnerable patients by calling and speaking to the patient in person but due to the change in methodology there was no data collected between May and October 2018. Calls started in November and feedback is currently being captured from around 250 patients each month. However, some of the patient comments are reflective of the care received rather than about our transport service and so we are reviewing the questions asked to ensure that our scores are more reliable in the coming year.

3.3.3.2 Improving patient experience in priority areas as measured by local and national surveys

Improving our patients' experience of waiting

a) Outpatient waiting priority

Table Q7 2018/19 progress against specific outpatient waiting priority – real-time survey results

Question – higher scores are better	2017/18 score	2018/19 target	2018/19 score	Performance compared with previous year
How long after the stated appointment time did the appointment start? (percentage of patients who waited 30 minutes or less for appointment to start)	70%	78%	70%	The same

Data taken from national patient experience survey results

We did not meet our real-time survey target for outpatient waiting and our overall performance has remained stable against the previous year, despite the work undertaken in local areas.

Our site data shows that UCH Macmillan Cancer Centre continues to perform poorly compared to other UCLH sites. This is disappointing as significant work has continued throughout the year. This has included the use of extra volunteers to welcome patients and help direct them to the appropriate areas, in-depth reviews of each individual area, improvements around recruitment and retention in pharmacy, helping with waiting times for medication, and looking at how patients move between departments.

Work has now begun to develop a patient waiting experience standard. We held a patient listening event in September to understand patients' current experience and seek views on what was important to ensure any waiting was a good experience. Feedback from this event showed that communication and the waiting environment were the main themes that are important to patients. This work will continue in 2019/20.

b) Specific inpatient waiting priorities

We use the Picker Institute for the national survey and this year they have changed the scoring methodology. Rather than use problem scores they have used positive scores which makes the data much clearer. They have supplied the data for this year and last year using the new methodology as below (this replaces the problem scores table used in last

year's quality report). Although the Picker Institute can revise the scores based on the new methodology we cannot review our performance against our target as the target cannot be recalculated using the new approach. This applies to all the national inpatient survey questions. We have provided information on the difference between the two different types of approach in the glossary.

Table Q8 Progress against specific inpatient waiting priorities for 2018

National inpatient survey question – higher scores are better	2017 result	2018 result	Performance compared with previous year
Admission date not changed by hospital (percentage of patients who did not have their admission date changed)	80%*	78%	Worse
Did not have to wait a long time to get to bed on ward (percentage of patients who did not have to wait for a bed on a ward)	72% **	68%	Worse

**In last year's quality report the score for 2017 was reported as 20 per cent as a problem score.*
***In last year's quality report the score for 2017 was reported as 28 per cent as a problem score.*
For information on the new Picker Institute scoring methodology please see the glossary.
Data taken from national patient experience survey results

It is disappointing that the waiting experience of our inpatients has worsened this year despite the good progress made with the Coordination Centre and the management of patient flow.

3.3.3.3 Improving our patients' experience of care

Table Q9 Progress against specific inpatient care priorities for 2018

National inpatient survey question – higher scores are better	2017 result	2018 result	Performance compared with previous year
Got enough help from staff to eat meals (percentage of patients who got enough help to eat meals)	83%*	84%	Better

** In last year's quality report the score for 2017 was reported as 35 per cent as a problem score. For information on the new Picker Institute scoring methodology please see the glossary.*
Data taken from national patient experience survey results

We developed best practice guidelines for mealtimes, rather than a standard operating procedure, and shared these with teams during the year. However following feedback from ward staff and other teams, we decided to focus on improvement work already underway to improve the patient experience at mealtimes. During the year, these included:

- embedding NHS England's Ten Key Characteristics of Good Nutritional Care, which we shared widely during Nutrition and Hydration week;

- supporting wards to apply protected meal time principles tailored to the specialty and patient needs;
- sharing good nutrition and hydration practices; and
- encouraging nutritional advocacy through our nutrition champions.

3.3.3.4 Improving our patients' experience of discharge

Table Q10 Progress against specific discharge priorities

National inpatient survey question – higher scores are better	2017 result	2018 result	Performance compared with previous year
Knew what would happen next with care after leaving hospital (percentage of patients who knew what was happening with care after leaving hospital)	85%*	84%	Worse

** In last year's quality report the score for 2017 was reported as 46 per cent as a problem score. For information on the new Picker Institute scoring methodology please see the glossary.*
Data taken from national patient experience survey results

It is disappointing that our score has worsened on our specific discharge priority with more patients unclear of what will happen when they are sent home despite improvements that have been made during the year.

As part of the North Central London initiative on supporting patients' choice to avoid a delayed discharge, a new letter is being given to patients prior to (or on) admission explaining what will happen on discharge and how they can prepare. A multi-agency discharge event was held in quarter three which led to an increased focus and prioritisation at ward level of discussing the expected date of discharge with every patient. Following on from this the review of expected date of discharge is beginning to be used more at daily ward huddles and a weekly review of all long stay patients is now held at ward level to look at the key challenges for discharging patients home.

Both these initiatives, although not directly linked to our priority are part of our ongoing work to ensure that patients' experience of the discharge process is improved.

3.3.3.5 Improving our cancer patients' experience of care

Table Q11 specific cancer patient care priority

National cancer patient survey question – higher scores are better	2016 result	2017 target	2017 result*	Performance compared with previous year
Patient given easy to understand written information about their cancer type (percentage of patients who received easy to understand information)	67%	72%*	70%	Better

** The results for the 2017 cancer patient survey were published in September 2018. We were unable to define a target in last year's quality report as the results were not available for 2017. The target chosen was based on scores achieved by similar trusts in the same survey.*
Data taken from national patient experience survey results

Although there is improvement on the 2016 score, we remained below the target of 72 per cent. It is worth noting that this priority was set after the 2017 survey had been completed so the effects of any improvement work are unlikely to be seen until the 2018 results become available in spring 2019. Work that has already taken place this year includes:

- Working with clinical nurse specialists (CNS) and support workers to simplify information given to patients at diagnosis.
- Having the most common UCLH cancer information leaflets given to patients professionally printed so that they are more appealing to read.
- Working with the learning disabilities team to raise awareness of already available easy read leaflets for patients with a learning disability having cancer treatment.
- Setting up an information display stand on the Molly Lane Fox unit at NHNN displaying cancer information (for example about brain cancer and managing the effects of cancer treatment).
- Establishing other stands, such as an information point in the atrium area of the main UCH site.

3.4 Priorities for improvement 2019/20

How we consulted on our priorities for 2019/20

In choosing our quality priorities for the coming year, we consulted widely – with our staff, with representatives of local GPs, our commissioners and with UCLH governors on behalf of our patients and the public. We sought input from our staff through the clinical boards, the patient safety committee (PSC), the quality and safety committee (QSC) and the patient experience and engagement committee (PEEC). We discussed the priorities and indicators with our governors through a session dedicated to the quality report and to issues of safety and effectiveness. The priorities take account of progress against those for 2018/19, described in section 3.3.3, with most of last year's priorities identified as needing ongoing focus in 2019/20. The 2019/20 objectives have taken into account the organisational changes with the roll out of the EHRS.

The priorities agreed are summarised here:

Table Q12 2019/20 UCLH quality priorities summary

Domains	Priorities
Patient safety	• Five steps to surgical safety (5SSS): reduce avoidable harm from surgery and invasive procedures • Reduce harm from failure to recognise and respond appropriately to deterioration • Reduce harm from failure to follow up on radiology results • Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels • Continue Trust wide learning
Clinical effectiveness	• Learning from deaths
Patient experience	• Friends and family test targets – inpatients, ED, transport and outpatients • Outpatient priorities – waiting • Inpatient priorities – waiting, help with meals and discharge • Cancer priorities – provision of easy to understand written information

3.4.1 Priority 1: Patient Safety

Our stakeholders have confirmed that they want to see us continuing to focus on core areas to improve patient safety. These include reducing avoidable harm from surgery and invasive procedures, reducing harm from failure to recognise and respond appropriately to deterioration and reducing harm from failure to follow up on radiology results. They have agreed to the addition of a further safety priority around patients with diabetes. We will also continue with Trust wide learning.

3.4.1.1 Five steps to surgical safety: reduce avoidable harm from surgery and invasive procedures

Why we have chosen this priority

We have observed successful developments in the approach to the five steps to safer surgery (5SSS) across surgery and invasive procedures but our observations show there is still progress to be made in ensuring best practice is followed for the 5SSS in every area, with every team, for every patient. With the increase in visits we have been able to start to identify themes from our enhancing safety visits (ESVs), share practice and formulate action plans for improvement. We were disappointed that we had ten surgery-related Never Events and a focus this year will be on ensuring we learn from these.

The introduction of the EHRS has the potential to change the way the five steps are performed across surgery and invasive procedure areas. A period of identifying and evaluating the benefits and risks across these areas will be critical to maintain patient safety and we need to focus on this for the first part of the year. We will therefore continue with our ESVs but, within these, we will also focus on how staff interact with the new EHRS and the impact that this has on performing the 5SSS.

This year we will	What success will look like?
Identify and evaluate the benefits and risks brought about by the introduction of EHRS, in order to improve the approach to the Five Steps to Safer Surgery. These findings will form local quality improvement initiatives.	We will spend up to six months observing how staff interact with the EHRS and collecting baseline information on the benefits and risks. Having established a baseline, we will spend the following six months working on improvement initiatives.
Provide local teams with training on how to carry out ESVs in their local areas. This aims to increase the volume of visits in these areas and improve local ownership. Continue to undertake visits by the core team.	At least three teams will be trained to carry out enhancing safety visits in their areas of expertise and will conduct local visits quarterly. The first team to receive training will be neuroradiology, where two Never Events have taken place. The core team will undertake a further ten ESVs. We will continue to identify themes from these visits.
Continue to embed the process of carrying out the 5SSS across areas performing invasive procedures outside of a main theatre, e.g. brachytherapy. We have visited 64 per cent of areas identified that perform invasive procedures thus far.	We will have visited 100 per cent of areas outside of the main theatres that carry out invasive procedures. We will review their current safety approach to carrying out procedures and support embedding the use of the 5SSS in these areas as required.

This year we will	What success will look like?
Develop systems to oversee learning and implementation from ESVs Trust wide.	We will create an action and monitoring process that is overseen at the reducing surgical harm steering group to ensure that agreed actions from ESVs are implemented.
Increase the percentage of staff completing the 5SSS e-learning module.	Achieve 90 per cent completion of the 5SSS e-learning module for staff working in theatres and anaesthetics.
Share learning from incidents relating to the 5SSS across the Trust.	Publish three At The Sharp End surgical safety bulletins. Learning from incidents will be a standing agenda item at the reducing surgical harm steering group. This will provide clinical leads with up to date knowledge on the latest incidents across the Trust that can be further shared with staff in their divisions.
Review investigations into the surgery-related Never Events for learning.	We will support teams to implement improvements in relation to the 5SSS, as set out in action plans from investigations where surgical Never Events have occurred.

How we will monitor progress

Our performance will be measured and monitored by the reducing surgical harm steering group (RSHSG), and reported to the quality and safety committee (QSC).

3.4.1.2 Reduce harm from failure to recognise and respond appropriately to deterioration

Unrecognised deterioration is where a patient's health becomes worse and this is not picked up and acted on quickly. We are continuing to focus on the prediction, timely recognition, escalation and management of deterioration. Evidence shows that sepsis and acute kidney injury (AKI) are the leading causes for deterioration; therefore we will continue to focus our improvement work in these areas.

Why we have chosen this priority

A multi-disciplinary team reviewed our achievements to date and considered what we needed to do to improve further. With the introduction of the EHRS there will be a period of learning about the new system, and identifying and evaluating the benefits and risks and understanding how the EHRS will help us to respond to, and manage, a deteriorating patient.

A revised early warning scoring system NEWS2 has been introduced nationally. There are two new indicators in NEWS2 – new confusion (meaning confusion that the patient has developed recently) and two different scales for SpO2 scale (peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood) depending on the clinical

needs of the patient. We felt this was an important area to focus on to support prediction, recognition and escalation of the deteriorating patient.

This year we will

Identify and evaluate the benefits and risks brought about by the introduction of the EHRS, in order to improve the approach to identifying and managing the deteriorating patient. This will be supported through improving care rounds (ICRs), matron quality rounds and the use of safety dashboards. A number of measures are new this year and will be recorded through our EHRS. We will obtain data from this system to establish a baseline, from which we will identify an improvement trajectory.

We will take this approach to all of the following areas:

This year we will		What success will look like?
Prediction of deterioration	Monitor and ensure completion of vital signs.	Maintain 96 per cent completion of vital signs.
	Measure compliance with NEWS2 indicators including the new indicators for new confusion and correct SpO2 scale.	We will spend six months establishing a baseline of data from our EHRS. We will use this data to identify improvements that we can achieve in the following six months.
Recognition of deterioration	Ensure observations are monitored according to NEWS2 score as set out in the vital signs policy.	We will spend six months establishing a new baseline of data from our EHRS. We will use this data and identify improvements that we can achieve in the following six months.
	Measure adherence to fluid balance monitoring.	We will spend six months establishing a baseline of data from our EHRS. We will use this data to identify an improvement trajectory in the following six months.
Escalation of deterioration	Ensure timely escalation of patients to a relevant clinician according to NEWS2 score, as set out in the vital signs policy.	We will spend six months establishing a baseline of data from our EHRS. We will use this data to identify an improvement trajectory in the following six months.
Management of deterioration	Ensure patients are responded to according to NEWS2 scores by a suitably trained professional as set out in the vital signs policy, focussing on patients with NEWS2 score >7.	We will spend six months establishing a baseline of data from our EHRS on patients who have NEWS2 score >7. We will use this data to identify an improvement trajectory in the following six months.
	Promote timely antibiotic provision in patients with sepsis.	We will achieve 90 per cent compliance with antibiotics provision within 60 minutes of recognition of sepsis, where appropriate.

This year we will		What success will look like?
	Improve the percentage of AKI patients receiving door to therapy treatment within six hours.	We will achieve 50 per cent more AKI patients receiving door to therapy treatment within six hours from baseline.

How we will monitor progress

Our performance will be measured and monitored by the deteriorating patient steering group (DPSG), and reported to the patient safety committee (PSC) and the QSC.

3.4.1.3 Reduce harm from failure to follow up on radiology results

Why we have chosen this priority

It is important that there are systems in place for communicating and following up on radiology results and that associated 'safety net' procedures are in place and are robust. Last year we continued to work on a policy which would define processes and assurance but it became apparent that our new EHRS would fundamentally change this and so the work was paused. This year we will be ensuring systems are understood and working and we will be developing data to measure our performance. Our stakeholders supported this continuing into 2019/20.

This year we will	What success will look like?
Closely review the systems and "safety nets" put in place with a view to gaining assurance that the systems and processes we have put in place are effective.	We will have defined how results are followed up within imaging and within specialities and what safety nets are in place. Reports and/or dashboards will be available from our EHRS to enable monitoring of this.

How we will monitor progress

Progress will be monitored through the QSC.

3.4.1.4 Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels.

Why we have chosen this priority

Failure to act or recognise and respond to both high and low glucose levels can have serious implications to patients with diabetes. Diabetes UK has recently released a report 'Making hospitals safer for people with diabetes'. The report highlights a number of serious issues with inpatient diabetes care. These include:

- 260,000 people have had a medication error that could have resulted in severe harm or death.
- Longer lengths of stay – people with diabetes stay in hospital for one to three days longer on average than people without diabetes.

In addition, UCLH has had at least four serious incidents in the past few years where harm has been caused due to lack of appropriate monitoring and management of episodes of high glucose and low glucose levels in patients with diabetes. These serious incidents included:

- A post-operative patient with diabetes acquired an infection where their high glucose levels directly contributed to the wound infection.
- A patient deteriorated following poor blood glucose monitoring and untreated low glucose levels.
- Early delivery of IVF twins at 26 weeks where the mother's diabetes was poorly controlled.
- Recurrent episodes of patients developing diabetic ketoacidosis due to insulin omission through poor prescribing or medication errors. Diabetic ketoacidosis is associated with significant morbidity and mortality.

Our monitoring of patient safety incidents shows that the vast majority of incidents are related to poor blood glucose monitoring and medication errors, the latter largely due to insulin prescribing and administration errors. In particular, the timing of insulin administration is often poor contributing to low and high glucose levels. The results of the National Diabetes Inpatient Audit (NaDIA) are described in section 3.6.3.

What we are trying to improve

Based on our findings, we identified a number of areas for improvement. We will set up a steering group including representation from the diabetes team, pharmacy, clinical practice facilitator team as well as a patient with diabetes. This year we will focus on the following:

This year we will	What does success look like?
Improve the management of low blood sugar (hypoglycaemia) in diabetic patients.	We will spend up to six months collecting baseline data from our new EHRS on the management of low glucose levels. Having established a baseline, we will spend the following six months initiating improvement initiatives including developing an alert and order set for management of low glucose levels to guide best practice and timely treatment. An order set is a group of related orders which a clinician can place easily via the EHRS. An order set allows users to issue pre-packaged groups of orders that apply to a specified diagnosis.
Improve the management of high blood sugar (hyperglycaemia) in diabetic patients.	We will spend up to six months collecting baseline data from our new EHRS on the management of high blood glucose. Having established a baseline, we will spend the following six months initiating improvement initiatives, including developing a best practice alert and order set for the management of high blood glucose to guide best practice and earlier treatment of high blood glucose.

This year we will	What does success look like?
Improve diabetes education and share learning from incidents relating to low and high blood sugar across the Trust.	We will have incorporated an update to the new diabetes e-learning module to take account of the EHRS. We will use incidents of low and high blood sugar to identify target wards for the e-learning. We will aim to achieve 50 per cent of staff trained on these wards, while working towards 90 per cent compliance. We will continue to share diabetes safety messages through message of the week and medication and quality and safety bulletins. We will add the management of low and high blood sugar to matron quality rounds and ICRs to assess knowledge of ward staff.
Improve timing of insulin administration by promoting self-administration.	We will establish a baseline for timing of insulin self-administration and set an improvement target. We will revise the self-administration policy to take into account the changes that will arise through the EHRS.

How we will monitor progress

Our performance will be measured and monitored by the diabetes steering group, and reported to the PSC and QSC.

3.4.1.5 Continue Trust wide learning

Why we have chosen this priority

Last year we said we would continue our focus on learning from serious incidents and that we would have no Never Events. Unfortunately, we have had 12 Never Events and our focus this year needs to be on what we can learn from these.

What we are trying to improve

We are trying to improve the learning from serious incidents including Never Events and ensure there are changes in practice. We will aim to have no Never Events in 2019/20 and have agreed a plan with our commissioners. This includes some of the measures identified below.

We were successful in improving human factors awareness across UCLH and wish to continue with this and see human factors addressed more in the serious incident investigation process.

We started work this year looking at how we are assured that we have robust systems in place to implement patient safety alerts and to prevent Never Events. For those alerts that we reviewed we 'RAG' (Red Amber Green) rated them according to how assured we were – with green meaning we were assured we had robust measures in place to prevent harm, with amber and red meaning that we had gaps in the measures in place or had limited assurance. A red rating was given when the risk was deemed higher e.g. that assurance mechanisms had identified significant gaps or that incidents had occurred. We will continue

this work in order to improve implementation of safety measures. We will develop ways of checking on learning at the front line e.g. a more systematic review through improving care rounds, matron quality rounds and enhancing safety visits.

The introduction of the EHRS at UCLH is a major change for the Trust which will be challenging during implementation. A key priority this year will be to manage safety issues both during and following implementation.

This year we will	What success will look like?
Monitor the implementation of the EHRS to identify patient safety risks and mitigation. We will do this by proactively looking for risks as well as monitoring incidents and patient safety dashboards	A risk register will have been developed and risks prioritised and linked to the EHRS optimisation programme
Raise awareness of Never Events	We will have implemented a communication plan to ensure that it is known what the Never Events are and the main actions to prevent them,
Ensure learning from the 12 Never Events incidents that occurred in 2018/19	We will follow up on action plans to ensure they have been implemented and assurance is in place.
	Complete the review of care delivery problems, contributory factors and root causes to identify themes and take action as appropriate
Continue our work on reviewing patient safety alerts and controls and assurances to prevent Never Events	We have undertaken reviews of ten patient safety alerts – this year we will do a review on a further 20, i.e. 30 in total. Of the 30 reviews we will seek to have those related to Never Events rated as green.
	We will check implementation of patient safety alerts in practice through our programme of matron quality rounds, ICRs and environmental monitoring observations.
Continue to promote consideration of human factors when undertaking serious incident investigation	At least 20 members of staff will have been trained in embedding human factors approaches into the serious incident investigation process
	At least two human factors based action plans will have been identified and implemented.
	Bespoke human factors work will have been undertaken in two specialities as a result of their Never Events
Continue to raise awareness of human factors	At least 150 members of staff will have attended training on human factors awareness in healthcare.

This year we will	What success will look like?
	A tool to assess pre and post-course knowledge and skills of staff who attend the human factors training course will have been developed and implemented

How we will monitor progress

Progress will be monitored through the PSC and the QSC.

3.4.2 Priority 2: Clinical Effectiveness

3.4.2.1 Learning from deaths

During 2019/20 we will continue to embed the Structured Judgement Review (SJR) process and train more SJR reviewers. We will continue to learn and refine our processes as we review deaths and start to look at other learning that arises from mortality and morbidity meetings where deaths are reviewed.

A new role of medical examiner will be introduced this year in line with national guidance. This will be a senior doctor not directly involved in the patient's care, who will add a level of scrutiny to deaths, ensuring an accurate cause of death is documented and there is accurate and timely referral to Her Majesty's Coroner when appropriate. The medical examiner will also support the early detection of any safety concerns. They will also act as a point of contact to next of kin, ensuring their concerns are heard.

An internal audit undertaken by our auditors KPMG in 2018/19 on how the Trust learns and reviews patient deaths was carried out and was rated as 'significant assurance with minor improvement opportunities'. Improvements planned for the coming year are to strengthen the feedback from mortality and morbidity reviews to the mortality surveillance group (MSG) which will ensure that learning which is well established locally is shared across the Trust. We will also develop a template to allow divisions to report information and learning from morbidity and mortality meetings.

We will continue to identify and share themes for learning.

Membership of the Trust's MSG includes the deputy chief nurse with responsibility for bereavement and patient affairs and the Trust lead for transforming care at the end of life so that a range of expertise is involved in the monthly review of patient deaths at UCLH.

This year we will	What success will look like?
Continue to increase the number of trained SJR reviewers.	We will have trained an additional 20 staff.
Standardise mortality and morbidity meetings reporting to the MSG where appropriate.	We will have developed a template for mortality and morbidity meetings to ensure that information on key learning points, actions and attendance data are captured. We will also have developed criteria for when an SJR should be undertaken following a discussion at a mortality and morbidity meeting.

This year we will	What success will look like?
Implement the new medical examiner role.	We will have implemented the new medical examiner role.
Continue to focus on learning and assessing the impact of actions taken as a result of reviews and investigations and report these in our quarterly reports.	Our quarterly reports will demonstrate learning from the review of deaths including changes in practice and learning from morbidity and mortality meetings.
Continue to review deaths relating to sepsis and AKI to identify and share further learning Trust wide.	We will have reviewed deaths relating to sepsis and AKI and will have reported quarterly on the learning to the DPSG and the MSG.

How we will monitor progress

Progress will be monitored through the MSG and the QSC.

3.4.3 Priority 3: Patient experience

Table Q13 2019/20 Patient experience priorities summary

Domains	Priorities
Patient experience	• Friends and family test targets – inpatients, ED, transport and outpatients • Outpatient priorities – waiting • Inpatient priorities – waiting, help with meals and discharge • Cancer priorities – provision of easy to understand written information

During this year we will be looking to use the information provided by our new EHRS to understand what else we might use to monitor the patient experience in real time. This will include patients using the new patient portal, MyCare UCLH.

Through MyCare UCLH, patients will be able to securely log in to the portal to view: appointment times, 'after visit summaries', discharge letters, medications and a library of information that is useful for their care, via a mobile device of their choice. Although all patients will have the ability to be signed up to the portal by their clinical teams the initial focus will be on those patients being seen within the maternity division.

3.4.3.1 Improving overall patient experience as measured by the Friends and Family Test (FFT) question

We know that good patient experience has a positive effect on recovery and clinical outcomes. To continue to improve that experience we focus on what patients tell us. The FFT asks patients whether they would recommend our services to friends and family should they need similar care or treatment. The FFT is described in section 3.3.3.1.

We will continue to focus on the same four FFT areas: inpatients/day case, outpatients, transport and ED because we made less progress than we had hoped for in 2018/19 for some areas. As in previous years, we have chosen the four areas giving us the widest reported experiences across our hospitals. These are the best measures of how we are doing and how we compare with others.

As the test scores stayed the same for inpatients/day case and outpatient areas and did not meet our targets, we will maintain these for next year. This would be a one per cent improvement target for inpatients and a two per cent improvement target for outpatients based on this year's performance. Having met the target for ED, we have set a two per cent improvement target, which would bring us more in line with peers (based on a recent review of three months of published data).

It is particularly important for us to continue to monitor our patients' experience of the transport service as this remains an area of concern for us and a key performance indicator for our transport provider. We want to maintain the target for 2019/20 as the score for last year has varied through the year.

What success will look like?

Table Q14 2019/20 FFT Priorities

Friends and Family Test area	Patients recommending UCLH to friends and family		Target for 2019/20
	2017/18	2018/19	
Inpatients and day-case	94%	94%	95%
Outpatients	92%	92%	94%
Emergency department	83%	85%	87%
Transport	69%*	88% **	85%

** This figure was incorrectly stated as 65 per cent in last year's quality report due to an administrative error*
*** Transport data not collected between May and October 2018*

Improving patient experience in priority areas as measured by local and national surveys

As well as the measures of overall experience, each year we target specific areas where patients have told us that experience could be improved. These are chosen based on performance in the national inpatient survey or as measured in real-time feedback from our patients.

As described in section 3.3.3.2 the Picker Institute has changed the scoring methodology for the national inpatient survey. Rather than use problem scores they have used positive scores which make the data much clearer. They have supplied the data for this year and last year using the new methodology as below (this replaces the problem scores table used in last year's quality report). This applies to all the national inpatient survey questions. The glossary explains the difference between the two different types of approach.

