Imperial College Healthcare NHS Trust

Annual report 2019/20

Our annual report for 2019/20 is dedicated to the commitment and expertise of all of our people who are playing a vital role in the UK's on-going response to COVID-19. We pay special recognition to our colleagues who have died during the pandemic to date and celebrate their lives and contribution to the NHS:

Melujean Ballesteros

Professor Mohammed Sami Shousha

Donald Suelto

Jermaine Wright

Welcome

Paula Vennells CBE, Chair

Welcome to the annual report for Imperial College Healthcare NHS Trust for 2019/20. As the year drew to a close, we faced probably our biggest ever challenge as an organisation. Along with the rest of the NHS, our five hospitals in central and west London became part of the frontline in the UK's response to COVID-19.

I could not be prouder of what our 13,000 staff have achieved. Within just a few weeks, we transformed our usual services and expanded intensive care to meet the growing, urgent need created by the global pandemic. Our people worked incredibly hard in very difficult circumstances, taking on new roles and working in unfamiliar areas while managing risks to their own health and worrying about family and friends. I am hugely grateful to them. I also want to express my heartfelt respect for our four colleagues who have died during the pandemic and for the many more who have suffered ill health or the loss of loved ones.

It is clear that there is much more challenge to come – not just the likelihood of further waves of infection but also the longer term transformation we'll need to make in the way we live and work as we await a reliable vaccine. Looking more broadly, we will continue to respond with kindness and expertise to the growing and changing care needs of our patients and wider population, which will only become more complex with the on-going demands of COVID-19.

Reassuringly, we have built strong strategic foundations, which will stand us in good stead for the difficult months and years ahead. This progress was recognised by the Care Quality Commission when they inspected us last year and increased our rating for well-led overall to 'good', as well as awarding 'good' or 'outstanding' ratings for all eight of the services that were under scrutiny. My congratulations to all maternity service colleagues – at Queen Charlotte's and Chelsea and St Mary's – for achieving 'outstanding'! NHS Improvement also acknowledged our improvement, moving us from level three oversight, under their single overview framework, to level two, reflecting no significant concerns.

We continued to build our strategy during 2019/20, working with colleagues and partners. Our focus on delivering 'better health, for life' – through integrated care for our local population, developing a sustainable portfolio of outstanding services (with international impact as well as local benefit), and ensuring learning, innovation and improvement in everything we do – will be even more important in a COVID-19 world.

Our chief executive, Professor Tim Orchard, his executive and teams right across the Trust have put huge energy into bringing our organisational values to the fore, ensuring that each of us knows them – kind, expert, aspirational, collaborative – and lives them. We've all been rewarded by the kindness we have witnessed over the past few weeks, especially at some of our bleakest moments. Our patients and staff have benefitted enormously from collaborations made possible by our deepening partnerships– with Imperial Health Charity, Imperial College London, our local

authorities, GPs and other NHS organisations. Our lay partners are increasingly core to the way we work – with their central role in all of our key projects, it was an obvious step to include them in shaping our COVID-19 response from the start.

We have continued to widen and strengthen our expertise in innovation, improvement and research. Along with Imperial College London, The Royal Marsden, Royal Brompton and Harefield and the Institute of Cancer Research, we bid successfully to be 're-designated' as an academic health science centre (AHSC). Our aspiration to drive even better outcomes for patients has seen us, together with Imperial College London, at the centre of some of the most promising developments in relation to COVID-19, devising reliable approaches to testing for patients and staff, vaccine trials and research to understand the disease and discover better treatments. I've also been delighted to see the ever growing impact of digital transformation. We adopted virtual outpatient appointments and consultations during the COVID-19 crisis and have learnt how many patients and clinicians have preferred them; while not a replacement for face-to-face, they have a significant role to play. They and other digital capabilities developed by our outstanding ICT teams are an essential element of preparedness for whatever the future holds.

Progress on other key strategic issues will require more of our attention in the year ahead. Even before COVID-19, our old and worn out buildings were being stretched to their limit – all of our sites are in desperate need of redevelopment or renovation. We continue to have the largest backlog maintenance liability of all NHS trusts and estate failures created more operational problems this year than ever. Our inclusion in the government's healthcare infrastructure plan was a major breakthrough, and we are currently exploring a partnership with a major developer to build a brand new St Mary's Hospital as a first stage of a multi-site improvement programme, but we have much to do and increasingly little time in which to do it.

We also continue to tackle a significant underlying financial deficit. Some of our challenge is related to our poor estate but there are other factors too and we have some way to go to ensure our finances are sustainable over the longer term. The team worked hard to achieve our financial plan in 2019/20 but we still had to rely on some non-recurrent measures to meet the more ambitious control total we were set – this has meant a slight worsening of our underlying position. It's unclear what the COVID-19 pandemic will mean for our financial plan for 2020/21 and for expectations around sector-level change. Whatever happens, maintaining our strong financial grip of the past four years will be essential.