Our aim is to improve the experience in areas where patients continue to experience poorer standards than we would like, or where a particular decline in experience is noted. We have continued our priorities from last year so we can ensure the improvements we have seen are embedded.

3.4.3.2 Improving our patients' experience of waiting

We have over one million outpatient attendances each year and we know that waiting times continue to be one of the biggest issues affecting patient experience.

We did not meet our target for outpatient waiting times last year, the target set last year was an improvement target and so we will keep this for 2019/20. There is no national survey planned again this year and so local real-time feedback surveys will be used to measure our performance.

Table Q15 2019/20 Specific outpatient waiting priority

Local real-time time survey question – higher scores are better	**Real-time survey result**		**2019/20– Real-time survey target**
	2017/18	**2018/19**	
How long after the stated appointment time did the appointment start? (percentage of patients who waited 30 minutes or less for appointment to start)	70%	70%	75%

While we have maintained our score, we have not yet met our target. As there is significant change taking place with the introduction of our new EHRS, we expect there to be some disruption at the start of the year. We have therefore lowered the target from 78 per cent to 75 per cent, which still gives us a five per cent improvement target.

There are a number of initiatives currently underway to improve patients' experience of waiting. We are developing a waiting experience standard which will set out how we should communicate with patients about delays and what the environment should be like. We hope this will improve our patients' experience of waiting. Alongside this, in advance of the Royal National Throat Nose and Ear Hospital and The Eastman Dental Hospital moving to a new building and with the introduction of our new EHRS, both hospital sites are working locally to improve waiting times through better scheduling and utilisation of clinics.

Table Q16 Specific inpatient waiting priorities

National Inpatient survey question – higher scores are better	2017 result	2018 result	2019 target***
Admission date not changed by hospital (percentage of patients who did not have their admission date changed)	80%*	78%	80%
Did not have to wait long time to get to bed on ward (percentage of patients who did not have to wait for a bed on a ward)	72%**	68%	72%

In last year's quality report the score for 2017 was reported as 20 per cent as a problem score.
In last year's quality report the score for 2017 was reported as 28 per cent as a problem score. For information on the new Picker Institute scoring methodology please see the glossary
**** The targets chosen are usually based on scores achieved by similar trusts in the same survey. However as we are still waiting for comparison data we have set targets based on previous performance.*

3.4.3.3 Improving our patients' experience of care

We have chosen two priorities to improve our patients' experience of care.
For inpatients we will continue to monitor the help with meals question. Although we have seen a small improvement in our score the action plan developed last year is still being implemented.

Table Q17 2019/20 Specific inpatient care priorities

National Inpatient survey question – higher scores are better	2017 result	2018 result	2019 target**
Got enough help from staff to eat meals (percentage of patients who got enough help to eat meals)	83%*	84%	86%

** In last year's quality report the score for 2017 was reported as 35 per cent as a problem score. For information on the new Picker Institute scoring methodology please see the glossary.*
*** The targets chosen are usually based on scores achieved by similar trusts in the same survey. However as we are still waiting for comparison data we have set a two per cent improvement target.*

We will continue the work already begun this year, including:

- Extending our network and community of nutrition champions, including a new clinical practice facilitator (CPF) lead and provision of a programme of in house nutrition education and training for staff.
- Re-establishment of the Trust wide catering group to identify issues and drive through improvements at local level. Close working between ward staff and catering staff will also enable us to deliver improved communication and understanding of ward and hostess roles, uptake and use of existing and new resources, such as

pictorial menus, and enable work to develop solutions to long standing limitations around use of ward kitchens and beverage bays.

We will bring these actions together in our food and drink strategy, which will be co-created with patients, staff and stakeholders to set out our vision and work plan for the coming years. The progress will be monitored through the nutrition and hydration steering group.

3.4.3.4 Improving our patients' experience of discharge

Table Q18 2019/20 Specific inpatient priority

National Inpatient survey question – higher scores are better	2017 result	2018 result	2019 target**
Patient knew what would happen next with care after leaving hospital (percentage of patients who knew what was happening with care after leaving hospital)	85%*	84%	85%

** In last year's quality report the score for 2017 was reported as 46 per cent as a problem score. For information on the new Picker Institute scoring methodology please see the glossary.*
*** The targets chosen are usually based on scores achieved by similar trusts in the same survey. However as we are still waiting for comparison data we have set targets based on previous performance.*

Understanding what was happening after leaving has continued to be a concern, so in 2019/20 we will work with patients and staff to understand how we can help our patients to feel as informed as possible about what will happen once they have left hospital. This work will include:

- Ensuring every patient has an expected date of discharge and that they are involved in decisions about their discharge including understanding any worries and fears they may have about going home.
- Preparing patients, families and carers for discharge with the right information, both written and verbal. This will include the right contacts for follow up appointments and who to contact or where to go if they have a problem once at home.

With the introduction of the EHRS the quality of discharge information will improve as it will be automatically generated from the patient record.

3.4.3.5 Improving our cancer patients' experience of care

Table Q19 2019/20 Specific cancer patient care priority

National cancer patient survey question – higher scores are better	2016 result	2017 result	2018 target
Patient given easy to understand written information about their cancer type (percentage of patients who received easy to understand information)	67%	70%*	73%

** The results for the 2017 cancer patient survey were published in September 2018.*

We chose to continue our cancer priority for 2019/20 as the results of previous improvement work will not be seen until the 2018 results become available in spring 2019.

Feedback shows that some patients are overwhelmed by the amount of information they are given at diagnosis. Information hubs are designed to help people in finding the right information or service for their individual need. We have continued to roll out additional information hubs across our sites, including NHNN and UCH. We will be auditing the take up of leaflets across all the new information hubs to see what written information is most used by patients and carers.

We will be assessing how best to make use of MyCare to share cancer information with patients. We are also now assessing the information needs of patients coming to our new site for the Royal National Ear Nose and Throat and Eastman Dental Hospitals which opens in 2019.

Based on next year's national survey results, we will work more closely with specific tumour groups to improve the information pathway for patients, ensuring that information is given to patients in the correct format at the most appropriate time.

How we will monitor progress

We will monitor progress against this priority through the PEEC and report to the QSC.

3.5 Overview of quality performance

This section includes progress against locally chosen priorities, progress against the indicators in the Single Oversight Framework, core indicators and mandated reporting on learning from deaths.

3.5.1 Progress against locally chosen priorities

The following table provides information against a number of national priorities and measures that in conjunction with our stakeholders we have chosen to focus on. These measures cover patient safety, experience and clinical effectiveness. Where possible we have included historical performance, national benchmarks or targets so that progress over time can be seen as well as performance compared to other providers. In the following table the benchmark used is the comparison with the national average or comparable UCLH or local target and relates to 2018/19 unless otherwise stated.

Table Q20 Progress against locally chosen indicators

We have chosen to measure our performance against the following metrics:	2016/17	2017/18	2018/19	2018/19 Benchmark	What this means	Notes
Safety measures reported						
Falls per 1000 bed days +	4.2	4.4	3.5	No benchmark available	Lower numbers are better.	The Royal College of Physicians (RCP) National Audit of Inpatient falls no longer report the rates of falls.
Inpatient falls with moderate harm, severe harm and death per 1000 bed days	0.07	0.04	0.05	No benchmark available	As above.	As above.
Cardiac arrests	59	52	51	No local target	Lower numbers are better.	Only includes cardiac arrests as per the criteria for a deteriorating patient by UCLP and excludes those in critical care areas, theatres, ED and catheter labs.
Surgical site infections +	5.4%	3.9%	4.4%	0.0%	Percentage is equal to number of surgical site infections (SSIs) divided by number of SSI operations. Ideally there should be no infections. Lower numbers are better.	Data for 2017/18 has changed from the previous quality report because data in last year's report was only until December 2017 not full year. Data for 2018/19 is only until December 2018.

We have chosen to measure our performance against the following metrics:	2016/17	2017/18	2018/19	2018/19 Benchmark	What this means	Notes
Clinical outcome measures reported						
Stroke mortality rates (based on diagnoses codes 161x, 164x, P101, P524)	7.30%	6.89%	8.1%	No local target	Lower numbers are better.	This indicator looks at the number of patients with these codes who died in the Trust in that time period compared with the total number of patients discharged with the same codes. The numbers of deaths for this indicator are relatively few and confidence limits for this indicator can be provided on request
Percentage of elective operations cancelled at the last minute (on the day) for non-clinical reasons +	0.75	0.80	0.66	0.60	Lower numbers are better.	
Percentage of last minute cancellations operations readmitted within 28 days +	99.4	98.0	97.3	95	Higher numbers are better.	This is the percentage of patients cancelled on the day of surgery for non-clinical reasons, who are then readmitted within 28 days.
28 day Emergency Readmission rate + (readmissions to UCLH)	5.9%	6.0%	6.0%	8.4%	National benchmark is taken from Dr Foster.	Lower numbers are better. Data up to January 2019. We have moved from CHKS to Dr Foster and because of this the data has been refreshed for previous years.

We have chosen to measure our performance against the following metrics:	2016/17	2017/18	2018/19	2018/19 Benchmark	What this means	Notes
Studies approved (NHS permission) UCLH and study type	334 (140 clinical trials + 194 other studies)	287 (122 clinical trials + 165 other studies)	267 (103 clinical trials + 164 other studies)	316 (131 clinical trials + 185 other trials)	Benchmark is previous three year average. Higher numbers are better.	The number of new clinical research studies approved to take place at UCLH categorised by the type of study. In January 2019 a new portfolio management system was introduced and as part of the migration process a very detailed review of all records was undertaken to ensure that the data transferred was correct and up to date. As a result some information has been added that was missed due to gaps left in the previous system (dates, statuses etc.) and any errors corrected. This means there have been retrospective changes in data for the previous years.
Number of trial participants	17,620	14,511	15,564	15,898	Benchmark is previous three year average. Higher numbers are better.	The number of subjects (usually patients) consented to take part in clinical trials at UCLH – it is important for UCLH to have many studies and good recruitment of patients to studies because they are indicators of the level of engagement with research across UCLH, for how research active UCLH is and for how integral research is within UCLH's clinical departments. The change in reported figure for 2017/18 follows a data cleansing exercise as described above.

We have chosen to measure our performance against the following metrics:	2016/17	2017/18	2018/19	2018/19 Benchmark	What this means	Notes
Academic paper which acknowledge NIHR (National Institute for Health Research)	683	725	800	No local target		The number of research papers published in journals and the number of times that the papers have been cited in other journal articles (citations are a measure of the importance of the paper amongst the academic community – this is important as a measure of the quality of our research and therefore affects our reputation and the likelihood of further research opportunities).
Percentage of patients on Diagnostic waiting list seen within six weeks +	96.4	99.2	98.5	99	Higher numbers are better. The benchmark is the national target.	

We have chosen to measure our performance against the following metrics:	2016/17	2017/18	2018/19	2018/19 Benchmark	What this means	Notes
The percentage of inpatient discharge summaries e-messaged to GPs within 24 hours of discharge for those with NHS numbers	97 for Camden and Islington patients	98 for Camden and Islington patients	98 for Camden and Islington patients	No benchmark but the standard NHS contract states that hospitals are required to send discharge summaries by direct electronic or email transmission for all inpatient day cases or ED care within 24 hours	Prompt discharge summaries enable GPs to follow up hospital care efficiently and safely.	Currently, this data is only collected for patients with GPs in Camden and Islington. The work to extend the service to other CCGs was halted pending the implementation of EHRS which will change the way electronic letters are sent to GPs. 98 per cent of UCLH patients have an NHS number at discharge. e-messaging will end when the new EHRS is introduced. It will use Docman Connect to send electronic letters to a far greater number of GPs.

Patient Experience – *national inpatient survey* – 2018 data or a current benchmark is not available until June 2019*						
	2016	**2017**	**2018**	**Benchmark**	**What this means**	**Notes**
Overall satisfaction rating +	8.4	8.3	Not available	Not available	Higher numbers are better.	Weighted aggregated score based on a rating scale of zero to ten where is zero is the lowest score.
How many minutes after you used the call button did it usually take before you got the help you needed? +	6.2	7.9	Not available	Not available	More points for answering in less time. Higher scores are better.	Score based on an aggregate of the following responses: • 0 minutes/straight away • 1-2 minutes • 3-5 minutes • More than five minutes • I never got help when I used the call button • I never used the call button
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand? +	9.2	Not available	Not available	Not available	Higher numbers are better.	Score based on an aggregate of the following responses: • Yes, completely • Yes, to some extent • No • I did not want an explanation • Not applicable This question was removed in 2017 and so the last data set was in 2016. It was not replaced with any like worded question.

After the operation or procedure, did a member of staff explain how the operation or procedure has gone in a way you could understand? +	8.5	7.9	Not available	Not available	Higher numbers are better.	Score based on an aggregate of the following responses: • Yes, completely • Yes, to some extent • No
We have chosen to measure our performance against the following metrics:	**2016**	**2017**	**2018**	**Benchmark**	**What this means**	**Notes**
Staff Experience – national staff surveys*						
Appraisal +	93%	92%	91%	87.7%	Higher numbers are better.	Percentage of staff reporting that an appraisal has taken place in the last 12 months.
The question previously was 'staff would recommend the Trust as a place to work or receive treatment' – this is no longer a question. We have replaced this with 'I would recommend the Trust as a place to work' +	70.0%	70.6%	69.5%	63.0%	Higher numbers are better. Benchmark is the national average as per published data by NHS England.	This question allows respondents to strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. Percentage reflects the number of staff who 'agree' or strongly agree' with the statement. Last year the score was the average out of five. For 2018 NHS England amended the calculation of this question and it is now a percentage. The figures for 2016 and 2017 have been recalculated by NHS England in line with this change in question and calculation as a percentage. NHS England have changed their Key Findings to themes this year, which focus on a different range of results from the staff survey to previous years. This is based on the raw data from the survey.

We have chosen to measure our performance against the following metrics:	2016	2017	2018	Benchmark	What this means	Notes
If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust +	83.6%	83.2%	82.1%	71.0%	Higher numbers are better. Benchmark is the national average as per published data by NHS England.	NHS England have amended the calculation of this question for 2018. This question allows respondents to strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. It was percentage of staff who 'strongly agree' with the statement and is now the percentage of staff who 'agree' or strongly agree' with the statement. Figures for 2016 and 2017 have been recalculated by NHS England in line with this change. NHS England have changed their Key Findings to themes this year, which focus on a different range of results from the staff survey to previous years. These numbers are based on the raw data from the survey.

Staff engagement +	7.2	7.2	7.2	7.0	Higher numbers are better. Benchmark is the national average as per published data by NHS England.	Previously the score was the average out of five. This was reported in 2016/17 as 3.89 and 2017/18 as 3.88. For 2018 this was scored out of ten. In line with this NHS England have re-calculated scores from the previous years. NHS England have changed their Key Findings to themes this year, which focus on a different range of results from the staff survey to previous years. This is based on the raw data from the survey. The overall score is calculated by using the scores for the theme of staff engagement, the questions asked that contribute to this score are: Q2a "I look forward to going to work." Q2b "I am enthusiastic about my job." Q2c "Time passes quickly when I am working." Q4a "There are frequent opportunities for me to show initiative in my role." Q4b "I am able to make suggestions to improve the work of my team / department." Q4d "I am able to make improvements happen in my area of work." Q21a "Care of patients / service users is my organisation's top priority." Q21c "I would recommend my organisation as a place to work." Q21d "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."

Table notes

+ These indicators use nationally agreed definitions in their construction. Otherwise, indicators are necessarily locally defined.

** Headings for patient and staff experience are to a calendar year rather than a financial year as the survey reflects a calendar year.*

3.5.2 Progress against the indicators in the Single Oversight Framework

Table Q21 Progress against the indicators in the Single Oversight Framework

Indicator	Threshold 2018/19	2018/19
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	90.4%
A&E (Emergency department): maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	83.9%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	68.4%*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	84.2%*
C.difficile due to lapses in care	96	4
Total C.difficile (including: cases deemed not to be due to lapse in care and cases under review)	96	56
C.difficile cases under review	-	15
Summary Hospital-level Mortality Indicator	See section 3.5.3.1	
Maximum 6-week wait for diagnostic procedures	99%	98.5%
Venous thromboembolism (VTE) risk assessment	See section 3.5.3.6	

** Data is provisional until 4th June 2019*

We undertake extensive validation work on the data underpinning our performance reporting for RTT, six week diagnostics and A&E (ED) access standards. Along with the rest of the NHS, we need to carry out this validation to ensure that data collected by a wide range of clinical and non-clinical staff is put on to our systems accurately, and then processed in line with rules that are sometimes complex to follow.

The audit undertaken by Deloitte, our external auditors, into the indicator 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' has shown some clinical and administrative data entry errors in the management of cancer pathways. To

address these we will continue to use and develop operational reports which help clinical teams closely manage waiting lists. We have operational meetings at all levels of the organisation to ensure that waiting lists are scrutinised at least weekly. Teams have a suite of data quality reports, including identification of where errors occurred, to help pinpoint issues. The introduction of our new electronic health record system (EHRS) gives us additional tools with which we can identify common data entry themes and those staff who might need more support in their waiting list management responsibilities. We will also introduce sample audits for cancer waiting times data quality, as these audits have been useful in identifying issues on RTT pathways.

Deloitte also undertook an audit into the indicator 'A&E maximum waiting time for four hours'. This identified issues with availability of patient records to undertake the audit and inconsistent recording of correct 'clock stops'.

Our new EHRS will also give us much more control and assurance over the accuracy of the waiting times data captured in our ED, since all information will be captured as part of the clinical care being provided to our patients. Also, we will only have one source of truth for waiting times information, addressing the concern about inconsistencies in records.

3.5.3 Core indicators for 2018/19

3.5.3.1 Summary hospital level mortality indicator (SHMI) and patient deaths with palliative care

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate.

Table Q22 SHMI indicator* and patient deaths coded for palliative care

	UCLH Performance October 2015 – September 2016	UCLH Performance October 2016 – September 2017	UCLH Performance October 2017 – September 2018	National Average October 2017 – September 2018	Highest Performing Trust October 2017 – September 2018	Lowest Performing Trust October 2017 – September 2018
a) The value and banding of the summary hospital – level mortality indicator ('SHMI') for the Trust for the reporting period.	0.738 (Band three)	0.7673 (Band three)	0.7361 (Band three)	1.0	0.6917	1.2681
b) The percentage of patient deaths with palliative care coded at either diagnostic or speciality level for the Trust for the reporting period.	32.5	39.1	37.2	33.6	59.5	14.3

**The Summary hospital level mortality (SHMI) indicator is composed of 140 different diagnosis groups and these are aggregated to calculate the overall SHMI value for each trust. This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, taking into account the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge.*

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline. University College London Hospitals NHS Foundation Trust has taken the following action to improve these indicators and so the quality of its services by:

- Monthly review of specialty level mortality at local and Trust level
- Patient level clinical and coding review of any specialty or conditions, which show as mortality outliers when compared with national data.

3.5.3.2 Patient Reported Outcome Measures (PROMs)

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust has processes in place to ensure that relevant patients are given questionnaires to complete. However, it has no control over their completion and return.

Table Q23 Patient Reported Outcome Measures (PROMs)

Adjusted Average Health Gain (EQ-5D)	UCLH Performance 2016/17	UCLH Performance 2017/18	National Average 2017/18	Lowest Performing Trust 2017/18	Highest Performing Trust 2017/18
Hip – primary	0.46	0.48	0.47	0.41	0.57
Hip – revision	**	**	0.29	0.14	0.35
Knee – primary	0.29	0.37	0.34	0.23	0.41
Knee – revision	**	**	0.29	0.20	0.34

Groin and varicose veins ceased to be collected 1st October 2017
***denotes less than 5 patients so data not available*

University College London Hospitals NHS Foundation Trust has taken the following actions to improve these scores and so the quality of its services by:

Monitoring performance and agreeing actions with appropriate specialties through the PROMs steering group, chaired by a consultant lead and with consultant representatives from all relevant specialties.

- When the steering group noted variance on the PROMs from the national averages for knee arthroplasty and was an outlier, it was investigated at patient level and noted that this was linked to patients with multiple co-morbidities. PROMs are influenced by a variety of issues other than surgery including patients' experience, psychosocial status and their co-morbidities.
- The UCLH EQ-5D adjusted average health gain for hip arthroplasty surgery remains greater than the national average. For knee arthroplasty surgery there has been a considerable improvement in performance and safeguards are in place to ensure we continue to offer our patients the best chance of making a full recovery from their surgery. These include review of post-operative radiographs in fortnightly speciality meetings; consultant agreement to the listing of any patient for total knee replacement; discussion of complex cases in a multidisciplinary team meetings (MDT), continuous monitoring of outcome scores through PROMs capture, and National Joint Registry data review.

3.5.3.3 28-day readmission rate

There has been no new data available from NHS Digital since 2011/12. We have therefore provided our performance data from our benchmarking partner, Dr Foster.

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: UCLH has a robust process for clinical coding so is confident that the data is accurate.

Table Q24 28 day readmission rate

The percentage of patients aged as below readmitted within 28 days of being discharged	UCLH Performance 2016/17	UCLH Performance 2017/18	National Average 2017/18	Lowest Performing Trust 2017/18	Highest Performing Trust 2017/18
(i) 0 to 15	5.40[1]	5.37	9.15	16.49	0.00
(ii) 16 or over	5.90[2]	6.01	8.27	11.50	6.01

[1] *In last year's quality report this was reported as 2.66, the change in figure is due to a change in benchmarking partner from CHKS to Dr Foster.*
[2] *In last year's quality report this was reported as 3.97, the change in figure is due to a change in benchmarking partner from CHKS to Dr Foster.*

University College London Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services by:

- collaborative working with primary care and other secondary care providers across patient pathways.
- continuing to focus on ensuring safe and timely discharge for patients across the Trust to reduce the risk of re-admissions. This includes provision of training to clinical teams on safe discharge processes and daily support to clinical teams from the Integrated Discharge Service in addressing complex discharge issues through collaborative working with external partners and agencies.

3.5.3.4 Responsiveness to personal needs of patients*

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: undertaken independently as part of the annual national inpatient survey.

Table Q25 Responsiveness to Personal Needs of Patients*

	UCLH Performance 2016/17	UCLH performance 2017/18	National Average 2017/18	Lowest Performing Trust 2017/18	Highest performing Trust 2017/18
The Trust's responsiveness to the personal needs of its patients during the reporting period	70.9	69.9	68.6	60.5	85.0

**Responsiveness to personal needs of patients is a composite score from five CQC National Inpatient Survey questions.*

The five questions are:

- Were you as involved as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

University College London Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by:

- monitoring performance using our real-time survey tool, through regular discussion at quality huddles and agreeing local action plans.
- re-introduction of the 'welcome packs' during July to December 2018 to help patients to know what to expect during their stay.

3.5.3.5 Staff recommendation of UCLH as a provider of care

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: survey undertaken independently as part of the annual national staff survey.

Table Q26 Staff recommendation of UCLH as a provider of care

	UCLH performance 2016	UCLH Performance 2017	National Average of Acute Trusts 2017	Lowest performing Acute Trust 2017	Highest performing Acute Trust 2017
The percentage of staff employed by, or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	83.8	83.4	70.0	41.6	93.2

University College London Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services: please refer to section 3.4.3 on how we are working to improve patient care.

3.5.3.6 Venous Thromboembolism (VTE): Risk assessment of patients admitted to hospital

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: University College London Hospitals NHS Foundation Trust has a robust electronic process for measuring VTE risk assessment.

Table Q27 Percentage of adult patients VTE risk-assessed on admission to UCLH

	UCLH Performance Oct 2017 to Dec 2017	UCLH Performance Oct 2018 to Dec 2018	National Average Oct 2018 to Dec 2018	Lowest Performing Trust Oct 2018 to Dec 2018	Highest Performing Trust Oct 2018 to Dec 2018
Percentage of admitted patients risk-assessed for VTE	95.9	96.6	95.7	54.9	100.0

University College London Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and maintain the quality of its services:

- monthly monitoring of key performance indicators via the Trust performance packs
- identifying and empowering low performing areas to formulate and execute a local action plan

3.5.3.7 *Clostridium difficile* rate

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the data has been sourced from the Health and Social Care Information Centre and compared to internal Trust data and data hosted by Public Health England

Table Q28 *Clostridium difficile* rate

	UCLH Performance 2016/17	UCLH Performance 2017/18	National Average 2017/18	Lowest Performing Trust 2017/18	Highest Performing 2017/18
C. difficile infection rate per 100,000 bed days	34.1	27.4	13.7	0	91

This refers to all Trust attributable *C.difficile* infections, including those subsequently appealed and under review. Our threshold, set by Public Health England, is to have less than 96 patients suffering from *C difficile* whilst in our hospitals.

The threshold is based on patient characteristics and previous performance of UCLH and our threshold is higher because we have a high number of cancer/haematology patients and other high risk groups. However, we continue to see a decline in case numbers which remain below expected levels.

University College London Hospitals NHS Foundation Trust has taken the following actions to improve this rate and the quality of its services by:

- continuing the close working relationship between microbiology and infection prevention and control (IPC) teams through the *C. difficile* virtual and clinical ward rounds. We have combined the tool used to record patient reviews by both the

clinical microbiology/ID teams and IPC team, the aim of which is to reduce the number of cases of relapse through proactive measures by more effective communication between the teams.

- continuing to undertake a multidisciplinary root cause analysis (RCA) review of all cases of toxin positive *C difficile*. The RCA is then reviewed with the commissioners and any lapses in care identified. Lapses include delays in isolation, sampling and treatment. Learning from lapses is included in action plans for improvement.
- monthly monitoring of a central action plan in addition to local plans. This includes the funding and introduction of ultraviolet (UV) decontamination and monitoring of isolation room cleaning.
- monitoring improvements and identifying barriers to basic compliance in our quality improvement monitoring tool which is reported monthly.
- continuing focus on antibiotic stewardship to optimise practice and patient outcome which is also monitored and reported.

3.5.3.8 Incident Reporting

University College London Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: data has been submitted to the National Reporting and Learning System (NRLS) in accordance with national reporting requirements.

Table Q29 Incident reporting

	UCLH Performance October 2016 – March 2017	UCLH Performance October 2017 – March 2018	National Average October 2017 – March 2018	Lowest Performing Trust October 2017 – March 2018	Highest Performing Trust October 2017 – March 2018
Number of patient safety incidents reported within the Trust during the reporting period	5798	5315	4999	287	19897
The rate of patient safety incidents reported within the Trust during the reporting period	43.4	41.7	43.6	17.6	158.3
The number of such patient safety incidents that resulted in severe harm or death	22	4	17	99	0
The percentage of such patient safety incidents that resulted in severe harm or death	0.4	0.1	0.3	0.5	0

University College London Hospitals NHS Foundation Trust has taken the following actions to improve these numbers and rates and so the quality of its services by:

- continuing to encourage incident reporting through the monthly quality and safety bulletin, which shares learning on reporting from incidents and near misses.
- sharing learning through the patient safety committee monthly meeting and report.

3.5.4 Learning from Deaths Report 2018/19

During 2018/19, 845 of University College London Hospitals NHS Foundation Trust patients died (of which 57 were neonatal deaths or stillbirths, four were patients with learning disabilities or with a severe mental illness).This comprised the following number of deaths which occurred in each quarter of that reporting period:

Table Q30 Numbers of deaths by quarter of 2018/19

Quarter	Stillbirths, neonatal deaths, paediatric deaths or maternal deaths	Deaths of those with learning disabilities or with severe mental illness	Total Deaths
Q1	12	2	189[1]
Q2	17	2	199[2]
Q3	13	0	212
Q4	15	0	245

[1] *Learning from deaths report to the Board states 186 – administrative error*
[2] *Learning from deaths report to the Board states 206 – this figure included private patients* by error

By March 2019 115 case record reviews and eight SI investigations, in total 123, had been carried out in relation to 845 of the deaths included in the numbers above. In six cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Table Q31 Number of deaths in each quarter for which a case record review or an investigation was carried out

Quarter	Total number of deaths in each quarter for which a case record review or an investigation was carried out	Number subject to SI Investigation	Number of stillbirths, neonatal deaths, paediatric deaths or maternal deaths	Number of SJR reviews	Number of deaths of those with learning disabilities or with severe mental illness	Number of deaths of patients who were not under UCLH care at the time of death but where another organisation suggests that the trust should review the care provided to the patient in the past
Q1	40	2	12	23	2	1
Q2	43	3	17	20	2	1
Q3	21	1	13	7	0	0
Q4	19	2	15	2	0	0

In 2018/19, 42 cases (SJRs, SIs and complaints) were judged by the mortality surveillance group (MSG) and no deaths were judged to be more likely than not due to problems in care provided to the patient.

Reviews of deaths are undertaken as follows

Stillbirth review

Term or unexpected stillbirths are reviewed by the maternity clinical incident review group (CIRG). Meetings of CIRG are held weekly. If there are concerns about care or potential avoidable factors in a stillbirth, an investigation will be instigated. Some of these cases are expected stillbirths e.g. with fetal anomalies or growth restriction, and therefore not all cases trigger an investigation.

Intrapartum stillbirths (where there is a fetal heart beat detected at the onset of labour) are always discussed at CIRG and there is always an investigation to consider whether there were avoidable factors in the death. These cases are also reported to 'Each Baby Counts' and Healthcare Safety Investigation Branch (HSIB) and a review is undertaken using the perinatal mortality review tool (PMRT) where appropriate. For the period April 2018 – February 2019 a total of 43 deaths have been reviewed using the PMRT.

Neonatal deaths

Previously, deaths were discussed at the weekly perinatal mortality and morbidity meetings. From April 2019 there will be quarterly multidisciplinary neonatal mortality review meetings. The deaths for the previous quarter will be presented and discussed. All staff involved in the cases will be invited, including those from other hospitals if the infant has been transferred into UCLH. These meetings can also include staff from other agencies as appropriate to the cases. A draft analysis form is completed for each case and sent to the Child Death Overview Panel (CDOP) for review.

The UCLH neonatal unit is part of the North East and North Central Operational Delivery Network. As part of this organisation there are yearly mortality meetings, where all deaths are discussed at network level with representatives from all neonatal units. Learning is shared and where infants have been transferred between units information is fed back.

Paediatric deaths

All deaths relating to children under the age of 18 years are subject to a review by the CDOP and are reported externally.

Maternal deaths

A maternal death is defined as the death of a woman while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management and not from accidental causes (WHO 2010). All maternal deaths are reviewed by the maternity CIRG and are also investigated as a serious incident in line with the Trust investigation policy.

Deaths relating to people with learning disabilities

All deaths relating to patients with learning disabilities are subject to a case review and are reported to the LeDeR (Learning Disabilities Mortality Review) programme. The LeDeR programme is a review process for the deaths of people with learning disabilities and provides support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR programme also collates and shares the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

Deaths of patients with severe mental illness

All deaths relating to patients with severe mental illness are subject to an SJR review and or serious incident investigation where appropriate.

Deaths during the reporting period for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient

Zero representing zero per cent of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Table Q32 2018/19 deaths judged more likely than not to have been due to problems in the care provided to the patient

Quarter	Number and percentage of patient deaths by quarter that are judged to be more likely than not to have been due to problems in the care provided to the patient.	
	Number	Percentage
Q1	0	0%
Q2	0	0%
Q3	0	0%
Q4	0	0%

These numbers have been estimated using the Royal College of Physicians (RCP) structured judgement review (SJR) method, serious incident investigation process, the perinatal mortality review tool (PMRT), child death overview process (CDOP) or the LeDeR (Learning Disabilities Mortality Review) programme.

Ten SJRs have been reviewed by the MSG due to the care being scored as poor and subsequently a second SJR has been completed to establish whether the death can be judged to be more likely than not to have been due to problems in the care provided to the patient. The MSG and the second reviews confirmed that in none of the cases was the patient's death judged to be more likely than not due to problems in care.

Learning from Structured Judgment Reviews

In January 2019 the Trust produced the first mortality surveillance newsletter highlighting the learning and good practice found from SJRs and investigations. This was circulated Trust wide as part of the quality and safety bulletin.

The following outlines examples of learning from some of the SJRs we have undertaken. Next year we will be able to undertake a more detailed review of themes and trends as we will have more data.

Good practice	Areas for improvement
End of life palliative care	
There has been clear evidence of appropriate end of life care discussions with consideration given to culture or religious beliefs and excellent symptom control. Excellence in care at the end of life is evident. Patients are asked where they would like to die.	Do not resuscitate discussions could sometimes happen earlier, especially when patients are deteriorating from disease progression. A treatment escalation plan has also not always been considered, and in a small number of cases this has led to confusion about the level of care the patient should receive. Patient preference for place of death cannot always be accommodated.

Good practice	Areas for improvement
Escalation when patient deteriorates	
There was good evidence that NEWS scores are monitored and deteriorating patients are being referred to Patient Emergency Response and Resuscitation Team (PERRT) or ITU.	In a couple of cases NEWS scores were incorrectly totalled resulting in a slight delay in referral and review. Sometimes wards try to manage very complex patients without asking PERRT or ITU for support or advice.
Acute kidney injury	
Close monitoring of bloods, frequent senior medical reviews and fluid balance monitoring including the recording of patient weights are evident in many cases. Discussions about risk of using contrast for investigations documented in most cases.	Medication review and reconciliation in renal impairment was not always evident. Local pharmacists can identify and assist when drug doses should be reduced or alternatives suggested when renal function is impaired. Fluid balance charts not always totalled or monitored accurately.
Communication	
Good multi-disciplinary discussions evident in many cases, and evidence of discharge planning at early stage even if events had meant discharge was not then possible.	Ward round decisions not always captured. When treatment plans change the rationale is not always evident. If a review has been requested it is not always clear if the referral has been made and could lead to delays.

All of these themes have been included in the mortality surveillance newsletter which is part of the quality and safety bulletin. This learning is also shared as part of training for SJR reviewers.

Learning from investigations

Splenic irradiation

Following the death of a young man in another hospital from septic shock and multi-organ failure, his mother expressed concern about the lack of antibiotics following removal of his spleen five years earlier at UCLH. The investigation showed that the patient's spleen had not been removed but it was irradiated and the investigation reviewed the impact of this. Care delivered by the consultant oncologist was entirely appropriate for the disease. However, there was not a policy in place which covered total body or splenic irradiation at the Trust or nationally which considered whether patients undergoing such irradiation should be considered for antibiotic prophylaxis.

Action taken

As a result of this incident the professional body for clinical oncologists, the Royal College of Radiologists decided to commission national guidelines to be developed by a group representing all relevant stakeholders including the Royal College of Pathologists for haematology and microbiology input. A working group was established within the Trust to write local guidelines.

Delay in diagnosis of neutropenic fever

A female patient with a medical history of chronic obstructive pulmonary disease (COPD), heart failure and lupus was admitted for debulking of a neuroendocrine tumour. She was discharged post-procedure then re-admitted three days later with suspected neutropenic fever and died the following day. Suspected neutropenic fever was not considered for two hours despite the fact that she met the criteria for this diagnosis.

Action taken

A teaching session for ED staff was provided highlighting the "Suspicion of Neutropenia and Fever guidelines" and the flowcharts relating to these two policies printed and laminated and displayed to maintain awareness of the criteria for neutropenic fever and the required actions. These have also been added to the induction pack for new staff and the learning was shared in the quality and safety bulletin.

Unexpected death

A male patient, diagnosed with small bowel obstruction, had an insertion of a nasogastric (NG) tube which did not drain. The normal expectation is that following insertion, an NG tube would be allowed to drain freely (free drainage) and there would be regular (two hourly) aspiration for patients with known or suspected small bowel obstruction. In this case after the NG tube was inserted there was no aspirate on insertion and no documented further attempts at aspiration. No drainage was seen or documented and there had been no concern or escalation to senior medical staff despite there being known fluid in the stomach (an earlier CT scan had shown 1.5 litres of fluid present). The patient subsequently suffered a cardiac arrest. It is unclear whether any actions would have prevented the cardiac arrest, however if the lack of aspirate / no free drainage had been noted and escalated, this action could have potentially prevented the vomiting suffered by the patient.

Action taken

The main learning was that there is no written guidance for junior doctors or nursing staff on the management of nasogastric tube drainage in small bowel obstruction including how to manage these tubes and when to be concerned and to escalate. Guidance on the management of acute bowel obstruction has now been developed and shared with staff.

Reviews of 2017/18 deaths

12 case record reviews and zero investigations were completed after 2017/18 which related to deaths which took place before the start of the reporting period. These numbers have been estimated using the Royal College of Physicians (RCP) structured judgement review (SJR) method, serious incident investigation process, the perinatal mortality review tool (PMRT), child death overview process (CDOP) or the LeDeR (Learning Disabilities Mortality Review) programme.

There were no deaths that were reviewed before the reporting period, that were judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the RCP SJR method, serious incident investigation process, PMRT, CDOP or the LeDeR programme.

Zero representing zero per cent of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

3.6 Statements of assurance from the Board

3.6.1 Introduction

All providers of NHS services are required to produce an annual quality report and certain elements within it are mandatory. This section contains the mandatory information along with an explanation of our quality governance arrangements.

The quality governance arrangements within UCLH ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board.

There are a number of committees and executive groups with specific responsibilities for aspects of the quality agenda which report to the quality and safety committee (QSC). The QSC is a sub-committee of the Board of Directors which provides the Board of Directors with assurance over the three key areas of quality; safety, effectiveness and patient experience. It is responsible to the board for ensuring that appropriate arrangements are in place for measuring and monitoring quality, challenging assurance and determining what needs to be drawn to the Board's attention, identifying and escalating potential risks to quality of services, sharing learning from serious incidents and deaths and ensuring that agreed actions are implemented as appropriate. On behalf of the Board, it reviews compliance and receives assurance in meeting regulatory standards set by the Care Quality Commission (CQC).

The committee is led by a non-executive director and consists of three additional non–executive directors, the chief executive, the four medical directors, the chief nurse, director for quality and safety, the director of planning and performance, the director for quality and safety for the research support centre and two Council of Governors representatives.

Some examples of how the QSC undertakes this role are as follows:
The QSC raised a concern about the availability of MRI scanning for patients with spinal injuries in the emergency department. As a result, the provision of this service was carefully reviewed and revised so that MRI scanning is now available. We are seeking assurance through audit that MRI scanning is available as required.

The QSC noted the risk of needle stick injuries following a presentation from the infection control team. The QSC received further assurance in March 2019 that the action plans to minimise this risk had been delivered.

Following the Gosport Independent Panel Report the QSC received a report identifying that the Trust had good processes in place for the control and monitoring of prescribing of opioid medication. This report also identified processes in place to ensure that patient and relatives' concerns are heard and addressed which includes oversight of complaints or concerns through the mortality surveillance group (MSG). In addition, the QSC received a presentation from the end of life care lead on an audit of opioid prescribing which provided assurance on doses used and controls in place to prevent excessive prescribing.

The QSC received an update on the action plan from a serious incident involving an early neonatal death following severe hypoxic ischaemic brain injury during labour and delivery. The QSC received assurance on the progress with cardiotocograph (CTG) training and competencies.

The audit committee is responsible on behalf of the Board for independently reviewing the systems of governance, control, risk management and assurance. It will regularly assure itself as to the effectiveness of risk management and internal control of other Board committees in particular, the work of the QSC.

The Board receives a regular corporate performance report (available on the UCLH website as part of the published Board papers) that includes a range of quality indicators across the three domains of quality - patient safety, experience and clinical effectiveness.
In addition, the Board receives a number of reports relating to quality such as quarterly reports on serious incidents, and quarterly and annual reports on adult and child safeguarding and complaints. The Board has a safety presentation at the beginning of each meeting which has included end of life care, the research hospital, human factors in safety, response to the findings from the CQC inspection, safety and the EHRS. The Board is further assured by reviews undertaken by internal audit which this year has included serious incidents, risk management and learning from deaths.

We have a well-established programme of visits focusing on the CQC domains of safe, effective, caring, responsive and well-led. These include ICRs, matron quality rounds and the governors' visits to clinical areas. Board members including the chair and chief executive, medical directors, and the chief nurse also undertake walkabouts around UCLH talking to staff and patients.

3.6.2 A review of our services

During 2018/19 University College London Hospitals NHS Foundation Trust provided and/or subcontracted 77 relevant health services. University College London Hospitals NHS Foundation Trust has reviewed all the data available to us on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by University College London Hospitals NHS Foundation Trust for 2018/19.

3.6.3 Participation in national and local audits

Clinical audit evaluates care against agreed standards, providing assurance and identifying improvement opportunities. University College London Hospitals NHS Foundation Trust carries out an annual programme of clinical audits in three categories – national, corporate and local. For national audits, we aim to participate in all that are applicable to us.

During 2018/19, 49 national clinical audits and six national confidential enquiries covered relevant health services that University College London Hospitals NHS Foundation Trust provides. During 2018/19, University College London Hospitals NHS Foundation Trust participated in 98 per cent of national clinical audits and 100 per cent of the national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University College London Hospitals NHS Foundation Trust participated in and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table Q33 National clinical audits

	Audit	UCLH eligible?	UCLH participation	Percentage of cases submitted
1	Adult Cardiac Surgery	No	Not applicable	N/A
2	Adult community acquired pneumonia	Yes	Yes	Study still in progress
3	British Association of Urological Surgeons (BAUS) Urology Audits: Cystectomy	Yes	Yes	Study still in progress
4	BAUS Urology Audits: Female stress urinary incontinence (SUI)	Yes	Yes	Study still in progress
5	BAUS Urology Audit – Nephrectomy	No	Not applicable	N/A
6	BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	No	Not applicable	N/A
7	BAUS Urology Audits: Radical prostatectomy	Yes	Yes	Study still in progress
8	Cardiac Rhythm Management (CRM)	No	Not applicable	N/A
9	Case Mix Programme (CMP)	Yes	Yes	100%
10	Elective Surgery (National PROMs Programme)	Yes	Yes	Knees – 91% Hips – 86%
11	Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Service Database	No	Not applicable	N/A
12	FFFAP – Inpatient Falls	Yes	Yes	100%
13	FFFAP – National Hip Fracture Database	Yes	Yes	100%
14	Feverish children in ED (Royal College of Emergency Medicine RCoEM)	Yes	Yes	100%
15	Inflammatory Bowel Disease (IBD) registry	Yes	Yes	100%*
16	Major Trauma Audit (TARN)	Yes	Yes	100%
17	Mandatory surveillance of bloodstream infections and Clostridium Difficile infection	Yes	Yes	100%

	Audit	UCLH eligible?	UCLH participation	Percentage of cases submitted
18	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%
19	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme – Secondary Care Plus Asthma	Yes	Yes	93%
20	National Audit of Anxiety and Depression	No	Not applicable	N/A
21	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100%*
22	National Audit of Cardiac Rehabilitation	Yes	Yes	100%
23	National Audit Care at the End of Life (NACEL)	Yes	Yes	100%
24	National Audit of Dementia – Care in general hospitals	Yes	Yes	100%
25	National Audit of Intermediate Care (NAIC)	Yes	Yes	N/A Just organisational audit required 18/19
26	National Audit of Percutaneous Coronary Interventions (PCI)	No	Not applicable	N/A
27	National Audit of Pulmonary Hypertension	No	Not applicable	N/A
28	National Audit of Seizures and Epilepsies in Children and Young People – Epilepsy 12	Yes	Yes	100%
29	National Bariatric Surgery Registry (NBSR)	Yes	Yes	100%*
30	National Bowel Cancer Audit (NBOCAP)	Yes	Yes	100%
31	National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
32	National clinical audit for rheumatoid and early inflammatory arthritis (NCAREIA)	Yes	Yes	100%
33	National Clinical Audit of Psychosis	No	Not applicable	N/A

	Audit	UCLH eligible?	UCLH participation	Percentage of cases submitted
34	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	Yes	N/A
35	National Comparative Audit of Blood Transfusion programme (NCABT)	Yes	Yes	100%
36	National Congenital Heart Disease (CHD)	No	Not applicable	N/A
37	National Diabetes Audit – Adults – National Inpatient Audit (only reporting data on services in England only)	Yes	Yes	100%
38	National Diabetes Audit – Adults – National Foot Care Audit	Yes	Yes	100%
39	National Emergency Laparotomy Audit (NELA)	Yes	Yes	96%**
40	National Cardiac Audit Programme (previously Heart Failure audit)	Yes	Yes	100%
41	National Joint Registry (NJR) – Hip replacement	Yes	Yes	98%
42	NJR – Knee replacement	Yes	Yes	92%
43	National Lung Cancer Audit (NLCA)	Yes	Yes	100%*
44	National Maternity and Perinatal Audit	Yes	Yes	N/A Just organisational audit required 18/19
45	National Mortality Case Record Review Programme	Yes	Yes	Ongoing reporting and completion of audit process as required
46	National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
47	Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%*
48	National Ophthalmology Audit – Adult Cataract surgery	No	Not applicable	N/A

	Audit	UCLH eligible?	UCLH participation	Percentage of cases submitted
49	Diabetes (Paediatric) (NPDA)	Yes	Yes	Study still in progress
50	National Prostate Cancer Audit	Yes	Yes	100%*
51	National Vascular Registry	Yes	Yes	100%*
52	Neurosurgical National Audit Programme	Yes	Yes	100%*
53	Non-invasive ventilation – adults	Yes	Yes	Study still in progress
54	Paediatric Intensive Care (PICANet)	No	Not applicable	N/A
55	Prescribing Observatory for Mental Health (POMH-UK)	No	Not applicable	N/A
56	Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Yes	Yes	100%
57	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
58	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	100%
59	Seven day hospital service	Yes	Yes	89%
60	Surgical site infection surveillance service	Yes	Yes	100%
61	UK Cystic Fibrosis Registry	No	Not applicable	N/A
62	Vital signs in adults in the ED (RCoEM)	Yes	No	0%
63	VTE risk in lower limbs in the ED (RCoEM)	Yes	Yes	100%

**These audits are all based on automated data extraction sent by UCLH performance team to the audit host aiming for 100% percentage of cases submitted. However, this cannot be confirmed until the host reports are published in up to 2 years' time*

*** Based on quarters one – three. Full year data not available until June 2019*

Table Q34 National Confidential Enquiries

	National Confidential Enquiry	UCLH eligible	UCLH participation	Percentage of cases submitted
1	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Peri-operative Diabetes	Yes	Yes	100%
2	NCEPOD Pulmonary Embolism	Yes	Yes	100%
3	NCEPOD Long Term Ventilation	Yes	Yes	Study in progress
4	NCEPOD Acute Bowel Obstruction	Yes	Yes	Study in progress
5	NCEPOD In Hospital Management of Out of Hospital Cardiac Arrests	To be confirmed by NCEPOD based on data which we are currently submitting	Not known currently	N/A
6	NCEPOD Dysphagia in Parkinson's Disease	To be confirmed by NCEPOD based on data which we are currently submitting	Not known currently	N/A
7	LeDeR Programme	Yes	Yes	Ongoing reporting and completion of audit process as required
8	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Yes	Yes	Ongoing reporting and completion of audit process as required

Corporate audits such as the recognition and treatment of sepsis are driven by UCLH priorities and all divisions are expected to undertake them. Local audits are set up by clinical teams and specialties to reflect their local priorities. Audit findings are reviewed by clinical teams in quality and safety (governance) meetings, as a basis for peer review and for targeting or tracking improvements. The clinical audit quality and improvement committee (CAQIC) oversees the corporate clinical audit programme and activity, and reports to the Board via the QSC.

The reports of six national clinical audits and three local clinical audits were reviewed by the University College London Hospitals NHS Foundation Trust in 2018/19 and University College London Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Examples of actions from National Clinical Audits presented to the CAQIC

National Clinical Audit of inpatients with diabetes

What was looked at?	The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes whilst they are admitted to hospital whatever the cause, and aims to support quality improvement, by answering the following questions: • How well did hospital staff manage patients' diabetes whilst they were in hospital? • Did the patient experience complications as a result of their stay in hospital? • What did patients say about their stay in hospital? • Has the quality of care and patient feedback changed since the previous audits?
What did we find?	We found that 28 per cent of patients had been visited by the diabetes team on the day of the audit; the national average was 34 per cent. UCLH matched the national average of prescription errors in 20 per cent of patients, but had a higher than average percentage of medication errors (43 per cent UCLH; 31 per cent nationally). 75 per cent of UCLH patients reported they were satisfied with the overall diabetic care they receive at UCLH (nationally, 84 per cent did) but only 43 per cent (65 per cent nationally) reported that staff knew enough about diabetes, with 27 per cent stating staff looking after them did not know they had diabetes (18 per cent nationally).
What are we doing to improve?	Blood sugar monitoring charts have been updated with high and low blood sugar algorithms to support staff interpreting results. The blood sugar monitoring devices will be linked to the new EHRS so results can be flagged immediately. E-learning in diabetes management is being developed to improve knowledge and confidence. We see many more complex patients with diabetes than the national average and have a relatively small diabetic team. These patients require regular specialist diabetic support. Specific guidelines have been developed for complex patients to aid good blood sugar control. Actions to address medication errors include FY1 doctor prescribing teaching which is based on previous errors / incident reports, an e-learning module under design, the configuration of insulin into the new EHRS has clear instructions and medication errors are regularly highlighted in the trust safer use of medicines (SUMtips) safety bulletin. We have decided to look at aspects of diabetic control as a priority for 2019/20.

National audits

Other national audits such as the Sentinel Stroke National Audit Programme (SSNAP), the National Emergency Laparotomy Audit (NELA) and the National Lung Cancer audit were reviewed by the QSC in 2018/19.

Sentinel Stroke National Audit Programme (SSNAP) audit report

What was looked at?	A stroke is a serious life-threatening condition that occurs when the blood supply to part of the brain is cut off. The sooner a person receives treatment for a stroke, the less damage is likely to happen. This audit looks at the quality of care of patients who have suffered a stroke in all the stroke units in England, Wales and Northern Ireland. It looks at how long it takes to get treatment and how many patients survive for 30 days.
What did we find?	Our overall performance is excellent with patients consistently surviving for over 30 days after a stroke, which places UCLH as one of the second or third best units in England, Wales and Northern Ireland. Performance of both the Stroke Unit and the Hyper Acute Stroke Unit (HASU) were rated A overall for clinical care. The audit did identify an area for improvement, in common with all London HASUs. All potential stroke patients are transferred directly to a hub hospital containing a specialist 24 hour HASU for immediate assessment and treatment. The London Stroke model does not require timely repatriation of patients back to the linked stroke units that would previously have managed the patient prior to the creation of the HASU model. This leads to an inevitable delay in new patients being transferred into HASU beds from the ED, which is associated with poorer outcomes. This is a greater problem for UCLH because the HASU is not co-located with our Acute Stroke Unit. Other units flex beds across the co-located HASU and Acute Stroke Units but this has never been easily possible within our Trust and so our opportunity to manage patient flow is more limited.
What are we doing to improve?	We have limited any risk to our patients by working to improve admission times, to create a team and a set of protocols to provide best care even in patients not immediately admitted to the stroke unit, to fix the local and sector blocks to immediate HASU admission. The service is addressing the areas for improvement in a series of ways. We will: • lead a North Central London sustainable transformation partnership to improve the whole sector stroke pathway to improve downstream flow. • have created new pathways with ED to facilitate early decision making in ED and maximise opportunity for timely admission for stroke patients. • have reviewed our staffing models and provided additional medical staff at times when stroke presentations to ED are highest or performance by the stroke team was worst (e.g. overnight admissions). • have piloted and then established Stroke Nurse Practitioner roles (we now have an Advanced Nurse Practitioner and additional funded nurse practitioner posts) to maximise the efficiency of stroke performance in the ED and management of stroke patients not immediately admitted to the HASU. • have piloted video-telemedicine systems to improve senior decision maker input into the patient admission pathway.

	• have embedded additional daily consultant review of all new patients to ensure management plans and admission plans are the best they can be. • have introduced a series of new practices to improve the management of any patient who is not immediately admitted to the HASU (e.g. a bespoke swallow screening training programme for junior doctors and a tool-bag for completion of swallow screen assessments outside of the HASU). These measures are already demonstrating benefit to patients. The mortality figures over the last three years have confirmed that we were already provided NHS leading care but the above initiatives will also improve on the metrics reported by SSNAP.

National Emergency Laparotomy Audit (NELA)

This is an audit run by the Royal College of Surgeons and Royal College of Anaesthetists. The audit has been running in the UK for a number of years and our performance at UCLH has improved following the first report.

What was looked at?	The audit measures performance against a number of key standards. Examples of the standards include how quickly the patient gets into theatre, the presence of a consultant surgeon and anaesthetist for patients at high risk, admission to critical care after surgery and specialist review of patients over 70 after surgery.
What did we find?	There has been significant improvement at UCLH since May 2017 including: identification of cases has increased to 100% from 60%, a pre-operative risk assessment 'landing card' has been introduced and our data shows that this has had a significant and sustained effect on improving pre-operative documentation of risk – this was 64% and is now 91%.
What are we doing to improve?	A new pathway of care has been implemented, designed to improve perioperative outcomes for these patients and to improve performance in a number of organisational metrics such as CT scan reporting before surgery, critical care admission and arrival in theatre in an appropriate timescale. A new, multi-disciplinary, perioperative medicine ward round is in place, specifically targeted at these patients with care of the elderly and pain team input. Areas for ongoing improvement include: to improve CT reporting times further and to reduce delays in getting patients to theatre.

National Lung Cancer Audit

What was looked at?	UCLH performance on indicators for patients diagnosed with lung cancer in 2016. The indicators include the proportion of all patients with pathological confirmation of cancer, patients assessed by a specialist nurse, patients who have anti-cancer treatment (surgery, radiotherapy systemic treatment), patients with stage I/II and PS 0-2 receiving treatment with curative intent (surgery or radical radiotherapy) and patients alive at 1 year after diagnosis.
What did we find?	UCLH scored highly on the majority of indicators in comparison with other London trusts and nationally. The proportion of lung cancers picked up in the early stages reflects a local project to improve early identification. The higher adjusted proportion of patients receiving the preferred surgical intervention in the early stages is 24.3 % compared with the England national average of 17.5% (Standard = 17%). We did not score well on the number of clinical nurse specialists (CNS) but this has been rectified as we now have three full time lung CNSs.
What are we doing to improve?	Work is underway to ensure that data will still be transfered to the national collection centres once the new EHRS is implemented at UCLH.

Examples of actions from local clinical audits

Of the local clinical audits reviewed by University College London Hospitals NHS Foundation Trust in 2018/19 three are presented here and University College London Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Critical Care division – Trialling a new fluid protocol: A quality improvement initiative

What was looked at?	An intravenous (drip) fluid management protocol, based on recent best practice, was developed and trialled at Westmoreland Street Post Anaesthetic Care Unit (PACU) in Critical Care. The aim for this project was to implement a new fluid protocol and reduce the incidence of hypernatremia (a high concentration of sodium in the blood) and hyperchloraemia (an electrolyte disturbance in the blood) and acid base disturbances (the normal balance of acids and bases in the body) in patients after surgery. Data was collected before the intervention and then once the protocol was implemented.
What did we find?	Key results showed that mean length of stay for both PACU and total hospital stay were reduced after implementation of the protocol. In addition the incidence of post-operative hyperchloraemia reduced following the introduction of the protocol from 58 per cent to 43 per cent. There was a significant drop in the number of incidences of metabolic acidosis (acid base disturbance) from 25 per cent to less than eight per cent.
What are we doing to improve?	The project suggests that four per cent glucose in 0.18 sodium chloride is recommended as maintenance intravenous (drip) fluid within the protocol and is associated with a significant cost saving to the Trust.

Urology department – Preventing blood clots after urological surgery

What was looked at?	This audit looked at patients' compliance with 28 days of extended treatment to prevent clots following major pelvic urological surgery. It evaluated the education provided to the patients provided by staff and why patients may not comply with the treatment. Forty-seven patients were contacted to find out if they had completed the full 28 days of clot preventing treatment or if they were advised to stop prior to the 28 days.
What did we find?	We found that 42 patients (89 per cent) reported that they did complete the 28 days of extended treatment, three patients missed one dose, one patient was advised to stop at 15 days by another clinician (not compliant with guidelines) and the final patient was advised to stop by their surgeon following blood in the urine. Complications were also looked at 45 patients reported minimal bruising or pain. The patient with blood in the urine, stopped treatment to reduce the bleeding and one patient who took the full 28 days of treatment, unfortunately suffered a deep vein thrombosis (clot).
What are we doing to improve?	Patient education and information is to be reviewed to ensure patients understand the importance of the extended 28 day treatment and to query if another clinician suggests they should stop prior to the 28 days. A further learning point from this study was about the dose of medication, that patients who weigh over 100kg should have their dose adjusted to match their weight, ensuring patients have sufficient medication for their body size. This has been fed back to staff completing venous thromboembolism risk assessments.

Improving quality of Treatment Escalation Plans (TEPs) in Oncology Inpatients at UCLH

What was looked at?	Treatment Escalation Plans are part of a national initiative to ensure every patient has an early, senior led decision on their ceiling of care. If a TEP is not documented properly it fails to confirm exactly what treatments are indicated, or not, for individual patients in the event of deterioration. This re-audit took place following implementation of improvement actions resulting from the original audit carried out in December 2017. Included in these actions was a new TEP proforma coupled with teaching on how to complete it. Changes to the TEP included the introduction of Yes/ No tick boxes covering specific required items and if complete (yes) or not (no) providing a clear position on outstanding items to consider. A narrative box remained, to document discussion of treatment options, as did the box regarding completion of a Do not attempt resuscitation (DNACPR) form and 'TEP no longer valid' The aim of this audit was to assess the quality of TEP completion for oncology inpatients at UCLH. The audit standard is that 100% of patients should have a TEP, with the treatment options clearly identified. The audit was carried out on all oncology inpatients (n= 47) on one day.
What did we find?	We found that there was poor uptake of the new TEP proforma, but when it was used all treatments were recorded.
What are we doing to improve?	The proforma is being built into the new EHRS which should improve the completion rate. Additional teaching sessions to raise the importance of TEPs and increase the completion rate are being offered to staff.

Quality Improvement

Clinical audit is complemented with quality improvement (QI) projects. Over the last year, six clinical audit presentations have been replaced with QI presentations and education sessions on improvement work to apply locally and share with colleagues. Some examples include: 'reducing surgical harm', 'driver diagrams', 'Lean: six sigma', 'making data count – statistical process control (SPC) charts', and 'pressure ulcer collaborative project'.

An example of a QI project is outlined below:

Emergency division – Pressure Ulcer Collaborative Project

What was looked at?	This initiative, in collaboration with NHS Improvement, was a pilot project across several emergency departments (EDs) in the UK; aiming to improve early recognition, assessment and intervention of pressure ulcers (sores). The Waterlow Scoring method was used to assess risk to patients, but routinely 55 per cent of patients in the ED were not assessed. Wards outside of the ED highlighted inaccuracies in assessments completed in the ED as the tool is not designed for emergency settings. Therefore this collaborative project selected the Adapted Anderson Risk Assessment Tool to trial instead. It includes both the assessment and the care plan.
What did we find?	Key results of the trial showed that 85 per cent of patients in the ED had a risk assessment of which 78 per cent were fully completed. Sixty seven per cent of patients had a care plan (increased from 25 per cent previously). There was much positive feedback from staff about how easy the tool was to use and its suitability for patients in the ED.
What are we doing to improve?	Going forwards, this project will continue to collect data feeding back results using the new tool, as well as to educate staff in the ED in using the tool, allowing for staff turnover. Additionally, the new Anderson tool will replace the Waterlow score in the ED clinical record.

In advance of the implementation of the EHRS in 2018/19 the CAQIC used several presentation sessions to receive updates and engage with the EHRS developers. Discussions included identifying automated data collection for applicable national clinical audits and tools within the system to identify patients via audit criteria.

3.6.4 Seven Day Care Services

University College London Hospitals NHS Foundation Trust continues to participate in the seven day service Regional Network for North Central London. The national process was amended in 2018/19, from the previous case-note audit self-assessment tool to a standard template Board assurance framework, whereby provider Trust Boards may gain assurance that the four priority standards are being met.

The four priority standards remain the same as in previous years:

- Standard two – All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- Standard five – Hospital inpatients must have scheduled access to diagnostic services. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: within one hour if critical, within 12 hours if urgent and within 24 hours for non-urgent patients
- Standard six – Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

- Standard eight – All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week unless it has been determined that this would not affect the patient's care pathway.

UCLH is compliant with the four priority standards, as reported to the Board in February 2019. Implementation in 2018 of the daily Clinical Utilisation Review practice on wards has assisted in evidencing standards two and eight, as has augmentation of the consultant team in the Acute Medical Unit.

3.6.4.1 Raising Concerns

It is important that all staff feel able to speak up. There are many options open to staff at UCLH and also many different people staff can talk to and seek support from both internally and external to the Trust. The workforce director is the Trust's designated executive lead for raising concerns. Staff are also able to raise concerns anonymously however this can limit the amount of investigation that can be undertaken because the investigation team is unable to speak with the individual (s) raising the concern and often clarification is unable to be sought as well as feedback given to the individual(s) on the actions to be taken by the Trust.

Staff are able to raise any concerns about clinical quality or safety or bullying and harassment with the manager in charge of their area, their divisional clinical director or divisional manager or medical director. Alternatively, they can contact the corporate medical director or the director for quality and safety.

For informal approaches the Trust has a 'Where do you draw the line?' campaign which is supported by a conflict resolution pathway providing different paths for staff to use, and be supported in using, to resolve conflict quickly and informally.

Other options for raising concerns include:

- **Line Management** – often concerns can be dealt with locally through the support of line management
- **Trade Union Representatives** – if staff are a member of a trade union, they can provide advice and support
- **Staff Psychological and Welfare Service** which can provide independent advice and guidance.
- **Employee Relations team** who will guide staff through the employee-led complaints process when an informal resolution cannot be reached.
- **NHS Whistleblowing Helpline**
- **Independent Guardian Service** available 24 hours a day to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment and work grievances.
- **Counter fraud** If the matter involves potential fraud

Any concern raised will be dealt with sensitively, and in confidence as far as possible. As the lead, the workforce director will ensure that where needed the concern is formally investigated by a trained investigator and will formally report back to staff raising the concern on any intended action once all information is received and within an agreed timeframe. This is normally no longer than four weeks from the date the workforce director receives the concerns.

The workforce director or the designated investigator (or in the case of fraud or bribery, the Local Counter Fraud Specialist) may need to speak to staff during the period of the investigation. Staff will be under no obligation to attend such meetings but they may help in reaching a speedy and satisfactory conclusion. A colleague or trade union companion may support staff in any such discussions or meeting. All discussions will be held in the strictest confidence as far as possible and every effort made to resolve the matter as quickly as possible. Staff receive feedback either verbally and or via a written outcome letter.

The Trust is committed to supporting any member of staff who wishes to raise a concern.

The Trust's raising concern policy and legislation protects those raising a concern (often referred to as whistleblowing) and the Trust would seek to take appropriate action if any detriment was suffered as a result of a concern being raised in good faith.

3.6.4.2 Rota gaps and the plan for improvement to reduce gaps

An annual report on rota gaps is a requirement of the junior doctor contract. Junior doctors are trainees who are doctors operating on the same level, but who are not on the training pathway. Our report has highlighted areas with the biggest rota gaps. These areas, and the plans to mitigate, are as follows:

Anaesthetics

The department review the rota for each junior doctor change-over and re-work the rota to cover any gaps. Local pay arrangements are in place to support maximum flexibility. Other initiatives include skill-mix changes such as introducing physician associates and international recruitment.

Oncology (medical and clinical)

The department is looking to develop advanced nurse practitioner roles and further cover for out of hours on call is now provided through a contract with postgraduate students at the London School of Tropical Medicine and Hygiene.

Obstetrics and Gynaecology

Discussions are ongoing with the clinical department and the medical workforce team about whether it is possible to re-design the on call rota and to review work schedules to provide better cover overnight.

Accident and Emergency

The department is looking at re-designing the rota and is putting plans in place to support the service with advanced nurse practitioners.

Paediatrics

Measures currently under consideration are establishing an advanced nurse practitioner post, re-designing a post to support a doctor recruited via the medical training initiative, who can also support service delivery whilst widening their clinical experience, negotiating with clinical research fellows to contribute to the on-call rota, over-establishing the number of doctors on the rota to cover maternity leave and review of sick leave policies to ensure juniors are well supported.

Summary

The trust will continue to keep these areas under review. Going forward we will continue to improve the data quality on rotas.

3.6.5 Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by University College London Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 15,564.

A key focus for the National Institute for Health Research is the development and delivery of high quality, relevant, and patient focused research within the NHS. UCLH embraces this aim, remaining at the forefront of research activity, creating and supporting research infrastructures, providing expert and prompt support in research and regulatory approvals, and promoting key academic and commercial collaborations. UCLH continues to develop the active involvement of patients and the public in research design and process through training, bursaries and other resources, ensuring studies which take place at the Trust are relevant to, and inclusive of, patients. UCLH actively promotes research through patient engagement events such as the large-scale annual Research Open Day.

During 2018/19 a total of 267 new research studies were approved to begin recruitment at UCLH. These range from clinical trials of medicinal products and devices, through to service and patient satisfaction studies. There are currently 1,654 studies involving UCLH patients running at UCLH. Of these, approximately 66 per cent are adopted onto the National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio of research.

UCLH is recognised as one of the leading centres for experimental medicine in England. In partnership with University College London (UCL), the Trust has National Institute of Health Research Biomedical Research Centre (BRC) status. UCLH BRC supports UCLH and UCL's world class strengths for innovative early phase research in cancer, neuroscience, cardiovascular disease and inflammation, immunity and immunotherapies. From 2016, their support expanded to focus on other areas of strength, including hearing and deafness, oral health, mental health, obesity, dementia, healthcare engineering and imaging and healthcare informatics. The Trust's commitment to research is further evidenced by the fact it is part of UCL Partners (UCLP), one of five Academic Health Science Partnerships. UCLP itself has a director of quality committed to sharing best practice across the partnership.

3.6.6 CQUIN update

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed quality improvement and innovation work.

A proportion of University College London Hospitals NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals between University College London Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Through discussions with our commissioners, we agreed a number of improvement goals for 2018/19 that reflect areas of improvement nationally, within London and locally. The total income received conditional upon achieving quality improvement and innovation targets for 2018/19 is predicted to be £14.7m which would represent 93.1 per cent of the total available.

The total CQUIN achieved in 2017/18 was £12,769,530 which is 84.1 per cent of the total available.

A high level summary of the CQUIN measures for 2018/19 is shown in the following table together with the forecast income taking into account performance against each CQUIN target.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at: https://www.uclh.nhs.uk/CQUIN.

Table Q35 CCG CQUIN measures 2018/19

CCG CQUINs	Full year value (£) (provisional)
Improvement of health and wellbeing of NHS staff	256,259
Healthy food for NHS staff, visitors and patients	320,324
Improving the uptake of flu vaccinations for frontline clinical staff (target is 70 per cent)	80,081
Timely identification of patients with sepsis in emergency departments and acute inpatient settings	240,243
Timely treatment of sepsis in emergency departments and acute inpatient settings	204,206
Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours	240,243
Reduction in antibiotic consumption per 1,000 admissions	160,963
Working with partners to improve services for people with mental health needs in A&E (emergency department)	576,044
Tobacco and alcohol screening	743,955
Achievement of contract for engagement in sustainability and transformation partnership (STP)	4,804,852

Table Q36 NHSE CQUIN measures 2018/19

NHSE CQUINs	Full year value (£) (provisional)
Clinical utilisation review	1,464,426
Medicines optimisation	778,950
Neonatal outreach	436,212
Haemaglobinopathy network	186,948
Patient activation management	592,002
Shared decision making	112,169
Dose banding for intravenous chemotherapy	623,160
Optimising palliative therapy decision making	218,106
Enhanced supportive care	311,580
Spinal surgery networks	153,608
Stroke system and rehab/ acute kidney injury	638,739
Dental CQUIN	631,197

3.6.7 Care Quality Commission (CQC) registration and compliance

University College Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that all University College Hospitals NHS Foundation Trust locations are fully registered with the CQC, without conditions.

The CQC has not taken enforcement action against University College Hospitals NHS Foundation Trust during 2018/19.

University College Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19: The joint targeted area inspection of the multi-agency response to sexual abuse in the family in Islington which included a visit made by a CQC and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) inspector to the Lighthouse. The high level findings are reported in the joint inspection letter which is available here: https://files.api.ofsted.gov.uk/v1/file/50052395

University College Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC: there were no concerns or actions for UCLH but we are currently working with our partners to prepare an action plan in response to the conclusions reported by the CQC.

3.6.8 Data Quality

3.6.8.1 NHS number and General Medical Practice Code Validity

University College Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
which included the patient's valid NHS number was:

- 97.4 per cent for admitted patient care
- 95.3 per cent for outpatient care and
- 86.1 per cent for accident and emergency care

which included the patient's valid General Medical Practice Code was:

- 96.2 per cent for admitted patient care
- 96.9 per cent for outpatient care and
- 82.8 per cent for accident and emergency care

3.6.8.2 Data Security and Protection Toolkit (previously Information Governance Toolkit attainment levels)

The Data Security and Protection toolkit is based on ten data security standards. It provides an overall measure of the quality of data systems, standards and processes. The score a Trust achieves is therefore indicative of how well they have followed guidance and good practice.

University College London Hospitals NHS Foundation Trust Data Security and Protection assessment was graded as 'standards not fully met (plan agreed)'.
This is subject to approval of the improvement plan by NHS Digital. The Trust must be compliant with the improvement plan within six months.

3.6.8.3 Clinical coding error rate

University College London Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

University College London Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The continuation of a systematic training and development programme that ensures clinical coders possess the knowledge base and skill set to deliver high quality coding.
- The continuation of a systematic audit framework comprising of daily work checks and bi-monthly audits to provide ongoing assurance of coding accuracy standards.
- Ongoing clinician and coder engagement to ensure symmetry between clinical intervention and the coding classifications to promote ongoing awareness of the coding function and drive best practice activity recording.

Appendix 1: At The Sharp End surgical safety bulletin December 2018

uclh

University College London Hospitals NHS
NHS Foundation Trust

At The Sharp End

December 2018

Welcome to issue 11 of At the Sharp End! Our mission is to share lessons learnt from observed good practice as well as from incidents and near misses reported by teams. Ultimately we aim to reduce harm from surgery and invasive procedures and to enhance teamwork and safety culture throughout the Trust.

Debriefing: How do you do yours?

Debriefs are just as important as Team Briefs. It gives you and your team a chance to identify and discuss any issues and to work out how to (and who will) deal with them. It's a way of celebrating your successes too. Say well done to your new team member, praise the individual who got that difficult to get hold of piece of equipment for you. A Debrief is a natural reflection about how the day went. It can take as little as a minute and will be worth it!

You might not get everyone there to start with but soon people will join in and even come to expect it…
Stick with it!

Annex 1: Statements from our commissioners, Healthwatch Camden and UCLH Council of Governors

Statement from NHS Camden Clinical Commissioning Group

Camden Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from University College London Hospitals (UCLH) NHS Foundation Trust, for Camden's population and surrounding boroughs.

Camden CCG has worked closely with UCLH to ensure we have the right level of assurance regarding commissioned services, obtained mainly via regular Clinical Quality Review Group (CQRG) meetings. The CCG welcomes the opportunity to provide this statement on UCLH Trust's Quality Account. We have taken particular account of the identified priorities for improvement within UCLH, and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in April 2019). The document received, complies with the required content as set out by the Department of Health, or where the information is not yet available a place holder was inserted. We have discussed the development of this Quality Account with UCLH over the year and have been able to contribute our views on consultation and content.

This account has been shared with the following Clinical Commissioning Groups, NHS Islington, NHS North West London, NHS Haringey, NHS Enfield and NHS Barnet. The document was also shared with colleagues in NHS North and East London Commissioning Support Unit for their review and contributions.

The Care Quality Commission rated UCLH as "Good" for being effective, caring, responsive and well-led and rated as "Requires Improvement" for being safe, following their inspection in 2018. The Trust are disappointed by this finding, an action plan has been developed in response to the 'must do' and 'should do' actions. The CCG receive regular progress reports on this action plan through the Clinical Quality Review Group.

We recognise the work undertaken by the Trust in improving administration processes on information technology, data quality and electronic referral systems, and in particular implementing a new electronic records system, Epic. As commissioners we expect the Trust to have robust systems in place to support the delivery of services, and provision of data that meets the national requirements for the content and timeliness of discharge summaries and clinic letters being sent to GPs. The Trust has worked hard as part of their Access and Patient Administration Programme and further improvement is expected as part of the Healthcare Records System Implementation which we expect will improve communication between medical teams, GPs and patients.

As part of the Trust Quality Improvement work a number of priorities have been identified and work will continue to deliver these throughout 2019/10 and beyond. These include, improving waiting times within the outpatient setting and providing support to patients at meal times. We acknowledge the development of best practice guidelines for mealtimes, which we hope will improve patient experience at mealtimes.

The Trust are confident that following the introduction of Epic, all relevant patient information will be recorded in one place. We acknowledge that staff will require training and time to adjust to the new system and commissioners will be provided with regular assurance reports that the new system has had a positive impact on the quality and safety of services provided.

It is disappointing that the Trust were unable to meet their Q4 CQUIN target where 90% of patients with sepsis received antibiotics within one hour of diagnosis. We expect improvements in achieving this target throughout 2019/20, particularly within the Inpatient areas. We expect all staff to be compliant with assessing and recording patient vital signs using the National Early Warning System 2 (NEWS2), in order to recognise and respond appropriately to deterioration.

We are very disappointed to note the Trust have reported 12 Never Event Incidents during 2018/19. Assurances have been provided on actions taken for improvement for those incidents where reports have been completed, we look forward to receiving the final reports and action plans for the remaining reports. The Trust's patient safety team compile a monthly bulletin where lessons learned from incidents and near misses are shared across the organisation. The CCG is pleased to note the Trust's continued focus on reducing avoidable harm in surgery and invasive procedures as a safety priority for 2019/20, incorporating the learning to date from investigations into these Never Events.

A national review conducted by the Care Quality Commission (CQC), in 2018 found significant variation in the timescales for reporting on radiology examinations and a range of arrangements in place to monitor and manage backlogs of unreported images at NHS hospital trusts across the country. Commissioners have sought assurance from UCLH on their compliance against these findings. The Trust have a plan to mitigate against delays and we expect to see continued improvements throughout 2019/20.

The Trust continue to proactively encourage patients and their families to raise complaints and concerns about the quality of care provided as part of their continuous improvement work streams. However, we expect to see significant improvements with processes for investigating and responding to complaints, and implementing learning and changes to practice.

At the time of writing this statement, Camden CCG were unable to authenticate the achievement of 2018/19 CQUINs, as some of the data required had not been submitted.

Overall, this is a positive Quality Account and we welcome the vision described and agree on the priority areas.

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Alison Kelly, and it should not be understood as a response on behalf of the Committee.

Thank you for sending your 2018/19 quality report for comment. The report is comprehensive, well written and well structured.

The Trust is to be congratulated on the progress made in 2018 /19 and for the dedication of so many UCLH colleagues who ensured that this happened.

Other Trusts included a section on key achievements and exciting developments in their annual quality reports. Perhaps the Trust should, succinctly, celebrate its achievements a bit more loudly early on in its report.

The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do

The report makes clear that patient safety, clinical effectiveness and patient experience were the top three priorities for the Trust in 2018/19. And will be for 2019/20.

2) Focusing on a common purpose, setting objectives, planning

The report contains three clear, patient focused priorities and plans which were taken forward during 2018/19, and into 2019/20.

It clearly explains what the Trust has done, or will be doing, to further improve performance. Highlighting where performance has improved and where there is still more to do. It is specific about actions taken and to be taken.

The London Borough of Camden has received several complaints about patient transport in the past – however less so recently. It is good to learn about how this improvement is being achieved and what will be done next.

3) Working collaboratively

The Trust demonstrates in the report how seriously it takes working with, listening to and learning from patients.

It is disappointing that patients' experience of discharge is moving in the wrong direction. The Trust takes this complex issue seriously and is working with NCL partners in health and local government to address barriers to progress.

We know from experience that the Trust takes exceedingly seriously its work with local, regional, national and international partners to achieve the best possible outcomes and patient experience. However there is not much reference to this in the report.

4) Acting in an open, transparent and accountable way – using inclusive language, understandable to all – in everything it does

The quality report starts by covering the CQC inspection in 2018. The inspectors praised the UCLH staff for treating patients with compassion, patience and respect. The Trust is to be commended for highlighting, early in the report, that the Trust's approach to safety requires improvement.

The comprehensive actions taken to address this hugely important issue and the subsequent learning are fully explained. However, it would be helpful to understand why it took a CQC inspection to highlight the need for such comprehensive action and what is been done differently across the whole Trust as a result.

It was disappointing to read that there were 12 Never Events in 2018/19, but positive that the Trust is open about action needed.

Must do's and actions are clear, as is learning from complaints. 'What we said we would do' and 'what we have done' are clear.

Data is clearly linked to the issues being covered, including the results of the Family and Friends Test.

Nearly seven pages of data on locally chosen indicators with national benchmarks, where available, are welcome. The data provides another example of how the Trust seeks to work consistently in an open and transparent way.

The Trust is to be congratulated on the positive scores on staff recommendations in table Q26. Similar but different data in table Q20 is confusing.

Table Q30 on deaths of patients with severe mental illness is confusing.

Ideally the national clinical audits information should be linked to the Trust' three priorities.

The report, overall is clear and well written. It might be helpful to share how this is achieved with other Trusts in North Central London.

We would like to finish by thanking the Trust for their huge commitment to high clinical standards and the best possible patient experience throughout the Trust. The report is a good read! Many congratulations indeed to all.

Councillor Alison Kelly

Chair of Health and Adult Social Care Scrutiny Committee

Comments from the Director of Healthwatch Camden

Healthwatch Camden thanks the Trust for the opportunity to comment on your Quality Accounts. We are grateful for the helpful way in which the Trust facilitated our recent visits to your outpatient departments. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS means that we do not have the human resources to consider Quality Accounts in the detail that they deserve this year. We look forward to commenting in future years.

Frances Hasler
Director Healthwatch Camden

Statement from UCLH Council of Governors

Introduction

The Council of Governors represents the collective interests of UCLH foundation trust members (including patients, carers, staff and London residents) and of the public. On consideration of the UCLH 2018/19 Quality Report, the following additional perspectives are presented on behalf of the Council. These do not constitute a comprehensive commentary on all the detailed information contained in the report. (Please see Annex 4 to the quality report for a glossary of terms and conditions.)

Although Governors hear from patients and carers about difficulties they have encountered – for example, telephoning UCLH or with transport, long waits or administration – the overall impression we receive from patients is that UCLH enjoys a reputation for good and, often, excellent quality treatment and care. 2018/19 has seen significant additional pressures on UCLH and it is a sign of the dedication, hard work and skill of staff that many patients we meet still tell us that, given a choice, they would opt to be treated at UCLH.

CQC report, December 2018

We would like to highlight some of the positive comments made in the CQC 2018 report. It was excellent to see an overall outstanding rating awarded for medical care at the Sir William Gowers Centre – the section of the National Hospital for Neurology and Neurosurgery providing specialised assessment and treatment for people with epilepsy and non-epileptic attack disorder. There was recognition of outstanding practice in other areas at the National (for example, neuroimaging related to deep brain stimulation to improve symptoms of Parkinson's disease) and in maternity and gynaecology services (such as fetal surgery for spina bifida and 'one stop' clinics in gynaecology). There was welcome acknowledgement from the CQC of sympathetic attention from senior clinical staff, kind and caring nurses and access to counselling and psychological support for outpatients with supportive chaplaincy services. All of this is encouraging for staff and patients.

Although UCLH was rated 'good' overall by the CQC in December 2018, it was disappointing that the rating for UCH and the Elizabeth Garrett Anderson Wing was moved down by the CQC to 'requires improvement'. This was the case even though maternity and gynaecology services overall were both rated 'good'. The CQC also judged UCLH as 'requires improvement' overall in relation to the question 'Are services safe?'. Governors are concerned that the CQC imposed 'must do' requirements on the Trust when none were required after its 2016 inspection. Governors will be looking for assurance that action plans to address the CQC's 'must do' and 'should do' lists are being implemented within 2019/20.

The CQC did not assess the non-emergency patient transport service provided by UCLH through its provider G4S – see section 4.1 below for Governors' comments on this service in 2018/19.

Patient safety and clinical effectiveness

We are pleased to read in the quality report about the progress in 2018/19 with patient safety initiatives such as Five Steps to Safer Surgery and Enhancing Safety Visits. We recognise the potential for further enhancing patient safety at UCLH by embedding the approaches and learning in these initiatives across surgery and invasive procedures at UCLH.

We take assurance about the safety of patients at the trust from the Learning from Deaths Report (section 3.5.4 of the quality report) which states that none of the patient deaths at UCLH during the reporting period are judged to be more likely than not due to problems in

patient care. It is also encouraging to read that the new Structured Judgement Review process has identified that, within 77 per cent of the reviews conducted, the overall assessment is that the patient received good or excellent care as opposed to care that was adequate or below.

It is excellent to see that UCLH remains in band three of the summary hospital level mortality indicator for October 2017 – September 2018. This means that it had lower than the expected number of deaths in hospital (or within 30 days of being discharged) given the characteristics of the patients treated. Governors are also pleased that UCLH's stroke unit and Hyper Acute Stroke Unit were rated A overall for clinical care by the Sentinel Stroke National Audit Programme.

Governors are also encouraged by the innovative treatments, as mentioned in the quality report, that are being offered at UCLH such as mechanical thrombectomy (clot retrieval rather than clot busting) for stroke; also, by the emphasis UCLH places on research and experimental medicine in collaboration with the NIHR UCLH Biomedical Research Centre.

We note that there was an increase in the number of Never Events reported in 2018/19 compared to the number reported in each of the previous three years. Although we share the trust's disappointment, and are concerned, about this, we derive assurance about the trust's rigorous approach to learning after such events from our observation of the work of the trust's Quality & Safety Committee, which has two Governor members, and the information presented to the Council by the trust's Director for Quality & Safety at regular governance meetings. We support the trust's emphasis on promoting surgical safety and, especially, its work to encourage all team members involved in surgery and invasive procedures to raise concerns, and share lessons that arise from incidents or near misses as well as good practice.

We hope to hear how the trust will act upon any recurring themes that emerge from its identification of 'poor care' in its Structured Judgement Reviews and to see progress on its care of in-patients with diabetes. Governors also hope to see evidence of widespread and informed use of treatment escalation plans for cancer inpatients. Following the recent introduction of a written letter given to patients and carers that explains the discharge process when being admitted to hospital, we look to evidence of an improvement in patient and carer experience of the discharge process and a reduction in the 28-day discharge re-admission rate.

Patient experience

Governors would like to highlight three areas relating to patient experience:

- Non-emergency patient transport
- Aspects of maternity care
- Care of patients living with mental health issues

Non-emergency patient transport

Governors have been concerned about the quality of non-emergency patient transport (NEPTS) at UCLH for over two years. The Minutes of the Council of Governors held on 25 April 2017 record 'the Executive was working tirelessly with G4S to resolve issues and improve the service for patients'. In our commentary on the 2017/18 quality report, we reported that 'Governors have received assurance that UCLH is taking measures to improve the NEPTS so that an acceptable service is delivered by the middle of 2018 but await further

information before we can assure patients and trust members that the anticipated improvements are indeed being consolidated in the service used by our patients'.

The 2018/19 quality report identifies that complaints about NEPTS halved from 2017/18 to 2018/2019 (see 3.2.2, 1. Transport complaints). This may be due in part to the effects of initiatives put in place to improve the service, as UCLH states, but Governors fear that some of the reduction may be due to regular users of the service feeling that there is no longer any point in lodging a complaint. As reported in section 3.3.2, 'there are still concerns being raised … regarding the quality and reliability of the transport provided'. Furthermore, as reported in that section, there was a gap in data collection from May to October 2018.

Governors were especially concerned that, despite assurances received, the second half of 2018/19 saw a significant number of journeys where patients were collected very late (ie mostly waits of 120 – 180 minutes) or where booked transport did not arrive at all (ie mostly waits of over 180 minutes). In August 2018, 3.3 per cent of NEPTS journeys involved waits of over two hours. It was still 3.2 per cent in February 2019 although there was some improvement for March 2019. Given the large number of NEPTS journeys to and from UCLH sites carried out by G4S per month – 8,324 journeys in August 2018, 6,676 journeys in December 2018 (see Council of Governors Patient Transport Report 30 January 2019) – the number of patients affected by waits of over 2 hours was significant. 273 journeys were affected in this way in August 2018, 435 in November 2018 and 216 in December 2018 (see Council of Governors Patient Transport Report 30 January 2019). Governors are also aware that booked journeys can be cancelled and then be rebooked meaning patients experience longer waits than are recorded for the re-booked journey alone.

Although the trust accepts in the 2018/19 quality report that 'there is still room for further improvement', Governors consider that some of the circumstances in which patients have been placed over the year owing to failures in NEPTS have been unacceptable. We understand that even transfers of patients to a hospice for end of life care have been delayed so that the patient has not been admitted to the hospice in the timely way that had been planned. It is a matter of regret to the Council that, despite sustained challenge from Governors over two years, the service delivered by UCLH through its provider, G4S, was still failing to provide by March 2019 reliable transport for a significant number of patients particularly those who required stretcher or specialist transport.

Aspects of maternity care

The CQC maternity services survey published in January 2019 (revised, April 2019) includes the results of survey responses from 170 UCLH patients who gave birth at UCLH in February 2018. There were some disappointing findings when comparing the response of UCLH patients to the response of patients at other trusts in relation to certain aspects of care (for example, not being left alone by doctors or midwives at a time when it worried the patient, or not being able to move around and choose the most comfortable position during labour). Seven of the findings ranked UCLH as 'worse' compared with other trusts, the remainder were 'about the same' and none were 'better' than other trusts. At the Council of Governors held on 16 July 2018, the Clinical Director for Women's Health discussed the survey findings and how UCLH is responding. The Director is due to provide an update on progress at the Council of Governors to be held on 20 May 2019.

The survey is not included in the 2018/19 quality report but some of its findings appear to resonate with factors that the CQC inspection report mentioned in 2018. Those included that midwifery staffing levels were low in relation to the acuity of women; women did not always receive one-to-one care in established labour in line with national guidance; and there was low staff morale due to staffing and capacity issues. The CQC did observe features of good care also: such as staff giving compassionate care to women; access to specialist staff such

as a perinatal mental health team; and better than national average performance in the National Neonatal Audit programme and perinatal mortality rate (MBRRACE audit).

Care of patients living with mental health issues

The CQC observed in their 2018 report on UCH and the Elizabeth Garrett Anderson Wing that patients with mental health needs often experienced delays within A&E although UCLH was working with its psychiatric liaison service provider to identify and address problems with service delivery.

The Council of Governors remains concerned about the pathways of care for patients living with mental health issues who present at A&E at UCH. Patients with significant mental health issues can experience some of the longest waits before suitable onward care can be secured for them. Governors are also concerned about the care of those patients living with mental health issues who are admitted for elective treatment for other conditions. Governors have pursued these concerns through their consultation response on the Trust's objectives for 2019/20. We also hope to see increased focus on training for ward staff across UCLH in this specific area of care. We applaud the appointment of a specialist mental health midwife in the Elizabeth Garrett Anderson Wing and the acknowledgement this represents of the importance of mental health concerns.

Performance against national targets

We note that throughout 2018/19, UCLH did not meet the national targets for A&E performance and 62-day waits for cancer treatment (ie the targets of 95 per cent of patients to be admitted, transferred or discharged within four hours of arrival at A&E; and 85 per cent of cancer patients to receive first treatment within 62 days from urgent GP referral). The Council of Governors is concerned that UCLH also failed to meet the lower, monthly 'trajectories' for performance against those targets that it had agreed for the year although we see evidence of a great deal of work taking place at UCLH (and with local partners) to improve performance.

We recognise that UCLH's performance against these targets and trajectories in 2018/19 was affected, to some extent, by factors outside its control and that, nationally, very few trusts met the A&E target in the year. We are encouraged by the CQC's observations in its 2018 report of an improved culture in the A&E department compared to 2016 and good team working at all levels. We recognise that improvement in care provision to deteriorating patients and the introduction at UCLH of accelerated patient discharge arrangements should lead to some improvement in performance in future.

EHRS

The Trust introduced its new Epic electronic health records system (EHRS) at the end of March 2019, as planned. The development and implementation of EHRS has been a major project and, as a result, the 2018/19 quality report identifies various other improvement initiatives that have been paused. We hope work on developing these initiatives can get back on track in 2019/20. In the longer-term, EHRS should prove beneficial to the trust in many ways including by assisting it to improve the flow of patients through its hospitals.

Claire Williams
Lead Governor, with contributions from:
Frances Lefford, Public Governor and **Christine Mackenzie**, Patient Governor

Annex 2: Statement of directors' responsibilities

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- the content of the quality account is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2018 to 22 May 2019
- papers relating to quality reported to the board over the period April 2018 to 22 May 2019
- feedback from commissioners dated 13 May 2019
- feedback from governors dated 13 May 2019
- feedback from local Healthwatch organisations dated 13 May 2019
- feedback from Camden Health and Adult Social Care Scrutiny Committee dated 8 May 2019
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2018.
- the latest national patient survey May 2018
- the latest national staff survey 12 April 2018
- the Head of Internal Audit's annual opinion of the trust's control environment dated 14 May 2019
- CQC inspection report dated 11 December 2018

Baroness Julia Neuberger DBE
Chair

Professor Marcel Levi
Chief executive

23 May 2019

Annex 3: Independent auditor's report to the Council of Governors of University College London Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of University College London Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of University College London Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

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

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement ("NHSI"):

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (4 hour A&E); and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules (62 days cancer wait)

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance issued by NHSI.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2018/19 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the NHS foundation trust annual reporting manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- board minutes and papers for the period April 2018 to 24 May 2019
- papers relating to quality reported to the board over the period April 2018 to 24 May 2019
- feedback from commissioners, dated 13 May 2019
- feedback from governors dated 13 May 2019
- feedback from local Healthwatch organisations dated 13 May 2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2018
- National patient survey, dated 13 June 2018 and 29 January 2019
- National staff survey, dated 26 February 2019
- Care Quality Commission inspection, dated 11 December 2018
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 31 March 2019

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

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

Assurance work performed

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

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

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University College London Hospitals NHS Foundation Trust.

Basis for qualified conclusion

Percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge

The “percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge” indicator requires that the NHS Foundation Trust accurately record the start and end times of each patient’s wait in A&E, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of unplanned attendances at A&E for which patients’ total time in A&E from arrival is four hours or less until admission, transfer or discharge as an inpatient.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 4 cases of our sample of patients’ records tested, the end time was not accurately recorded affecting the calculation of the published indicator;
- In 5 cases of our sample of patients’ records tested, the end time was not accurately recorded, but did not affect the calculation of the published indicator; and

As a result of the issues identified, we have concluded that there are errors in the calculation of the “percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge” indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

In addition, we identified:

- in 7 cases of our sample of patients’ records tested, we were unable to obtain sufficient supporting evidence to confirm the start or end time necessary to test the calculation of the published indicator; and
- In 3 cases of our sample of patients’ records tested, we were unable to obtain sufficient supporting evidence to confirm the start time necessary to test the calculation of the published indicator.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge
for the year ended 31 March 2019.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules

The "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 1 case of our sample of patient records tested, the end date of the pathway was not accurately recorded affecting the calculation of the published indicator;
- In 1 case of our sample of patients' records tested, the end date of the pathway was not accurately recorded, but did not affect the calculation of the published indicator;
- In 2 cases of our sample of patients' records tested, the duration of a clock pause was not accurately recorded but did not affect the calculation of the published indicator; and

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules for the year ended 31 March 2019.

In addition, we identified:

- In 9 cases of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result there is a limitation upon the scope of our procedures which means we are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting the "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules" indicator for the year ended 31 March 2019. We are unable to quantify the effect of the errors identified on the reported indicator.

The Trust's Quality Report summarises the actions the Trust is taking post year end to address the issues identified in its processes.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for quality reports for Foundation Trusts 2018/19; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

Deloitte LLP
Statutory Auditor
St Albans

23 May 2019

Annex 4: Glossary of terms and abbreviations

Acute kidney injury (AKI): A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days.

At the Sharp End surgical safety bulletin: A bulletin that is published three times a year with the aim of sharing lessons learnt from incidents, good practice and near misses with teams, ultimately reducing surgical harm and creating safer teamwork cultures throughout the Trust.

Best practice advisories (BPAs): Digital display in EHRS of clinical advice provided when action is required in response to abnormal patient findings.

Care Quality Commission (CQC): The independent regulator of all health and social care services in England .

Cardiac Arrest: A collapse when the heart stops beating.

Cardiotocography (CTG): Cardiotocography is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

CCG: Clinical commissioning groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CHKS: A provider of healthcare intelligence and quality improvement services, using data from the NHS Secondary Uses Service to enable trusts to review performance and benchmark.

CNS: Clinical nurse specialist.

Commissioners: The local and national bodies contracting to buy care for UCLH patients.

Complaints: A complaint is upheld (fully agreed) by UCLH when it is agreed that action(s) need to be taken to prevent the subject of the complaint occurring again. It is partially upheld (partly agreed when some aspects of the complaint require action and not upheld (not agreed) when no action is required. Patients are always offered an apology.

Commissioning for Quality and Innovation (CQUIN): A framework that allows commissioners to make payments to hospitals for agreed improvement work.

Deterioration: An evolving, predictable and symptomatic process of worsening physiology towards critical illness (worsening of the patients' condition).

Docman Connect: Docman Connect is a structured messaging platform which enables clinical communication between care settings. The Trust will be using Docman Connect to send and receive electronic discharge summaries to GPs.

DPSG: Deteriorating patients steering group.

Dr Foster: A provider of healthcare data on a number of measures of healthcare quality indicators which are considered a good pointer of overall performance. These include whether the number of deaths in hospital are higher or lower than expected (mortality rates).

Electronic Health Records System (EHRS): EHRS is a single, integrated, and comprehensive electronic record. Our electronic health record system, enabled by Epic, will replace paper notes and most of our clinical systems.

Enhancing Safety Visits (ESVs): The Enhancing Safety Visits are a collaborative way of observing, improving and measuring practice. All staff are encouraged to participate in a visit. They provide opportunities to talk to teams about safety, flagging issues and barriers as needed, as well as sharing learning across different sites, areas and specialties.

Environmental monitoring observations: These are undertaken by an environmental monitoring officer who is a member of the estate and facilities team. They join other staff in the improving care rounds (ICRs) and look out for environmental issues such as cleanliness and equipment concerns. These concerns are then reported back to the service in line with improving care rounds (ICRs).

EQ-5D: A standardised measure of health status to provide a simple, generic measure of health for clinical and economic appraisal. It provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care and in population health surveys. EQ-5D is designed for self-completion and is ideally suited for use in postal surveys, clinics, and face-to-face interviews.

Essence of Care audits: Department of Health guidance on standards of care which should be delivered to patients.

'Each Baby Counts': Each Baby Counts is the Royal College of Obstetricians & Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Friends and Family Test (FFT): An important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

Gosport Independent Panel Report: The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths. The report is an in-depth analysis of the Gosport Independent Panel's findings. It explains how the information reviewed by the Panel informed those findings and illustrates how the disclosed documents add to public understanding of events.

Harm definitions (NHSI):

- **Moderate harm:** Person affected required a moderate increase in treatment; the incident caused significant but not permanent harm to the person. Moderate increase in treatment includes an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

- **Severe harm:** Incident that appears to have resulted in permanent harm to the person affected. This means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage that is related directly to the incident and not related to the natural course of the person's illness or underlying condition.
- **Death:** Incident that directly resulted in the death of the person affected rather than as a result of their underlying medical condition.

Human factors: Human factors encompass all those factors that can influence people and their behaviour. In a work situation, human factors are the environmental, organisational and job factors and individual characteristics which influence behaviour at work and so impact on patient safety.

HSIB: Healthcare Safety Investigation Branch. The Healthcare Safety Investigation Branch (HSIB) began operating on 1 April 2017. They offer an independent service for England, guiding and supporting NHS organisations on investigations, and also conducting safety investigations.

Improving Care Rounds (ICRs): At UCLH, multidisciplinary and multi-level teams visit a clinic, ward, or facility to observe with 'fresh eyes' and give feedback, using the same questions as the Care Quality Commission (Is care safe, effective, caring, responsive and well led?).

ISBARD: A communication tool process to improve providing information and decision-making when urgent referrals are made – UCLH has amended SBAR to include I – Introduction and D – Decision resulting in: Introduction, Situation, Background, Assessment, Recommendation and Decision (ISBARD).

Lean Six Sigma: a method that relies on a collaborative team effort to improve performance by systematically removing waste and reducing variation.

Matron quality rounds: Quality, environmental and patient/staff experience reviews by groups of UCLH matrons, outside of their own clinical areas, with instant feedback via a 'huddle'.

MyCare UCLH: As part of EHRS, we will also offer patients an online patient portal called MyCare UCLH accessible on a computer, smartphone or tablet. Patients will be able to access their own data safely and securely to help manage and improve their conditions and communicate with their care team.

MSG: Mortality surveillance group.

Mortality and Morbidity meetings: a key activity for reviewing the performance of the multidisciplinary team and ensuring quality. M&M meetings have a central function in supporting services to achieve and maintain high standards of care.

National Joint Registry (NJR): The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole.

Near miss incidents - An incident that was prevented from occurring:
Reporting a 'near miss' event is as important as reporting incidents that actually occurred and caused harm. Although a 'near miss' did not cause harm the potential for recurrence probably still exists and this needs to be managed effectively.

NEWS and NEWS2: The National Early Warning Score (NEWS) is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion
6. temperature

NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017

Never Event: Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available.

NHSE: NHS England is an executive non-departmental public body of the Department of Health and Social Care. NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. On 1st April 2019 NHSE and NHSI merged into one organisation.

NHSI: NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

NICE: National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Order set: An order set is a group of related orders which a clinician can place easily via the EHRS. An order set allows users to select pre-packaged groups of orders such as lab tests, x-rays, and medications that apply to a specified diagnosis effective clinical care

Patient pathway: The route that a patient will take from first contact with the NHS, through referral, to the completion of treatment.

Patient Safety Alerts: Patient safety alerts are issued via the NHSI Central Alerting System (CAS) which issues alerts, important public health messages and other safety critical information and guidance to the NHS.

PSC: Patient safety committee.

PEEC: Patient experience and engagement committee.

PERRT: Patient emergency response and resuscitation team.

Perinatal Mortality Review Tool (PMRT): A national standardised tool to look at care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

The Picker Institute survey – Positive versus problem scores: The 2017 scores reported in the 2017/18 quality report cannot be directly compared to those reported in 2018/19 quality report due to the change in methodology as described below.

In 2017/18 patient experience data was recorded using problem scoring. A problem score shows the percentage of respondents who were not fully satisfied. Applicable responses include all of the following response options.

- 'No'
- 'Yes to some extent'
- 'Never'
- 'Yes, sometimes'
- 'Yes, etc.'

Problem scores exclude responses where the question is not relevant to the respondent but include 'Don't know'/'Can't remember' responses.
The most positive responses of 'Strongly agree', 'Agree' and 'Yes, always' are also excluded.
In 2018/19 patient experience data is recorded using positive scoring. A positive score shows the percentage of respondents who gave a favourable response to applicable questions.

Applicable responses include:

- 'Strongly agree'
- 'Agree'
- 'Yes, always'
- 'Yes, sometimes '
- 'Yes, etc.'

Positive scores exclude the responses' Don't know'/'Can't remember' and the responses where the question is not relevant to the respondent e.g. 'No, but I did not need it'.
QSC: Quality and safety committee.

RSHSG: Reducing surgical harm steering group.

Root Cause Analysis (RCA): A framework for an investigation into why specific patient safety incidents happen and identify areas for change to make care safer.

Safety huddles: Daily meetings on the ward to highlight safety and quality issues and promote discussion among team members.

Sampled data: Data that is randomly taken from a larger group of data in order to test and understand the larger group.

Serious incident (SI): serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Statistical Process Control (SPC) Chart: These charts show the average (mean) in green and upper and lower control limits in red which is calculated as three times the standard deviation above the mean. The red lines represent the limits of 'normal variation'. When the

red and green lines move upwards or downwards this means there has been a significant change.

Summary hospital level mortality indicator (SHMI): The ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It includes deaths, which occur in hospital, and deaths, which occur outside of hospital within 30 days (inclusive) of discharge. NHS Digital release the external SHMI every quarter but there is a six-month time lag.

SSI: Surgical site infections.

Thrombectomy: The interventional procedure of removing a blood clot (thrombus) from a blood vessel.

UCL: University College London.

UCLH: University College London Hospitals NHS Foundation Trust.

UCLP: University College London (UCL) Partners is an academic health science partnership organisation.

UCLP deterioration network: A group of NHS trusts within UCLP catchment sharing learning and updates on the approach to deteriorating patients.

Vital Signs: describes six physiological parameters: (measurements)
1. Respiratory rate
2. Oxygen saturation
3. Pulse rate,
4. Blood pressure
5. Level of consciousness
6. Core body temperature
7. The requirement for supplemental oxygen (by mask or nasal cannulae)

VTE: Venous thromboembolism (blood clot).

World Health Organisation (WHO) Surgical Safety Checklist: A core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway**.** Safety checks before anaesthesia ("sign in"), before the incision of the skin ("time out") and before the patient leaves the operating room ("sign out").

4 Annual accounts

Foreword to the accounts

These accounts, for the 12 months ended 31 March 2019, have been prepared by the University College London Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

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

Marcel Levi
Chief executive

23 May 2019

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of University College London Hospitals NHS Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Taxpayers' Equity;
- the Statement of Cash Flows and
- the related notes 1 to 32

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

Basis for opinion

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

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

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Recognition of NHS revenue; • Property valuations; • Management override of controls and • Accounting for capital expenditure Within this report, any new key audit matters are identified with ⌃⌃ and any key audit matters which are the same as the prior year identified with ⌃⌃.
Materiality	The materiality that we used in the current year was £11.0m which was determined on the basis of 1% of the Trust's total revenue recognised in the 2018/19 financial year.
Scoping	Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the senior statutory auditor.

Significant changes in our approach	There have been no significant changes in our approach to the audit in 2018/19 compared to 2017/18.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

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

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

Recognition of NHS Revenue

Key audit matter description

As described in the accounting policies and specifically notes 1.4 and 1.23 there are significant judgements in recognition of revenue from care of NHS patients and in accounting for disputes with commissioners due to:

the judgements taken in evaluating Commissioning for Quality and Innovation ("CQUIN") income;

the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income with commissioners; and

the Provider Sustainability Funding (PSF) which is dependent on the Trust meeting certain financial performance targets and therefore recognition of this funding is affected by other accounting estimates.

Details of the Trust's income, including £852.0m (2018: £809.5m) of Commissioner Requested Services and £57.1m (2018: £50.4m) of Provider Sustainability Funding (PSF), are shown in note 3.1 to the financial statements. NHS debtors of £115.2m (2018: £92.2m) are shown in note 18 to the financial statements.

The Trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.

How the scope of our audit responded to the key audit matter	We evaluated the design and implementation within the payment by results process for recording and reporting revenue, specifically those controls around the agreement of disputes and challenges and the agreement of contracts. We have held discussions with the finance team and contracts team and we challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for accounting treatment adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners. We have selected a sample of unsettled NHS revenue at year-end and sought evidence that cash has been received post year-end, where cash has not been received post year-end we have sought further evidence to support the validity and accuracy of the unsettled amounts. We have selected a sample of differences between the amounts that the Trust reports as receivable from commissioners, and the amounts that commissioners report that they owe the Trust, in the agreement of balances ("mismatch") report. For this sample, we have sought explanations from management for the variances together with documentary evidence to corroborate those explanations.
Key observations	We concluded that the recognition of NHS revenue is appropriate and we considered the estimates made by the Trust in respect to their recognition of NHS revenue to be within an acceptable range.

Property valuations

Key audit matter description	The Trust holds property assets within Property, Plant and Equipment at a gross modern equivalent use valuation of £501.4m (2018: £519.5m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value and which have been described in notes 1.7, 1.23 and 11. The net valuation movement on the Trust's estate shown in note 14 is a net impairment of £10.8m (2018: £27.7m).
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2019. We have reviewed the disclosures in notes 1.7, 1.23 and 11 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU upon property valuations in evaluating the property valuations and related disclosures. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in

	particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations 	We consider the valuation of the property assets held by the Trust to be reasonable and the assumptions used in its calculation to be appropriate.
Management override of controls 	
Key audit matter description 	We consider that in the current year there continues to be a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The Trust has been allocated £57.1m (2018: £50.4m) of the Provider Sustainability Fund, contingent on achieving financial and operational targets each year, equivalent to a "control total" for the year. NHS Improvement has allocated funding for a "bonus" to organisations that exceed their control total, including offering foundation trusts £1 of additional funding for each £1 above the control total. This creates an incentive for reporting financial results that exceed the control total surplus of £14.5m (including PSF). The Trust's reported results show a surplus of £70.2m (2018: £98.4m), equivalent to £55.7m above the control total. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.23.
How the scope of our audit responded to the key audit matter risk 	**Manipulation of accounting estimates** Our work on accounting estimates included considering areas of judgement, including those identified by NHS Improvement. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates (including in respect of NHS revenue recognition and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system

	between the general ledger and the financial statements. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.
Key observations	We concluded that the journal entries and accounting estimates made to be reasonable.
Accounting for capital expenditure	
Key audit matter	The Trust has £162.8m (2018: £100.5m) of additions to tangible and intangible assets under construction as per note 11 and 12 of the financial statements. Where the Trust develops properties as part of its capital programme, determining whether or not expenditure should be capitalised under International Financial Reporting Standards and depreciation commenced, can involve judgement over whether the expenditure meets the conditions for capitalisation. The Trust has an extensive capital programme which requires large amounts of capital spend. As there is judgement over whether items included in capital spend meet the conditions for capitalisation under IFRS it is a key audit matter regarding whether costs have been inappropriately capitalised.
How the scope of our audit responded to the key audit matter	We have assessed the design and implementation of controls around the capitalisation of costs. We have tested spending on a sample basis to confirm that it complies with the relevant accounting requirements, and that the depreciation rates adopted are appropriate. We have reviewed the status of individual projects to evaluate whether they have been depreciated from the appropriate point.
Key observations	We consider that capital expenditure incurred has been recognised appropriately.

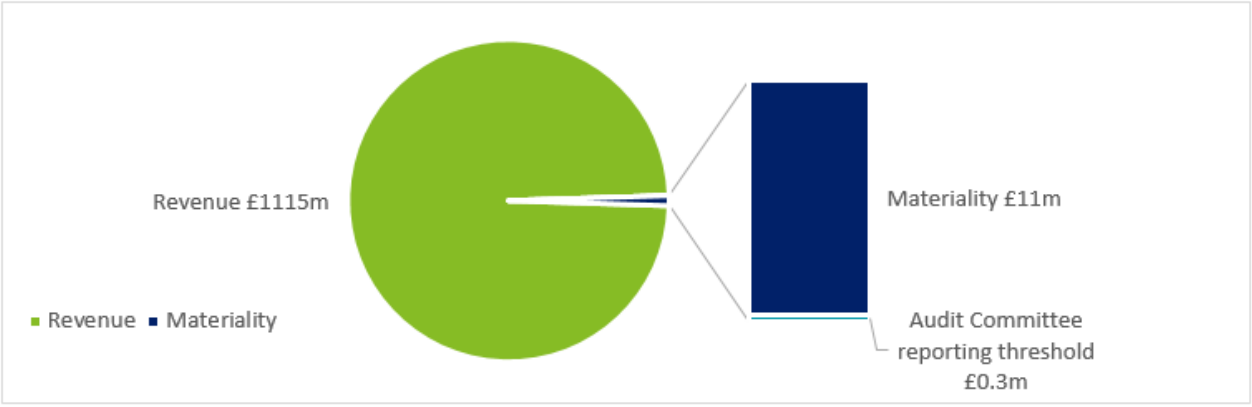
Our application of materiality

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

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

Materiality	£11.0m (2018: £10.5m)

Basis for determining materiality	1% of revenue (2018: 1% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2018: £300k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the senior statutory auditor.

The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

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.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

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

Reports in the public interest or to the regulator

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

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

We have nothing to report in respect of these matters.

Certificate

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

Use of our report

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

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

23 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 March 2019

	Note	**2018/19 Year Ended 31 March 2019 £000**	2017/18 Year Ended 31 March 2018 £000
Operating income from patient care activities	3	**890,351**	840,378
Other operating income	3.1	**267,401**	244,505
Operating expenses	4	**(1,087,313)**	(974,677)
Operating surplus from continuing operations		**70,439**	110,206
Finance costs:			
Finance income	9	**1,142**	307
Finance expense	10	**(35,908)**	(34,229)
PDC dividend charge		**(10,480)**	(9,622)
		(45,246)	(43,544)
Other Costs			
Gains on disposal of assets		**45,113**	30,560
Share of profit of joint ventures	13	**(77)**	1,187
SURPLUS FOR THE YEAR		**70,229**	98,409
Other comprehensive income			
(will not be reclassified to income and expenditure)			
Impairments	14	**(3,701)**	(4,405)
Revaluations	14	**1,502**	9,673
TOTAL Other Comprehensive (Expense) / Income		**(2,199)**	5,268
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**68,030**	**103,677**

Note to Statement of Comprehensive Income

This note describes the primary view used by the Board of Directors to monitor UCLH's financial performance, which excludes the impact of estate revaluation and other exceptional items that are reported within the comprehensive income figure above but are non-operational in nature.

SURPLUS FOR THE YEAR		**70,229**	98,409
Add back impairments and reversal of impairments included in surplus above	a	**8,617**	(22,453)
Donated asset impact	b	**1,196**	476
Profit on disposal of property, plant and equipment and investments	c	**(45,113)**	(30,560)
Other exceptional items	d	**(47,650)**	(38,095)
NET (DEFICIT) / SURPLUS EXCLUDING ITEMS ABOVE	2	**(12,721)**	7,777

a This is the total of impairments and impairment reversals charged to expenditure as in Note 14

b This is the reversal of the impact on the surplus or deficit for the financial year, as a result of change in accounting policy for donated assets as adopted in 2011/12

c This is the reversal of the total impact of gains on the disposal of fixed assets (sale of EDH tranche 1 and RRO in 2017/18, sale of EDH tranches 2 and 3 in 2018-19)

d In 2017/18, this represented incentive STF of £30.9m and £0.4m STF in relation to 2016/17 activity, along with bonus STF of £2.0m and generally distributed STF of £4.8m. In 2018/19 this represents PSF incentive income of £30.5m, generally distributed PSF of £9.1m, bonus PSF of £3.0m and donations of £5m from Royal Free Charity related to vacation of the RNTNE Hospital.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000	
Non-current assets				
Property, plant and equipment	11	**901,480**	791,662	*
Intangible assets	12	**32,145**	7,498	*
Investments in associates/joint ventures	13	**15,418**	15,495	
Trade and other receivables	18	**12,313**	9,838	
Total non-current assets		**961,356**	824,493	
Current assets				
Inventories	17	**15,075**	17,237	
Trade and other receivables	18	**178,971**	149,853	
Cash and cash equivalents	19	**257,342**	147,091	
Total current assets		**451,388**	314,181	
Total assets		**1,412,744**	1,138,674	
Current liabilities				
Trade and other payables	20	**(202,964)**	(170,845)	
Borrowings	21	**(8,418)**	(7,810)	
Provisions	25	**(6,060)**	(4,757)	
Other liabilities	22	**(26,081)**	(21,128)	
Net current assets		**207,865**	109,641	
Total assets less current liabilities		**1,169,221**	934,134	
Non-current liabilities				
Borrowings	21	**(521,264)**	(393,833)	
Provisions	25	**(1,873)**	(2,205)	
Other liabilities	22	**(4,130)**	(4,526)	
Total assets employed		**641,954**	533,570	
Financed by taxpayers' equity:				
Public dividend capital	SOCITE	**301,856**	261,424	
Retained earnings	SOCITE	**267,518**	194,138	
Revaluation reserve	SOCITE	**72,580**	78,008	
Total Taxpayers' Equity		**641,954**	533,570	

*Prior year balance realigned

The financial statements were approved by the Board on 22 May 2019 and signed on its behalf by:

Signed: …… **Tim Jaggard, Finance Director, 23 May 2019**

Signed: ……**Marcel Levi, Chief Executive, 23 May 2019**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Note	Public dividend capital (PDC)	Revaluation reserve	Retained earnings	Total
		£000	£000	£000	£000
Taxpayers' Equity as at 1 April 2018		**261,424**	**78,008**	**194,138**	**533,570**
Changes in taxpayers' equity for 2018/19					
Impact of implementing IFRS 9 on 1st April 2018	32	-	-	(78)	(78)
Surplus for the year	SOCI	-	-	70,229	70,229
Impairments	14	-	(3,701)	-	(3,701)
Revaluations	14	-	1,502	-	1,502
Public Dividend Capital received		40,432	-	-	40,432
Other reserve movements		-	(3,229)	3,229	-
Taxpayers' Equity at 31 March 2019		**301,856**	**72,580**	**267,518**	**641,954**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Note	Public dividend capital (PDC)	Revaluation reserve	Other reserves	Retained earnings	Total
		£000	£000	£000	£000	£000
Taxpayers' Equity as at 1 April 2017		**247,902**	**80,267**	**4,073**	**84,129**	**416,371**
Changes in taxpayers' equity for 2017/18						
Surplus for the year	SOCI	-	-	-	98,409	98,409
Impairments	14	-	(4,405)	-	-	(4,405)
Revaluations	14	-	9,673	-	-	9,673
Other Reserve Movements		-	(7,527)	(4,073)	11,600	-
Public Dividend Capital received		13,522	-	-	-	13,522
Taxpayers' Equity at 31 March 2018		**261,424**	**78,008**	**-**	**194,138**	**533,570**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2019

	Note	**2018/19 31 March £000**	2017/18 31 March £000
Cash flows from operating activities			
Operating surplus from continuing operations		**70,439**	110,206
Operating surplus		**70,439**	110,206
Non-cash income and expenses:			
Depreciation and amortisation		**29,028**	27,503
Net Impairments	14	**8,617**	(22,453)
Non-cash donations credited to income		**(1,420)**	(2,150)
(Increase)/Decrease in Trade and Other Receivables	18	**(32,857)**	17,495
Decrease / (Increase) in Inventories	17	**2,162**	(635)
Increase/(Decrease) in Trade and Other Payables	20	**26,206**	(1,959)
Increase in Other Liabilities	22	**4,558**	7,634
Increase/(Decrease) in Provisions	25	**922**	(3,230)
Other movements in operating cash flows		**(1,073)**	(595)
NET CASH GENERATED FROM OPERATIONS		**106,582**	131,816
Cash flows used in investing activities			
Interest received		**1,142**	307
Purchase of intangible assets		**(22,063)**	(215)
Sales of Investments		**0**	6,100
Purchase of Property, Plant and Equipment		**(149,947)**	(118,005)
Sales of Property, Plant and Equipment		**52,626**	29,108
Receipt of Cash Donations to Purchase Capital Assets		**422**	2,150
Net cash used in investing activities		**(117,820)**	(80,555)
Cash flows from financing activities			
Public dividend capital received		**40,432**	13,522
Movement on Loans from Department of Health and Social Care		**133,149**	55,208 *
Movement in other loans		**(233)**	(241)
Capital element of Private Finance Initiative Obligations		**(5,154)**	(4,833)
Interest on Loans		**(2,541)**	(1,673)
Interest element of finance lease		**(30)**	(30)
Capital element of Finance Lease Rentals		**(176)**	(130)
Interest element of Private Finance Initiative obligations		**(33,029)**	(32,524)
PDC Dividend paid		**(10,929)**	(8,617)
Net cash generated from financing activities		**121,489**	20,682
Increase in cash and cash equivalents		**110,251**	71,943
Cash and Cash equivalents at 1 April		**147,091**	75,148
Cash and Cash equivalents at 31 March		**257,342**	147,091

*Prior year figure realigned

1 NOTES TO THE ACCOUNTS

Accounting Policies and Other Information

1.1 Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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.

1.2 Going Concern

The directors have considered the application of the going concern concept to UCLH based upon the continuation of services provided by UCLH:

- NHSI, the regulator for health services in England, states that anticipated continuation of the provision of a service in the future is sufficient evidence of going concern, on the assumption that upon any dissolution of a foundation trust the services will continue to be provided. The directors consider that there will be no material closure of NHS services currently run by UCLH in the next business period (considered to be 12 months) following publication of this report and accounts.

For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

Given the challenging financial context within the trust and the wider NHS, the directors have also given serious consideration to the financial sustainability of UCLH as an entity and in relation to UCLH's available resources:

- In relation to UCLH as an entity, the directors have a reasonable expectation that UCLH has adequate resources to continue to service its debts and run operational activities for at least the next business period (considered to be 12 months) following publication of this report. UCLH has sufficient cash to ensure its obligations are met

over this time period given the potential mitigations identified for a downside scenario.

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 share of the assets, liabilities, income and expenses.

Joint Ventures

Joint ventures are separate entities over which UCLH has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The meaning of control is the same as that for subsidiaries.

Joint ventures are accounted for using the equity method with any investment originally recognised at cost.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Other Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.4 Income

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. This is considered an additional performance obligation to be satisfied under the original transaction price. 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 they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from Research Contracts

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

Where research income does not meet the criteria within IFRS 15, it is treated as grant income under IAS 20, and income is recognised in line with expenditure which meets the conditions set out in the grant documents.

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.

1.4.1 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 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.

1.4.2 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.

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.

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.

1.7 Property, Plant and Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to UCLH;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives. Assets classified as in use are depreciated from the beginning of the next quarter.

1.7.2 Measurement

Valuation

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

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

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

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use. Borrowing costs are not capitalised.

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

Subsequent Expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation Gains & Losses

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

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

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

Impairments

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

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

1.7.3 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable 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 ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

1.7.4 Donated, Government Grant and other Grant-Funded Assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor, in which case, the donation 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 assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.5 Private Finance Initiative (PFI) Transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by UCLH. In accordance with IAS 17, the underlying assets are recognised as Property, Plant and Equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

Lifecycle Replacement

An amount is set aside from the unitary payment each year into a Lifecycle Replacement Prepayment to reflect the fact that UCLH is effectively pre-funding some elements of future lifecycle replacement by the operator.

When the operator replaces a capital asset, the fair value of this replacement item is recognised as property, plant and equipment.

Where the item was planned for replacement and therefore its value is being funded through the unitary payment, the lifecycle prepayment is reduced by the amount of the fair value.

The prepayment is reviewed periodically to ensure that its carrying amount will be realised through future lifecycle components to be provided by the operator. Any unrecoverable balance is written out of the prepayment and charged to operating expenses.

Where the lifecycle item was not planned for replacement during the contract it is effectively being provided free of charge to UCLH. A deferred income balance is therefore recognised instead and this is released to operating income over the remaining life of the contract.

Assets contributed by UCLH to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in UCLH's Statement of Financial Position.

Other Assets contributed by UCLH to the Operator

Assets contributed (e.g. cash payments, surplus property) by UCLH to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to UCLH, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.8 Intangible Assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of UCLH'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, UCLH and where the cost of the asset can be measured reliably.

Internally Generated Intangible Assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- UCLH intends to complete the asset and sell or use it;
- UCLH has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to UCLH to complete the development and sell or use the asset; and
- UCLH can measure reliably the expenses attributable to the asset during development.

Software

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.

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 on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value.

The cost of inventories is measured using a weighted average cost basis recalculated monthly for Pharmacy stocks and annually for other consumables.

1.10 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

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

1.11 Cash and Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand.

1.12 Financial Instruments and Financial Liabilities

1.12.1 Recognition

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

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

1.12.2 Classification and Measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

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

Financial Assets and Financial Liabilities at Amortised Cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of

loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial Assets Measured at Fair Value through other Comprehensive Income

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

Financial Assets and Financial Liabilities at Fair Value through Income and Expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of Financial Assets

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

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

Contract and other receivables with other NHS organisations are not impaired. The Trust calculates a lifetime expected loss rate for different categories of receivable organisation, at the point of recognition of the asset. The expected loss rate is reviewed on an annual basis.

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

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

1.12.3 De-recognition

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

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

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.

1.13.1 UCLH 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 charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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.

Leased land is treated as an operating lease. When a lease includes both land and building elements, the Trust assesses the classification of each element as a finance or operating lease separately. In determining whether the land element is an operating or a finance lease, an important consideration is that land normally has an indefinite economic life.

1.13.2 UCLH as Lessor

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

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

1.14 Provisions

UCLH 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.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where UCLH has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when UCLH has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

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

Non-Clinical Risk Pooling

UCLH participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which UCLH pays an annual contribution to the NHS Litigation Authority 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.

1.15 Contingencies

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

Contingent liabilities are not recognised, but are disclosed in Note 26, 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.

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 trust. 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 UCLH, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of UCLH 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 and (ii) average daily cash balance held with the Government Banking Service and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as 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 of the audit of the annual accounts.

1.17 Value Added Tax

Most of the activities of UCLH 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.

1.18 Corporation Tax

NHS Foundation Trusts can be subject to corporation tax in respect of certain commercial non-core health care activities they undertake in relation to the Income Tax Act 2007 and Corporation Tax Act 2010.

UCLH does not undertake any non-core health activities which are subject to corporation tax, therefore does not have a corporation tax liability.

1.19 Foreign Exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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 Financial Reporting Manual. Details of third party assets are given in Note 30 to the accounts.

1.21 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.22 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.

1.23 Critical Judgements in Applying Accounting Policies

In the application of UCLH's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed overleaf:

Accounting Judgements

Valuation of Land and Buildings

UCLH's land and building assets are valued on the basis explained in Note 1.7 and Note 11 to the accounts.

In line with this policy specialised 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 could be appropriate.

The District Valuer (DV) provided UCLH with a valuation of land and building assets (estimated fair value and remaining useful life.)

The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury Guidance, leads to revaluation adjustments as described in Note 14 to the accounts. Future revaluations of UCLH's property may result in further changes to the carrying values of non-current assets.

Impairment of Receivables

UCLH calculates a lifetime expected loss rate for each category of customer traded with, based on analysis of historical collection rates for debts in that category. UCLH reviews the collection rates annually.

Sources of Estimation Uncertainty

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

Provisions

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 and basis of UCLH's provisions are detailed in Note 25 to the accounts.

Note 1.24 Standards Issued but not yet adopted for Foundation Trusts

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

1	**IFRS 14 *Regulatory Deferral Accounts***	2 3	Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
4	**IFRS 16 *Leases***	5	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.
6	**IFRS 17 *Insurance Contracts***	7	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
8	**IFRIC 23 *Uncertainty over Income Tax Treatments***	9	Application required for accounting periods beginning on or after 1 January 2019.

** The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.*

The Trust is continuing to assess the likely impact of IFRS 16.

2 Operating Segments

The NHS foundation trust operates solely in the UK. Patients who do not live in the UK are treated via reciprocal arrangements or are required to pay for their own treatment. £2.4m (2017/18 £2.4m) came from overseas patients without reciprocal arrangements.

UCLH's activity is organised into three clinical boards, which provide healthcare services, R&D and Education segments and one corporate segment.

The Board of Directors receive financial reports that analyse the financial performance of UCLH in several ways. However, income and expenditure is reported against budget for each of three Clinical Boards, Research and Development, Education and Corporate segments.

These segments are run on a day to day basis by a separate clinical or executive board. The clinical segments are Medicine, Surgery & Cancer and Specialist Hospitals. The latter encompasses the Eastman Dental Hospital, Paediatrics and Adolescents, Women's Health, The National Hospital for Neurology and Neurosurgery, the Royal Hospital for Integrated Medicine and the Royal National Throat, Nose and Ear Hospital.

The Chief Operating Decision Maker (CODM) of this Trust is the UCLH Board. It has been determined that this is the CODM as under our scheme of delegation the Board is required to approve the budget and all major operational decisions.

The monthly performance report to the CODM reports financial summary information in the format of the table below.

This financial information is the information reported to the May 2019 Board meeting for the year ended 31st March 2019.

	Medicine		Specialist Hospitals		Surgery & Cancer		Research & Development		Education		Corporate		TOTAL	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2017/18	2017/18	2018/19	2017/18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Direct Income	214.0	193.4	431.8	419.4	347.9	313.6	43.2	36.6	34.9	35.4	36.9	45.0	1,108.7	1,044.6
Direct Costs	(223.7)	(203.8)	(320.6)	(307.6)	(298.4)	(272.0)	(36.2)	(29.2)	(38.1)	(38.0)	(132.7)	(119.0)	(1,049.7)	(969.6)
Internal Trading & Indirect Costs	16.1	16.3	(57.7)	(57.1)	(29.8)	(30.8)	(7.0)	(7.0)	-	-	78.4	78.5	-	-
CONTRIBUTION /EBITDA (at Trust level)	**6.4**	**5.9**	**53.4**	**54.7**	**19.7**	**10.8**	**(0.0)**	**0.4**	**(3.2)**	**(2.6)**	**(17.4)**	**4.6**	**59.0**	**75.0**
ITDA (before donation adjustments & exceptional items)	-	-	-	-	-	-	-	-	-	-	(71.7)	(66.0)	(71.7)	(67.2)
I&E (before donation adjustments & exceptional items)	**6.4**	**5.9**	**53.4**	**54.7**	**19.7**	**10.8**	**(0.0)**	**0.4**	**(3.2)**	**(2.6)**	**(89.1)**	**(61.5)**	**(12.7)**	**7.8**
Bonus and Incentive STF	-	-	-	-	-	-	-	-	-	-	42.6	38.1	42.6	37.7
Disposal Profits	-	-	-	-	-	-	-	-	-	-	45.1	30.6	45.1	30.6
Exceptional items included in Control Total											4.6		4.6	
I&E surplus/(deficit) after exceptional items	**6.4**	**5.9**	**53.4**	**54.7**	**19.7**	**10.8**	**(0.0)**	**0.4**	**(3.2)**	**(2.6)**	**3.2**	**7.2**	**79.6**	**76.4**
Exceptional Items excluded from Control Total	-	-	-	-	-	-	-	-	-	-	*(9.4)*	*22.0*	*(9.4)*	*22.0*
Net Surplus/(Deficit)	*6.4*	*5.9*	*53.4*	*54.7*	*19.7*	*10.8*	*(0.0)*	*0.4*	*(3.2)*	*(2.6)*	*(6.2)*	*29.2*	*70.2*	*98.4*

Notes

1) At segmental level, positions are reported at the level of "Contribution". At Trust level this equates to "EBITDA".

2) The I&E position before donation adjustments reflects the old (pre-2012/13) NHS accounting rules. The Trust reports under both the old accounting regime (as the best measure of underlying financial performance as it is unaffected by the timing of charitable donations) and the new accounting regime, which accounts for charitable donations as income in the period in which they are received.

3) ITDA is the total of interest, taxation, depreciation and amortisation. EBITDA is earnings before interest, taxation, depreciation and amortisation.

4) Total assets and liabilities are not reported to the Chief Operating Decision Maker by reportable segment.

5) Exceptional items excluded from control total consist of impairments and reversals of impairments before the effect of accounting policy adjustments and donation adjustments which represent the accounting for donations in the year of receipt rather than matching with depreciation over the life of the donated asset and 2016/17 STF awarded in 2017/18

6) PFI costs including interest are allocated to and reported within the relevant segments, predominantly Medicine and Surgery & Cancer who occupy the majority of the PFI buildings.

3 Operating Income by Nature

	2018/19 Year Ended 31 March 2019 £000	2017/18 Year Ended 31 March 2018 £000
Income from Patient Care Activities by Nature		
Acute Trusts		
Elective income	**213,269**	206,060
Non elective income	**129,115**	117,940
First outpatient income	**51,085**	50,260
Follow up outpatient income	**100,955**	100,827
A & E income	**22,979**	21,701
High cost drugs income from commissioners (excluding pass-through costs)	**99,629**	91,547
Other NHS clinical income	**244,511**	229,802
AfC Pay Award Central Funding	**6,058**	-
Paying patient income (private and overseas chargeable to patient)	**22,750**	22,241
Total income from activities	**890,351**	840,378
Total other operating income (see note 3.1)	**267,401**	244,505
Total Operating Income	**1,157,752**	1,084,883
Commissioner Requested Income	**851,969**	809,470
Non-Commissioner Requested Income	**305,783**	275,413
Total Income	**1,157,752**	1,084,883

3.1 Operating Income by Type

	2018/19 Year Ended 31 March 2019	2017/18 Year Ended 31 March 2018
	£000	£000
Income From Patient Care Activities by Source* **		
NHS Foundation Trusts	**1,276**	1,579
NHS Trusts	**670**	777
Clinical Commissioning Groups (CCG) and NHS England	**851,969**	809,470
Department of Health - other	**6,058**	-
NHS Other	**6,543**	5,619
Non-NHS: Private Patients*	**20,376**	19,830
Non-NHS: Overseas patients (chargeable to patient)	**2,374**	2,411
NHS Injury scheme (previously RTA)****	**1,085**	692
Total Income From Activities	**890,351**	**840,378**
Other Operating Income Recognised in Accordance with IFRS 15		
Research and development	**15,343**	42,919
Education and training	**38,805**	41,650
Non-patient care services	**29,500**	39,147
Staff costs recharged to other organisations	**4,384**	3,572
Pharmacy sales	**44,967**	30,273
Clinical Excellence Awards	**6,359**	6,210
Provider sustainability fund / Sustainability and transformation fund income (PSF / STF)	**57,111**	50,399
Other (recognised in accordance with IFRS 15)	**22,776**	21,212
Total Other Operating Income (IFRS 15)	**219,245**	235,382
Other Operating Income Recognised in Accordance with Other Standards		
Research and development (non-IFRS 15 e.g. IAS 20)	**34,236**	-
Charitable and other contributions to expenditure	**9,442**	4,613
Rental revenue from operating leases	**4,478**	4,510
Total Other Operating Income (non IFRS 15)	**48,156**	9,123
Total Operating Income	**1,157,752**	1,084,883

*Non-NHS: Private Patients income includes contributions of £14.5m from HCA in respect of lease income and other services (£12.6m in 2017/18)
**PSF/STF income is comprised of core allocation £14.5m (£12.3m in 2017/18), incentive funding £30.5m (£30.9m in 2017/18), bonus funding £3.0m (£2.0m in 2017/18) and £9.1m PSF/STF general distribution (£4.7m in 2017/18). The 2017/18 figure also includes £0.4m relating to 2016/17 STF.
***Income from Patient Care Activities is recognised in accordance with IFRS 15
****Based on 78.11% likely collection as per DHSC guidance

3.2 Overseas Visitors (relating to patients charged directly by the Foundation Trust)

	2018/19 Year Ended 31 March 2019	2017/18 Year Ended 31 March 2018
	£000	£000
Income recognised this year	**2,374**	2,411
Cash payments received in-year (relating to invoices raised in current and previous years)	**1,664**	1,658
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**954**	753
Amounts written off in-year (relating to invoices raised in current and previous years) *	**318**	488

** Amounts written off includes items from previous financial years, bad debt provision was held for all amounts written off.*

3.3 Fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m

	2018/19 Year Ended 31 March 2019	2017/18 Year Ended 31 March 2018
	£000	£000
Income	**-**	-
Full cost	**-**	-

UCLH has significant pharmacy trading and undertakes a number of tests for other NHS organisations, which are billed at full cost.

3.4 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**14,092**
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

3.5 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised :	31 March 2019
within one year	**25,585**
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**25,585**

4 Operating Expenses

	2018/19 Year Ended 31 March 2019	2017/18 Year Ended 31 March 2018
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**13,580**	12,106
Purchase of healthcare from non NHS bodies	**11,836**	13,982
Employee Expenses - Non-executive directors	**179**	169
Employee Expenses - Staff	**526,351**	500,745
Drug costs	**186,371**	161,977
Inventories Written Down	**174**	59
Supplies and services - clinical (excluding drug costs)	**93,156**	88,785
Supplies and services - general	**11,652**	10,355
Establishment	**6,296**	6,407
Research and development	**22,575**	13,726
Transport including Patient Travel	**8,214**	8,433
Premises	**84,438**	79,954
Total increase in provision for impairment of receivables	**2,706**	1,943
Rentals under operating leases - minimum lease payments	**16,563**	14,669
Depreciation on property, plant and equipment	**28,814**	27,296
Amortisation on intangible assets	**214**	207
Impairments net of reversals	**8,617**	(22,453)
Audit fees- statutory audit *	**118**	119
Other services: audit related assurance services	**20**	22
Clinical negligence	**19,155**	19,554
Insurance	**341**	294
Legal fees	**144**	117
Consultancy costs	**4,324**	3,872
Internal Audit Costs	**243**	271
Training, courses and conferences	**3,812**	4,282
Other services, eg external payroll	**397**	383
Losses, ex gratia & special payments	**14**	11
Charges to operating expenditure for on-SoFP FRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	**23,177**	22,352
Other	**13,832**	5,040
Total operating Expenses	**1,087,313**	974,677

* The audit fee for the 2018/19 statutory audit was £138k (2017/18 £141k), comprising £98k Regulatory reporting fee (2017/18: £101k), £17k Quality Assurance reporting fee (2017/18: £17k), and irrecoverable VAT of £23k (2017/18: £23k).

5 Operating leases

5.1 As lessee

UCLH has a number of property leases for both clinical and administrative buildings. These leases are of varying length of term between 1 and 77 years, with the average being 10 years.
In addition, UCLH has a portfolio of equipment leases, typically with lease terms of between 5 to 7 years.

UCLH's operating lease contracts do not allow for the renewal of leases for a secondary period at substantially lower than market rates nor do they allow for UCLH to exercise beneficial purchase clauses allowing UCLH to acquire assets at other than market value.

Contingent rentals
The majority of UCLH rentals are fixed for any particular accounting period. Some of these leases include clauses that allow for an uplift of future rentals, typically on a five year basis, to prevailing market rates. Given the uncertainty of future rent reviews UCLH does not estimate such future uplifts. Accordingly lease payments under operating leases exclude contingent rental amounts.
Equipment leases are fixed for the period of the concession and accordingly contain no contingent rents.

All of the above leases have been assessed in accordance with IAS 17 and deemed to be classified as operating leases.	**2018/19 £000**	2017/18 £000
	31 March	31 March
Minimum lease payments	**16,563**	14,669
Minimum lease payments	**16,563**	14,669

The aggregate future minimum lease payments under non-cancellable operating leases are as follows :

	2018/19 31 March £000 Buildings	2018/19 31 March £000 Other	**2018/19 31 March £000 TOTAL**	2017/18 31 March £000 Buildings	2017/18 31 March £000 Other	2017/18 31 March £000 TOTAL
Not later than 1 year	12,711	200	**12,911**	11,450	284	11,734
Later than 1 year and no later than 5 years	37,881	317	**38,198**	36,043	445	36,488
Later than 5 years	63,473	-	**63,473**	15,711	729	16,440
Total	114,065	517	**114,582**	63,204	1,458	64,662

The operating lease expenditure shown is included under the headings of Transport, Premises and also Supplies and services - clinical within Note 4 Operating Expenses.

5.2 As lessor

UCLH is the lessor in a number of arrangements with other entities. The income by entity is listed below. UCLH includes this income within income derived from rental revenue from operating leases - minimum lease receipts (as reported in Note 3).

	2018/19	2017/18
	£000	£000
Great Ormond Street Hospital for Children NHS Foundation Trust	**529**	578
Hays Specialist Recruitment Limited	**755**	791
University College London	**1,382**	1,441
UCLH Charity	**124**	118
HCA	**1,201**	783
Other	**487**	799
Total	**4,478**	4,510

The aggregate future minimum lease receipts are as follows:

	2018/19	2017/18
	31 March	31 March
	£000	£000
Not later than 1 year	**2,354**	2,019
Later than 1 year and no later than 5 years	**6,729**	6,460
Later than 5 years	**5,230**	8,552
Total	**14,313**	17,031

6 Employee costs

	2018/19	**2018/19**	2017/18	2017/18
	Year Ended	**Year Ended**	Year Ended	Year Ended
	31 March	**31 March**	31 March	31 March
	Total	**Total**	Total	Total
	£000	**£000**	£000	£000
	Permanent	**Other**	Permanent	Other
Salaries and wages*	**386,212**	**58,330**	351,971	68,750
Employers' National Insurance Contributions	**42,464**	**-**	38,898	-
Apprenticeship Levy	**1,869**	**-**	1,449	-
Employer contributions to NHS Pension scheme	**44,963**	**-**	42,458	-
Pension Cost - Other	**8**	**-**	16	-
Total excluding Agency staff	**475,516**	**58,330**	434,792	68,750
Salary cost recharges	**(5,694)**	**-**	(5,072)	-
Agency staff	**-**	**10,158**	-	7,903
Total Employee Costs*	**469,822**	**68,488**	429,720	76,653
Less: Employee Costs Charged to Capital	**(11,959)**	**-**	(5,628)	-
Total Employee Costs as per Note 4*	**457,863**	**68,488**	424,092	76,653

Average number of people employed and staff exit packages are included in the staff report.

*Prior year restated to show split between permanent staff and other staff

7 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% of pensionable pay from this date.

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

8 Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year.

During 2018/19 there were 2 retirements (2017/18: 5), at an additional cost of £284,901 (2017/18: £354,022). This information has been supplied by NHS Pensions.
This cost is not reported within the Trust's accounts, but is met by the NHS Pension Scheme.

9 Investment revenue

	2018/19 Year Ended 31 March £000	2017/18 Year Ended 31 March £000
Interest revenue:		
Bank accounts	**1,142**	307
Total	**1,142**	307

10 Finance Costs

	2018/19 Year Ended 31 March £000	2017/18 Year Ended 31 March £000
Interest on loans from Independent Trust Financing Facility	**2,803**	1,673
Interest on obligations under PFI contracts:		
- main finance cost	**33,029**	32,524
Interest on finance leases	**27**	30
Unwinding of discount	**49**	2
Total	**35,908**	**34,229**

11 Property, plant and equipment

2018/19:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2018	92,676	426,823	196,748	111,224	272	34,314	29,559	891,616
Additions purchased	-	4,345	141,245	5,559	-	4,135	347	155,631
Additions leased	-	2,393	312	-	-	-	-	2,705
Additions - assets purchased from cash donations / grants	-	61	12	349	-	-	-	422
Additions - donations of physical assets	-	-	-	998	-	-	-	998
Impairments charged to revaluation reserve	(783)	(2,918)	-	-	-	-	-	(3,701)
Impairments recognised in operating expenses	(495)	(8,529)	(450)	-	-	-	-	(9,474)
Reversal of impairments recognised in operating income	14	843	-	-	-	-	-	857
Reclassifications	-	4,840	(9,696)	102	-	1,843	114	(2,797)
Revaluations	202	1,300	-	-	-	-	-	1,502
Disposals	(1,740)	(6,052)	-	(1,565)	-	-	(18)	(9,375)
Valuation/Gross cost at 31 March 2019	**89,874**	**423,106**	**328,171**	**116,667**	**272**	**40,292**	**30,002**	**1,028,384**
Accumulated depreciation at 1 April 2018	-	-	-	61,045	117	17,361	21,430	99,953
Provided during the year *	-	11,908	-	9,791	39	5,174	1,902	28,814
Reclassifications	-	-	-	-	-	-	-	-
Disposals	-	(303)	-	(1,542)	-	-	(18)	(1,863)
Depreciation at 31 March 2019	**-**	**11,605**	**-**	**69,294**	**156**	**22,535**	**23,314**	**126,904**
Net book value at 31 March 2019								
Owned	89,874	145,480	327,137	40,502	77	17,657	6,370	627,097
PFI	-	226,771	104	-	-	-	-	226,875
Finance Lease	-	-	-	1,261	-	-	-	1,261
Donated	-	39,250	930	5,610	39	100	318	46,247
Total at 31 March 2019	**89,874**	**411,501**	**328,171**	**47,373**	**116**	**17,757**	**6,688**	**901,480**
Analysis of property, plant and equipment								
Protected Property	**89,874**	**411,501**	**-**	**47,373**	**-**	**-**	**-**	**548,748**
Unprotected Property	**-**	**-**	**328,171**	**-**	**116**	**17,757**	**6,688**	**352,732**
Total at 31 March 2019	**89,874**	**411,501**	**328,171**	**47,373**	**116**	**17,757**	**6,688**	**901,480**

* Buildings depreciation was eliminated on revaluation at 31 March 2019 through the entries in "Impairments charged to revaluation reserve", "Impairments recognised in operating expenses" and "Revaluation surpluses". The 1 April 2018 Buildings opening value is as per the net book value as advised by the District Valuer at 31 March 2018.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Property, plant and equipment (continued)

2017/18:	Land £000	Buildings excluding dwellings £000	Assets under construct and payments on account ** £000	Plant and machinery £000	Transport Equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/Gross cost at 1 April 2017*	93,987	387,203	122,944	97,939	272	30,421	29,139	761,905
Additions purchased	-	17,499	91,828	11,095	-	876	410	121,708
Additions purchased from Cash Donations / Grants	-	14	1,756	336	-	28	8	2,142
Impairments charged to revaluation reserve	-	(4,405)	-	-	-	-	-	(4,405)
Impairments recognised in operating expenses	-	(9,331)	-	-	-	-	-	(9,331)
Reversal of impairments recognised in operating income	-	31,784	-	-	-	-	-	31,784
Reclassifications**	-	7,718	(19,781)	2,149	-	2,989	2	(6,923)
Revaluation surpluses	28	9,645	-	-	-	-	-	9,673
Disposals	(1,339)	(2,096)	-	(295)	-	-	-	(3,730)
Valuation/Gross cost at 31 March 18	**92,676**	**438,031**	**196,747**	**111,224**	**272**	**34,314**	**29,559**	**902,823**
Depreciation at 1 April 2017*	-	-	-	51,564	78	13,075	19,546	84,263
Provided during the year	-	11,311	-	9,776	39	4,286	1,884	27,296
Reclassifications	-	-	-	-	-	-	-	-
Disposals	-	(104)	-	(295)	-	-	-	(399)
Depreciation at 31 March 2018	**-**	**11,207**	**-**	**61,045**	**117**	**17,361**	**21,430**	**111,160**
Net book value at 31 March 2018								
Owned	92,676	152,314	194,746	43,214	101	16,802	7,720	507,573
PFI	-	232,604	-	-	-	-	-	232,604
Finance Lease	-	-	-	1,463	-	-	-	1,463
Donated	-	41,906	2,001	5,502	54	151	409	50,023
Total at 31 March 2018	**92,676**	**426,824**	**196,747**	**50,179**	**155**	**16,953**	**8,129**	**791,663**
Analysis of property, plant and equipment								
Protected Property	92,676	426,824	-	50,179	-	-	-	569,679
Unprotected Property	-	-	196,747	-	155	16,953	8,129	221,984
Total at 31 March 2018	**92,676**	**426,824**	**196,747**	**50,179**	**155**	**16,953**	**8,129**	**791,663**

* Buildings depreciation was eliminated on revaluation at 31 March 2018 through the entries in "Impairments charged to revaluation reserve", "Impairments recognised in operating expenses" and "Revaluation surpluses". The 1 April 2017 Buildings opening value is as per the net book value as advised by the District Valuer at 31 March 2017.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

** Assets under construction realigned between tangible and intangible assets

11. Property, plant and equipment (continued)

End of Year Valuation

In the year ending 31st March 2019 a desktop valuation exercise was carried out on UCLH's properties by the District Valuer (DV), following a full site valuation in 2018.

The valuation exercise was carried out in February 2019 with the prospective valuation date of 31st March 2019. It resulted in a number of revaluation adjustments, both upwards and downwards, some of which related to assets with existing revaluation reserve balances and some of which related to assets with no revaluation reserve balance. See note 14 for further details.

The valuations were undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.

As in previous years, management have elected to use an alternative site basis for the valuation of specialised assets and have valued the PFI assets net of VAT.

Basis of Valuation

Non-operational assets, including surplus land, are valued on the basis of Market Value, on the assumption that the property is no longer required for existing operations, which have ceased.

There is an assumption that properties valued will continue to be in the occupation of the NHS for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

a) Depreciated Replacement Cost

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC). The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis. This method of valuation allows an alternative location for replacement to be used if this can be demonstrated to meet the requirements of the service. In 2017/18 management have determined that the needs of the service could be met from locations away from the current sites and the valuation has been completed on this basis.

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS1.3 as:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Market Value

Market Value is the basis of valuation adopted for the reporting of non-operational properties, including surplus land, for financial accounting purposes. The RICS Standards at PS3.2 define MV as:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion."

Variations to RICS Valuation Standards

In order to meet the underlying objectives established by HM Treasury and the Department of Health for capital accounting and the capital charges system, the following variations from the RICS Valuation Standards were required and agreed between UCLH and the DV.

For assets valued using depreciated replacement cost, the replacement cost figures include VAT and professional fees but exclude finance charges, with an "instant building" being assumed.

The valuation figures reflect physical obsolescence and have been reduced to reflect functional obsolescence.

Assets in the course of construction at the valuation date are included at the cost incurred to the valuation date in accordance with current capital charging arrangements. When stating the certified cost of work carried out (as at the valuation date), no deduction has been made for the risk of failure to complete the project.

As regards alternative use values, it is confirmed that unless otherwise indicated operational assets have been valued to Fair Value on the assumption that their market value reflects the property being sold as part of the continuing enterprise in occupation. The value ascribed to the operational assets does not reflect any potential alternative use value, which could be higher or lower than the stated Fair Value.

Assumptions Arising from use of a Prospective Valuation Date

The following assumptions were made in respect of giving a prospective valuation as at 31st March 2019, on valuations carried out in February 2019:

The age and remaining lives of buildings and their elements have been assessed as at the valuation date. The assumption is that building elements will continue to be maintained normally over the period from the date of inspection to the valuation date and that there will be no untoward changes.

With respect to non-specialised operational property valued to fair value assuming the continuance of occupation for the existing use, non-operational properties valued to Market

Value and the land element of DRC properties, their valuations have been prepared having regard both to the market evidence available at the date of the report and to likely and foreseeable local and national market trends between the date of carrying out the valuation and the valuation date.

Interaction with Private Finance Initiative (PFI) Contracts

UCLH's PFI asset (the UCH and EGA hospital facilities) has been valued to fair value on the market value, subject to the assumption of continuance of the existing use, with the DRC approach being adopted because the asset is specialised. As in previous years, the value of the asset is shown net of VAT after detailed consideration of the obligations of the PFI company within the contract.

11.1.1 Disposal of Eastman Dental Hospital Site

UCLH owned Land and Buildings at Eastman Dental Hospital which are currently valued using the MEA method, with an alternative site option used. During 2017-18, UCLH entered into a contractual arrangement with UCL to sell the EDH site in three specific tranches based on the potential exercising of put and call options covering the financial years from 2017-18 to 2020-21.

Each of the three tranches was available for sale to UCL under put and call options structured as follows:

Tranche 1 can be called by UCL [with payment between 1 June 2018 and 30 October 2018] or put by UCLH with payment between 1 March 2018 and 31 July 2018

Tranche 2 can be called by UCL [with payment between 1 June 2019 and 30 October 2019] or put by UCLH with payment between 1 March 2019 and 31 July 2019 (notice in both cases to be given two months before these dates)

Tranche 3 can be called by UCL [with payment between 1 June 2020 and 30 October 2020] or put by UCLH with payment between 1 March 2020 and 31 July 2020 (notice in both cases to be given two months before these dates)

UCLH agreed a total sale value for the site of up to £96m, of which £80m is unconditional and constitutes sale values for each tranche as follows:

Tranche 1: £28.56m
Tranche 2: £21.84m
Tranche 3: £29.6m

Following the sale of Tranche 1 in 2017-18, UCLH agreed to sell both Tranches 2 and 3 during 2018-19, with a reduced price of £28.86m payable for Tranche 3 due to the accelerated timing. Prior to the sale tranches 2 and 3 were valued in UCLH's book as follows

Tranche 2: £2.27m
Tranche 3: £5.22m

In order to determine the appropriate accounting treatment for this transaction, UCLH has followed guidance contained within the Department of Health General Accounting Manual. Specifically, assets which are held for their service potential and are in use must be valued

at their current value in existing use. For specialist assets such as those applicable to this transaction this will be the present value of the asset's remaining service potential.

12 Intangible assets

2018/19:	Computer software - purchased	Intangible Assets Under Construction	Total
	£000	£000	£000
Gross cost or valuation at 1 April 2018	1,448	6,923	8,371
Additions purchased	805	21,259	22,064
Reclassifications	2,798	-	2,798
Gross cost at 31 March 2019	**5,051**	**28,182**	**33,233**
Amortisation at 1 April 2018	874	-	874
Provided during the year	214	-	214
Reclassifications	-	-	-
Amortisation at 31 March 2019	**1,088**	**-**	**1,088**
Net book value at 31 March 2019			
Purchased	3,963	28,182	32,145
Total at 31 March 2019	**3,963**	**28,182**	**32,145**

Prior year:

2017/18:	Computer software - purchased	Intangible Assets Under Construction	Total
	£000	£000	£000
Gross cost or valuation at 1 April 2017	1,230	-	1,230
Additions purchased	211	6,923 *	7,134
Additions donated	7	-	7
Gross cost at 31 March 2018	**1,448**	**6,923**	**8,371**
Amortisation at 1 April 2017	668	-	668
Provided during the year	206	-	206
Reclassifications	-	-	-
Amortisation at 31 March 2018	**874**	**-**	**874**
Net book value at 31 March 2018			
Purchased	574	6,923	7,497
Total at 31 March 2018	**574**	**6,923**	**7,497**

Intangible fixed assets represents application software identified in IT projects.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

*Prior year restated following realignment between tangible and intangible AUC.

13 Investment in Joint Ventures

UCLH holds an investment in the joint venture, Health Services Laboratories LLP (HSL LLP) with partners The Doctors Laboratory (TDL) and the Royal Free London NHS Foundation Trust (RFL) which performs pathology testing. UCLH has a 24.5% stake in this operation (TDL 51%, RFL 24.5%) with joint venture status agreed as a result of a series of significant decisions requiring unanimous agreement. This joint venture went live in April 2015 and is accounted as an investment using the equity method.

UCLH made no additional capital investments in the JV during 2018/19. UCLH has decreased the holding value of this investment by 24.5% of the projected trading loss incurred by the joint venture during 2018/19 (£76k).

UCLH previously held a 50% stake in a joint venture (Radiology Reporting Online (RRO)) delivering an imaging reporting service. In early 2017/18, UCLH sold its stake in RRO for £6.1m. At the time of sale, the recognised book value of RRO was £1.29m.

13.1 Investment in Joint Ventures

	Note	2018/19	2017/18
		£000	£000
Opening investment in joint venture		15,495	15,602
Share of (Loss) / Profit		(77)	1,187
Disposals		-	(1,294)
Carrying value at 31st March		**15,418**	**15,495**

13.2 Subsidiaries

UCLH has a wholly owned subsidiary company, MyUCLH Ltd, limited by guarantee, which was incorporated in England and Wales in April 2015 and commenced trading in 2016/17.

Due to immateriality, UCLH has not presented group and trust accounts. Balances in respect of MyUCLH are included within reported UCLH figures.

14 Impairments and Revaluations

Land and buildings were valued independently by the District Valuer as at 31 March 2019 in line with accounting policies. The valuation included positive and negative valuation movements. Revaluation gains were taken to the revaluation reserve, unless they related to a property which has previously been impaired through operating expenses, in which case the revaluation gain was taken to operating income. Revaluation losses were taken to the revaluation reserve to the extent that there was a revaluation surplus for that property. Any losses over and above the revaluation surplus were charged to operating expenses. The movement arising from the professional valuation can be summarised as follows:

Summary of impairments and revaluations:	**2018/19**			**2017/18**		
a) Impairments and reversals	Income and expenditure	Reserves	**Total**	Income and expenditure	Reserves	**Total**
	£000	£000	**£000**	£000	£000	**£000**
Impairment reversals credited to I&E - valuation	**857**	**-**	**857**	31,784	-	**31,784**
Impairments charged to operating expenses - valuation	**(9,024)**	**-**	**(9,024)**	(9,331)	-	**(9,331)**
Impairments charged to operating expenses - abandonment *	**(450)**	**-**	**(450)**	-	-	**-**
Impairments charged to revaluation reserve - valuation	**-**	**(3,701)**	**(3,701)**	-	(4,405)	**(4,405)**
Total impairment (charge)/reversal	**(8,617)**	**(3,701)**	**(12,318)**	**22,453**	**(4,405)**	**18,048**
b) Revaluations						
Credited to revaluation reserve as above - valuation	-	**1,502**	**1,502**	-	9,673	**9,673**
Total revaluations	-	**1,502**	**1,502**	-	**9,673**	**9,673**

Notes
There was a net decrease in the carrying value of UCLH's property as a result of the valuation exercise described in Note 11.

* Project replaced by alternative solution with incurred costs impaired

15 Property, Plant & Equipment Economic Lives

Property, plant and equipment is depreciated on current valuation over estimated useful life as follows:

	Minimum	*Maximum*
Buildings excluding dwellings	1	50
Plant & Machinery	5	15
Information Technology	2	8
Furniture & Fittings	5	7
Transport	7	7
Intangible Assets	3	10

16 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	**81,200** *	166,741
Total	**81,200**	**166,741**

*Capital commitments at 31st March 2019 include £50.4m on Phase 4/PBT construction and £7.6m on Phase 5 construction. (2017/18 £116m on Phase 4/PBT and £35m on Phase 5)

17 Inventories

17.1 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	**7,038**	8,321
Consumables	**7,862**	8,788
Energy	**175**	128
Total	**15,075**	**17,237**

17.2 Inventories recognised in expenses

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	(255,293)	(225,611)
Total	**(255,293)**	**(225,611)**

18 Trade and other receivables

18.1 Trade and other receivables

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	**68,399**	-	**-**	-
Contract receivables (IFRS 15): not yet invoiced / non-invoiced*	**85,223**	-	**-**	-
Trade receivables (comparative only)	**-**	36,382	**-**	-
Capital receivables (including accrued capital related income)	**2,385**	4,023	**-**	-
Accrued income (comparative only)**	**-**	85,545	**-**	-
Allowance for impaired contract receivables / assets	**(10,282)**	-	**-**	-
Allowance for impaired other receivables	**-**	(27,044)	**-**	-
Prepayments (revenue) [non-PFI]	**26,094**	26,606	**-**	-
PFI lifecycle prepayments (revenue)	**-**	-	**12,313**	9,838
Interest receivable	**-**	-	**-**	-
PDC Dividend Receivable	**500**	51	**-**	-
VAT receivable	**6,652**	5,077	**-**	-
Other receivables	**-**	19,213	**-**	-
	178,971	**149,853**	**12,313**	**9,838**
Of which receivables from NHS and DHSC group bodies:	**115,208**	92,234	**-**	**-**

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.

*Includes £47.7m accrued PSF funding in 2018/19.
**Includes £41.3m accrued STF funding in 2017/18

18.2 Provision for impairment of receivables 2018/19

	Total	Contract receivables and contract assets	All other receivables
	31 March 2019 £000	31 Mar 2019 £000	31 Mar 2019 £000
Allowance for credit losses at 1 April 2018 - brought forward (before IFRS 9 and IFRS 15 implementation)	**27,044**	**-**	**27,044**
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018 balance	**(18,972)**	**8,072**	**(27,044)**
New allowances arising	**2,706**	**2,706**	**-**
Utilisation of allowances (where receivable is written off)	**(496)**	**(496)**	**-**
Total allowance for credit losses at 31 March 2019	**10,282**	**10,282**	**-**
Loss / (gain) recognised in expenditure	**2,706**		

18.3 Provision for impairment of receivables 2017/18

	31 March 2018
Balance at 1 April	31,502
Net Increase in Provision	1,943
Amounts utilised	(6,401)
Balance at 31 March	27,044

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.

19 Cash and cash equivalents

	31 March 2019	31 March 2018
	£000	£000
Balance at 1 April	**147,091**	75,148
Net change in year	**110,251**	71,943
Balance at 31 March	**257,342**	147,091
Made up of		
Cash with the Government Banking Service	**257,147**	146,943
Commercial banks and cash in hand	**195**	148
Cash and cash equivalents as in statement of financial position	257,342	147,091
Cash and cash equivalents as in statement of cash flows	**257,342**	147,091

20 Trade and other payables

	Current		
	31 March 2019	31 March 2018	
	£000	£000	
Trade payables	**31,160**	13,534	
Trade payables - capital*	**22,817**	16,709	
Taxes payable	**18,617**	16,882	
Other payables	**28,434**	40,895	**
Accruals	**101,936**	82,825	**
Total	**202,964**	170,845	
Of which payables from NHS and DHSC group bodies	**29,279**	20,452	

* These items are considered non-operational and are excluded from the movement in payables shown in the cash flow statement
** Prior year balances realigned

21 Borrowings

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Loans from Independent Trust Financing Facility	**2,637**	2,248	**289,556**	156,341
Other Loans	**109**	233	**-**	109
Obligations under finance leases	**173**	176	**1,159**	1,335
Obligations under Private Finance Initiative contracts	**5,499**	5,153	**230,549**	236,048
Total	**8,418**	7,810	**521,264**	393,833

The outstanding balances on the Trust's Independent Trust Financing Facility loans at 31st March 2019 totalled £291.7m (31st March 2018 £158.6m). The total loan facility has been used to support the ongoing capital programme and to fund work on the Phase 4 and Phase 5 facilities and Emergency Department works.

Phases 4 and 5: two loan facilities totalling £285.2m (short term loan £139m with £139m drawn down to date; 18 year loan; 1.08% and long term loan facility £146.2m, £112.1m drawn down; 25 year loan; 1.90%)
Emergency Department: £19.6m loan (£19.3m drawn down to date; 25 years; 1.85%, £18.4m outstanding)
Capital Programme Support: £24.8m loan (fully drawn down with a balance of £22.2m outstanding at 31st March 2019; 20 years; 1.17%)
Proton Beam Therapy: £52.5m loan facility (£0m drawn down to date)

22 Other liabilities

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Deferred income: contract liability (IFRS 15)	**25,585**	21,128	**-**	-
Deferred income: other (non-IFRS 15)	**496**	-	**4,130**	4,526
Total	**26,081**	21,128	**4,130**	4,526

22.1 Reconciliation of movements in contract liabilities recognised under IFRS 15

	2018/19
	£000
Opening Deferred Income	**21,128**
Released (performance conditions met)	**(14,092)**
Arising (performance conditions not met)	**18,549**
Closing Deferred Income	**25,585**

23 Finance lease commitments

Other than those included as Private Finance Initiative contracts, UCLH has the following finance lease commitments:

2018-19	**Due < 1 Year**	**Due >1 Year and < 5 Years**	**Due > 5 Years**	**Interest Rate**
LINAC Machine	£173k	£753k	£406k	1.92%

2017-18	**Due < 1 Year**	**Due >1 Year and < 5 Years**	**Due > 5 Years**	**Interest Rate**
LINAC Machine	£176k	£739k	£576k	1.92%

24 Private Finance Initiative contracts

24.1 PFI schemes OFF-STATEMENT OF FINANCIAL POSITION

UCLH has no current off-statement of financial position PFI contracts.

24.2 PFI schemes ON-STATEMENT OF FINANCIAL POSITION

University College Hospital - Private Finance Initiative

A contract for the development of the hospital was signed on 12th July 2000, to build and run the hospital. The scheme is in conjunction with Health Management (UCLH) Plc (HMU), a consortium entity. The HMU consortium now consists of Semperian (part of Trillium group), Credit Suisse, Interserve PFI Holdings Ltd and Dalmore Capital.

The scheme is contracted to end on 1 June 2040, at which time the building will revert to the ownership of UCLH NHS FT.

The St Martin site, upon which the hospital has been constructed, was purchased in 2000/01 to provide the site for the hospital. A 40 year lease has been granted to the PFI partners, who contracted to build the hospital.

The new building was handed over in two phases, phase 1 on 19th April 2005 and phase 2 on 5th August 2008. Over the period, we, and our partners HMU Plc, invested £422m in building and equipping the new hospital. A number of existing UCLH NHS FT properties were sold and most of the income invested in the scheme.

UCLH NHS FT is committed to pay quarterly PFI unitary charge payments in advance which commenced with the opening of phase 1 of the development in 2005. This was initially at a reduced rate until phase 2 opened in 2008. After phase 2 was handed over to UCLH, UCLH

NHS FT is committed to annual unitary charge building availability payments to the end of the contract in 2040, with the original per annum figure of £27.9m uplifted by the Retail Price Index each year since the opening of the PFI. The total availability fee payable in 2018/19 was £42.6m, of which £33.0m was charged as interest (including contingent rent of £15.1m), £5.2m allocated to repayment of capital, and £2.5m payment into the lifecycle replacement fund, which at 31 March 2019 totals £12.3m and which is included in non-current trade and other receivables (2017/18: £9.8m). These costs are transferred to Property, Plant and Equipment as and when the operator undertakes lifecycle modifications to the asset. This pre-payment was re-estimated in 2015/16 based on a new assessment of the required level of pre-payments required to cover future lifecycle expenditure under the contract.
The PFI agreement has been assessed under IFRIC 12 and the asset is deemed to be on Statement of Financial Position. The substance of the contract is that UCLH has a finance lease and payments comprise three elements – imputed finance lease charges, lifecycle fund and service charge.

Total finance lease obligations for on-statement of financial position PFI contracts

	31 March 2019	31 March 2018
	£000	£000
Not later than one year	**20,296**	20,296
Later than one year, not later than five years	**81,186**	81,186
Later than five years	**324,743**	345,039
Gross PFI liabilities	**426,225**	446,521
Less: interest element	**(190,177)**	(205,320)
Net PFI obligation	**236,048**	**241,201**
- not later than one year	**5,499**	5,153
- later than one year and not later than five	**25,869**	29,007
- later than five years	**204,680**	207,041
	236,048	**241,201**

24.3 Charges to expenditure

Annual Unitary Payment

	31 March 2019	31 March 2018
	£000	£000
- Interest charge (including contingent rent)*	**33,029**	32,524
- Repayment of finance lease liability	**5,154**	4,833
- Service element**	**23,177**	22,352
- Capital lifecycle maintenance	**6,333**	6,105
Total	**67,693**	**65,814**

***** Interest charge includes contingent rent of £15.1m in 2017/18 (£15.5m 2017/18

**Excludes utility payments

Total Future PFI Commitments

UCLH is committed to the following future payments in respect of the on-SoFP and off-SoFP PFI contracts*

	31 March 2019	31 March 2018
	£000	£000
PFI scheme expiry date:		
Not later than one year	68,885	67,009
Later than one year, not later than five years	295,375	287,330
Later than five years	1,692,195	1,769,125
Total	**2,056,455**	**2,123,464**

*This assumes an average RPI rate of 2.8% per year over the life of the PFI

25 Provisions

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Pensions relating to other staff	**298**	293	**983**	1,389
Legal claims*	**250**	187	-	141
Restructurings	**680**	1,075	-	-
Other *	**4,832**	3,202	**890**	675
Total	**6,060**	**4,757**	**1,873**	**2,205**

*Prior year balance realigned

	Pensions relating to other staff	Legal claims	Restructurings	Other	Total
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2018	**1,682**	**328**	**1,075**	**3,877**	**6,962**
Arising during the year	335	**105**	-	5,368	**5,808**
Utilised during the year	(785)	**(134)**	(395)	(3,523)	**(4,837)**
Reversed unused	-	(50)	-	-	**(50)**
Unwinding of discount	49	1	-	-	**50**
At 31 March 2019	**1,281**	**250**	**680**	**5,722**	**7,933**
Expected timing of cash flows:					
- not later than one year;	298	250	680	4,832	**6,060**
- later than one year and not later than five years;	983	-	-	890	**1,873**
- later than five years.	-	-	-	-	**-**
Total	**1,281**	**250**	**680**	**5,722**	**7,933**

Staff pensions are calculated using a formula supplied by the NHS Pensions Agency. These pensions are the costs of early retirement of staff resulting from reorganisation.

Legal claims are estimates from UCLH legal advisors on employer and public liability claims. The risks are limited to the excess of the policy excesses with the NHS Litigation Authority.

Other provisions include provisions for contractual disputes (£4.2m), RNTNEH Compensation (£0.7m) and dilapidations (£0.3m).

£155.5m is included in the provisions of NHS Resolution at 31 Mar 2019 in respect of clinical negligence liabilities of UCLH (31 March 2018: £136.7m).

26 Contingencies

UCLH has no contingent liabilities.

27 Financial Instruments

27.1 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.

	Financial assets at amortised cost	Financial Assets at Fair Value through I&E	Total Carrying Value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	145,707	-	**145,707**
Other investments / financial assets	15,418	-	**15,418**
Cash and cash equivalents at bank and in hand	257,342	-	**257,342**
Total at 31 March 2019	**418,467**	**-**	**418,467**

	Loans and receivables	Assets at fair value through the I&E	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	118,120	-	**118,120**
Other investments / financial assets	15,495	-	**15,495**
Cash and cash equivalents at bank and in hand	147,091	-	**147,091**
Total at 31 March 2018	**280,706**	**-**	**280,706**

27.2 Carrying Values of Financial Liabilities

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	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	292,193	-	**292,193**
Obligations under finance leases	1,332	-	**1,332**
Obligations under PFI, LIFT and other service concession contracts	236,048	-	**236,048**
Other borrowings	109	-	**109**
Trade and other payables excluding non financial liabilities	184,345	-	**184,345**
Provisions under contract	7,933	-	**7,933**
Total at 31 March 2019	**721,960**	**-**	**721,960**

	Other financial	Held at fair value	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	158,589	-	**158,589**
Obligations under finance leases	1,511	-	**1,511**
Obligations under PFI, LIFT and other service concession contracts	241,201	-	**241,201**
Other borrowings	342	-	**342**
Trade and other payables excluding non financial liabilities	167,460	-	**167,460**
Other financial liabilities	-	-	**-**
Provisions under contract	6,961	-	**6,961**
Total at 31 March 2018	**576,064**	**-**	**576,064**

The fair value of financial assets and liabilities does not differ from the carrying amount.

27.3 Maturity of Financial Liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	198,818	337,109
In more than one year but not more than two years	19,624	2,248
In more than two years but not more than five years	22,256	25,928
In more than five years	481,262	210,779
Total	**721,960**	**576,064**

27.4 Reconciliation of Liabilities arising from financing activities

	31st March 2018	Cash Flows	Non-Cash Movements	31st March 2019
	£000	£000	£000	£000
Long Term Borrowings	158,930	132,916	455	292,301
Lease Liabilities	1,511	(176)	-	1,335
PFI Liabilities	241,201	(5,154)	-	236,047
Total Liabilities from Financing Activities	**401,642**	**127,586**	**455**	**529,683**

27.5 Financial Risk Management

UCLH's financial risk management operations are carried out by the Trust's treasury function, within parameters defined formally within the policies and procedures manual agreed by the Board of Directors. This activity is routinely reported and is subject to review by internal and external auditors.

UCLH's financial instruments comprise cash and liquid resources, borrowings and various items such as trade debtors and creditors that arise directly from its operations. UCLH does not undertake speculative treasury transactions.

Currency Risk and Interest Rate Risk

UCLH is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. As such, UCLH undertakes very few transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time.

UCLH has no significant overseas operations.

UCLH has loans from the Independent Trust Financing Facility (previously known as the Foundation Trust Financing Facility) with fixed repayments and fixed interest rate. Therefore UCLH's exposure to interest rate fluctuations is minimal.

Market Price Risk of Financial Assets

UCLH has no investments in overseas banks. Surplus cash is invested in the Office of the Government Banking Service.

Credit Risk

Due to the fact that the majority of UCLH's income comes from legally binding contracts with other government departments and other NHS Bodies UCLH is not exposed to major concentrations of credit risk. UCLH's investments in money market funds and money market deposits does expose UCLH to credit risk. This is managed by Treasury Policies limiting the investments to highly rated institutions and spreading the investments to restrict exposure. In 2018/19 no significant deposits were placed outside of the Trust's Government Banking Service account.

UCLH uses a simplified lifetime expected loss model to assess credit losses against defined customer groups. UCLH has a robust credit management policy and manages debt and debt impairment within this policy.

Liquidity Risk

UCLH has only utilised external borrowings in year associated with its PFI investment and Independent Trust Financing Facility Loan.

UCLH currently has substantial cash balances and is not currently exposed to any liquidity risk associated with inability to pay creditors.

28 Financial Performance Targets

Under the Use of Resources rating system, UCLH was rated as 1 in 2018/19.

29 Related party transactions

University College London Hospitals NHS Foundation Trust is a body corporate established by the Secretary of State. The Independent Regulator of NHS Foundation Trusts ("NHSI") and other Foundation Trusts are considered related parties.

The Department of Health and Social Care is regarded as a related party as it exerts influence over the number of transaction and operating policies of UCLH. During the year ended 31 March 2019 UCLH had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

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 UCLH, where material is defined to be transactions above £2m.

UCLH had material transactions with the following entities, listed opposite:

Organisation	2018/19 Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England	511,000.00	-	63,000.00	2,000.00
NHS Camden CCG	87,000.00	1,000.00	9,000.00	4,000.00
NHS Islington CCG	74,000.00	-	3,000.00	1,000.00
Health Education England	38,000.00	-	-	1,000.00
Department of Health and Social Care	42,000.00	-	1,000.00	3,000.00
Central and North West London NHS Foundation Trust	32,000.00	2,000.00	3,000.00	4,000.00
NHS Barnet CCG	34,000.00	-	4,000.00	1,000.00
NHS Haringey CCG	24,000.00	-	2,000.00	-
NHS Central London (Westminster) CCG	19,000.00	-	-	-
NHS City and Hackney CCG	16,000.00	-	-	-
NHS Enfield CCG	16,000.00	-	1,000.00	-
NHS Herts Valleys CCG	11,000.00	-	1,000.00	-
NHS Brent CCG	9,000.00	-	-	-
NHS East Berkshire CCG	2,000.00	-	-	-
NHS East and North Hertfordshire CCG	8,000.00	-	-	-
NHS Waltham Forest CCG	7,000.00	-	-	-
NHS Harrow CCG	5,000.00	-	-	-
NHS Redbridge CCG	5,000.00	-	-	-
NHS West London (K&C & Qpp) CCG	5,000.00	-	-	-
NHS Ealing CCG	4,000.00	-	-	-
NHS Newham CCG	4,000.00	-	-	-
NHS Tower Hamlets CCG	4,000.00	1,000.00	-	-
NHS West Essex CCG	4,000.00	-	-	-
Great Ormond Street Hospital for Children NHS Foundation Trust	3,000.00	1,000.00	2,000.00	6,000.00
Royal Free London NHS Foundation Trust	3,000.00	5,000.00	4,000.00	5,000.00
NHS Bedfordshire CCG	3,000.00	-	-	-
NHS Hammersmith and Fulham CCG	3,000.00	-	1,000.00	-
NHS Havering CCG	3,000.00	-	-	-
NHS Hillingdon CCG	3,000.00	-	-	-
NHS Lambeth CCG	3,000.00	-	-	-
NHS Wandsworth CCG	3,000.00	-	1,000.00	-
Barts Health NHS Trust	2,000.00	3,000.00	4,000.00	4,000.00
The Whittington Health NHS Trust	2,000.00	1,000.00	2,000.00	2,000.00
Camden and Islington NHS Foundation Trust	2,000.00	1,000.00	-	2,000.00
NHS Basildon and Brentwood CCG	2,000.00	-	-	-
NHS Bromley CCG	2,000.00	-	-	-
NHS Greenwich CCG	2,000.00	-	-	-
NHS Lewisham CCG	2,000.00	-	-	-
NHS Mid Essex CCG	2,000.00	-	-	-
NHS Southwark CCG	2,000.00	-	-	-
NHS West Kent CCG	2,000.00	-	-	-
NHS Resolution (formerly NHS Litigation Authority)	-	19,000.00	-	-

Organisation	2017/18			
	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England	479,000	-	53,000	-
NHS Camden CCG	93,000	2,000	6,000	4,000
NHS Islington CCG	75,000	-	4,000	1,000
Health Education England	41,000	-	-	-
Department of Health and Social Care	32,000	-	1,000	3,000
Central and North West London NHS Foundation Trust	29,000	3,000	5,000	2,000
NHS Barnet CCG	25,000	-	-	1,000
NHS Haringey CCG	22,000	-	1,000	-
NHS Central London (Westminster) CCG	19,000	-	-	-
NHS City and Hackney CCG	16,000	-	1,000	-
NHS Enfield CCG	16,000	-	-	1,000
NHS Herts Valleys CCG	10,000	-	-	1,000
NHS Brent CCG	8,000	-	-	-
NHS Slough CCG	8,000	-	-	-
NHS East and North Hertfordshire CCG	7,000	-	-	-
NHS Waltham Forest CCG	7,000	-	-	-
NHS Harrow CCG	5,000	-	1,000	-
NHS Redbridge CCG	5,000	-	-	-
NHS Tower Hamlets CCG	5,000	-	-	-
NHS West London (K&C & Qpp) CCG	5,000	-	1,000	-
NHS Ealing CCG	4,000	-	-	-
NHS Newham CCG	4,000	-	-	-
NHS West Essex CCG	4,000	-	-	-
Royal Free London NHS Foundation Trust	3,000	6,000	4,000	3,000
Barts Health NHS Trust	3,000	2,000	1,000	3,000
NHS Bedfordshire CCG	3,000	-	-	-
NHS Havering CCG	3,000	-	-	-
NHS Hillingdon CCG	3,000	-	-	-
NHS Lambeth CCG	3,000	-	-	-
The Whittington Health NHS Trust	2,000	1,000	1,000	2,000
Great Ormond Street Hospital for Children NHS Foundation Trust	2,000	-	1,000	6,000
NHS Bromley CCG	2,000	-	-	-
NHS Hammersmith and Fulham CCG	2,000	-	-	-
NHS Southwark CCG	2,000	-	-	-
NHS Trafford CCG	2,000	-	-	-
NHS Wandsworth CCG	2,000	-	-	-
NHS West Kent CCG	2,000	-	-	-
NHS Resolution (formerly NHS Litigation Authority)	-	20,000	-	-

29. Related Party Transactions – Continued

UCLH is a member of UCL Partners Limited (a company limited by guarantee) acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. During the year UCLH made payment to UCLP of £0.3m (2017/18: £0.2m) which was expensed to operating expenses.

As noted in Note 13, UCLH has a 24.5% share in HSL LLP, a pathology joint venture with The Doctors Laboratory (TDL) and Royal Free Foundation Trust.

During the year UCLH received services from HSL of £43.0m (2017/18: £42.4m), which are recorded in operating expenses. Additionally UCLH provided services to HSL of £0.9m (2017/18: £3.3m).

Included within other creditors is the sum of £8.0m (2017/18: £5.4m) representing sums due to HSL.

Included within other debtors is the sum of £ 3.3m (2017/18: £1.34m) representing sums due from HSL.

UCL is classed as a related party, with one Executive Board Member directly employed by UCL. During the year UCLH received services from UCL of £ 36.2m (2017/18: £27.86m), which are recorded in operating expenses. Additionally, UCLH provided services to UCL of £10.8m (2017/18: £6.40m) which are recorded in other income.

Included within other creditors is the sum of £18.1m (2017/18: £14.6m) representing sums due to UCL.

Included within other debtors is the sum of £8.5m (2017/18: £7.5m) representing sums due from UCL.

During the year UCLH made payments to HMRC in relation to the Income Tax deducted at source and Social Security costs as per Note 6, and relating to Value Added Tax payments / refunds.

Included within Trade and Other Debtors is a VAT debtor of £ 6.7m (2017/18: £5.1m)

Included within tax payable in Trade and Other Creditors is £ 11.7m owed to HMRC (2017/18: £10.5m)

During the year UCLH made payments to the NHS Pension Agency as per Note 6.

Included within tax payable in Trade and Other Creditors is £6.8m owed to NHS Pension Agency (2017/18: £6.4m.)

UCLH has a wholly owned subsidiary, MyUCLH, that was formed in 15/16. There are no material transactions during this year with MyUCLH. Related party transactions were made on terms equivalent to those that prevail in arm's length transactions.

30 Third Party Assets

UCLH held £13,161 cash and cash equivalents at 31 March 2019 (£13,161 at 31 March 2018) in relation to monies held on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 Losses and Special Payments

NHS Foundation Trusts are required to report to the Department of Health and Social Care any losses or special payments, as the Department still retains responsibility for reporting on these to Parliament. By their very nature such payments ideally should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

In the twelve months to 31 March 2019 the value of losses and special payments was £0.5m (2017/18: £2.3m) relating to 289 cases (2017/18: 1,043 cases). This includes write-offs of Private and Overseas Patient debt, charged to the provision for impairment of receivables.

Losses and special payments are reported on an accruals basis, and exclude provisions for future losses.

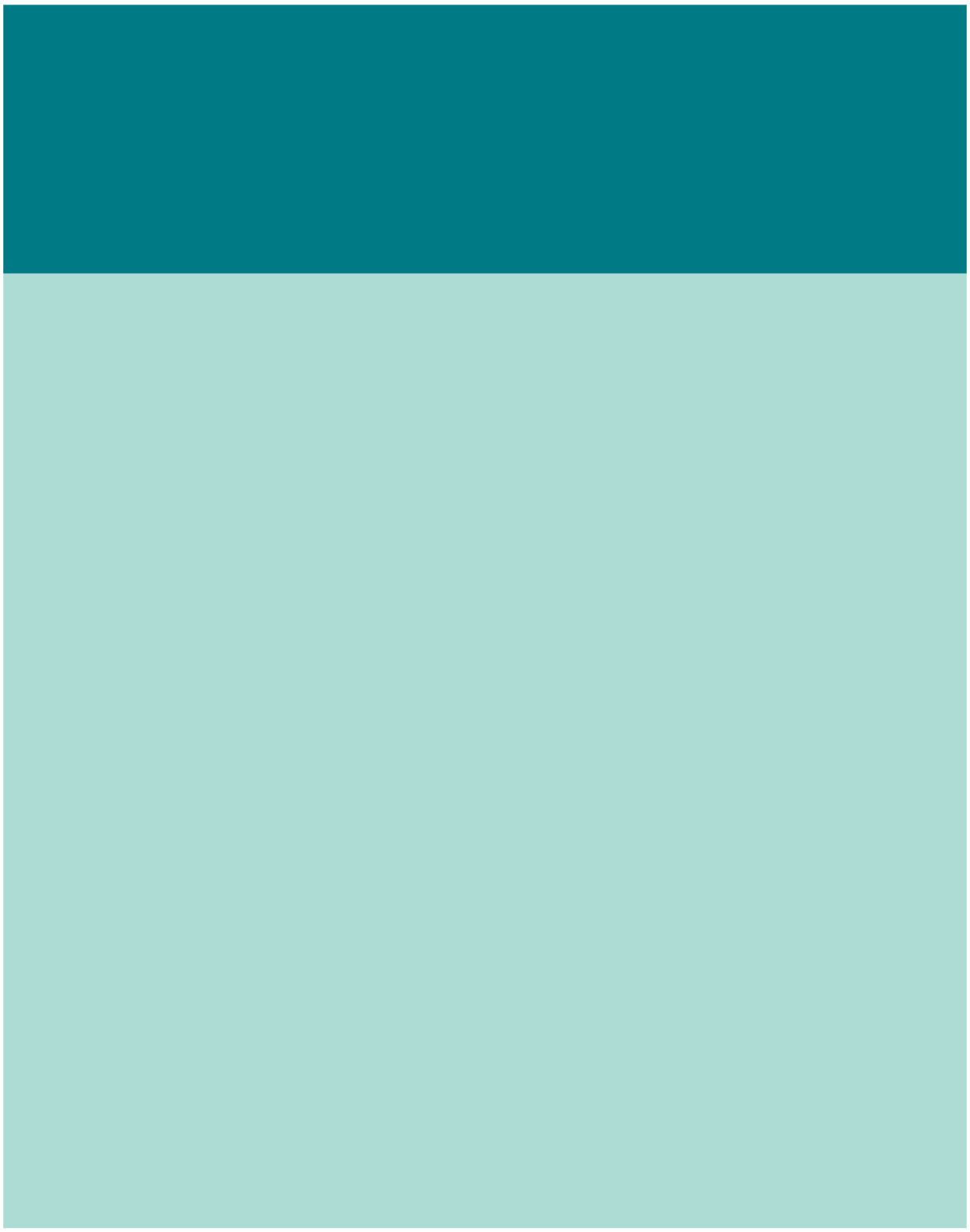
Details are shown in the table below

	2018/19	**2018/19**	2017/18	2017/18
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Fruitless payments	**28**	**3**	22	4
Bad debts and claims abandoned	**248**	**495**	1,002	2,090
Total Losses	**276**	**498**	**1,024**	**2,094**
Special payments - extra statutory	**1**	**10**	8	160
Special payments - ex gratia	**12**	**11**	11	7
Total Special Payments	**13**	**21**	**19**	**167**
Total	**289**	**519**	**1,043**	**2,261**

No individual special payments were made over £300k (2017/18: none)

32 SoFP adjustments for the implementation of IFRS 15 and IFRS 9 on 1 April 2018

Statement of financial position:	SoFP 31 March 2018 pre-implementation	IFRS 15 adjustment	IFRS 9 adjustment	SoFP 1 April 2018 post implementation
	31 Mar 2018 2017/18 £000	1 Apr 2018 2018/19 £000	1 Apr 2018 2018/19 £000	1 Apr 2018 2018/19 £000
Assets:	-	-	-	-
Investments / financial assets (non-current)	-	-	-	-
Investments / financial assets (current)	186,735	-	-	186,735
Receivables (gross)	(27,044)	-	(19,050)	(46,094)
Receivables - allowance for doubtful debts (credit losses)	978,983	-	18,972	997,955
All other assets (unlocked on request)	**1,138,674**	**-**	**(78)**	**1,138,596**
Total assets				
Liabilities:				
Other liabilities (includes deferred income / contract liabilities)	(25,654)	-	-	(25,654)
Trade and other payables (for reclassification of interest accrual only)	(170,843)	-	193	(170,650)
Borrowings	(401,643)	-	(193)	(401,836)
Other financial liabilities	-	-	-	-
All other liabilities	(6,961)	-	-	(6,961)
Total liabilities	**(605,101)**	-	-	**(605,101)**
Net assets	**533,573**	**-**	**(78)**	**533,495**
Equity and reserves:				
Income and expenditure reserve	194,140	-	(78)	194,063
Non-controlling interest reserve	-	-	-	-
Financial assets at FV through OCI reserve	-	-	-	-
All other reserves	339,433	-	-	339,433
Total equity	**533,573**	**-**	**(78)**	**533,496**



uclh

We are committed to delivering top-quality patient care, excellent education and world class research

Safety
Kindness
Teamwork
Improving