There is one further, emerging issue that I would like to share. In our 2019 strategic refresh, we made a new commitment to reduce health inequalities within our services and communities. The importance of this ambition is underlined as we learn that COVID-19 is disproportionately impacting black, Asian and minority ethnic communities and people who live in poorer areas. It must remain at the forefront of our agenda.

While I have been transparent about the scale of our challenges, I remain excited and optimistic for our future – and for what I believe we can achieve together with our patients and partners. Imperial College Healthcare NHS Trust is blessed with outstanding colleagues and inspiring and capable leadership. The COVID-19

pandemic has reminded everyone just how precious the NHS is and I am in awe of how hard my colleagues work to care for patients and to save lives. In recognition of that, our task – together with our patients, local communities and other stakeholders – is to make the most of the opportunity we have to learn lessons and to celebrate kindness and expertise, to ensure the best possible NHS for the future.

Performance report

Chief executive's overview

Just a couple of weeks past the peak of coronavirus infections in London, it's not an easy time to reflect on the whole of 2019/20. Everything changed in the last month of the year, when we had to more than double our intensive care capacity, redeploy hundreds of staff into new roles and learn all there was to know about how best to treat a new disease causing huge suffering across the world. At the same time, we did all we could to continue care for all our patients, including transferring planned surgery and treatments to other NHS providers and private hospitals less impacted by COVID-19 and transforming our outpatient appointments into telephone or video consultations.

Our staff have made this possible and I am incredibly grateful for their amazing commitment and compassion in these very difficult times. They are continuing to go well above and beyond, especially when considering so many have been personally affected along with thousands of families across the country. Four of our own people have died since the pandemic began and we worry there may be others in the months ahead. Our report begins by recognising and celebrating the dedication and commitment of all our staff but especially Melujean Ballesteros Professor Mohammed Sami Shousha, Donald Suelto, and Jermaine Wright.

I also want to recognise the huge contribution of a whole range of individuals and businesses who are continuing to provide additional funds, supplies and other support to help us with our response to Covid-19. Most of this support was co-ordinated through Imperial Health Charity who also rapidly restructured their volunteering programme to help us in new ways, such as staff shops and hot food deliveries direct to wards. Our colleagues at Imperial College, too, responded quickly with joint innovations for Covid-19 testing, research and treatment as well as many volunteering to work on the frontline themselves.

If we do look back at the first eleven months of 2019/20, themes emerge that are still relevant now, in what feels like a quite different world. They offer hope and support as we respond to the continuing challenges of both coronavirus and the longer-standing issues arising from growing and changing health and care needs.

Creating a positive organisational culture

While NHS trusts like ours have to grapple with a wide range of priorities, it's clear that, above all else, we need to create the best possible organisational culture. One directed by a clear and shared vision of what we want to achieve, shaped by a set of meaningful values, and in which staff feel listened to, empowered and valued. We expanded our work in this area during 2019/20, running interactive values awareness workshops for everyone, introducing active bystander training to support staff in challenging poor behaviours and developing an organisational management system.

We also targeted improvements in areas where staff had told us we needed to do more: improving equality, diversity and inclusion – addressing imbalances in our staff disciplinary processes, introducing reverse mentoring for senior leaders and expanding our staff-led networks; investing in initiatives and programmes to improve staff health and wellbeing; and improving our workplaces and making it easier for staff to collaborate and engage digitally through the supported roll out of Microsoft Office 365 applications. Our experiences during the COVID-19 pandemic have highlighted the critical importance of ensuring our staff are well supported, practically and emotionally.

A culture where everyone is committed to the organisation's goals – and understands the importance of their own role in that effort – is of particular importance in challenging times. The results of the latest annual NHS staff survey, received in February 2020, showed that we are on the right track. As the most improved NHS trust in London, our overall engagement score increased from 7.0 to 7.2 and we received improved scores across all areas surveyed, with our results now above the national average in six out of eleven categories.

Another major milestone was achieved on 1 April 2020 when all porters, cleaners and catering staff working in our hospitals moved to NHS basic pay rates and sick leave and access to the NHS pension scheme – and we took on direct employment for the first time in over ten years. We believe the move will help ensure our hotel services staff are able to play their full and fair role within our care teams and enable us to improve service quality collaboratively. We will undertake an evaluation after a year to ensure we are best able to deliver the improvements we need through this model and then either bring all staff up to full NHS terms and conditions or re-tender the contract with a significantly amended specification.

Supporting continuous improvement

We began our commitment to quality improvement in 2015, introducing an organisation-wide improvement methodology and a central support function. Over the past four years, nearly 7,000 staff have been trained on quality improvement and more than 200 have become local improvement coaches. We currently have 130 active quality improvement projects and our Flow Coaching Academy established an additional nine major clinical pathway improvement initiatives.

In July 2019, we received a further boost as the CQC improved their quality ratings for a range of services inspected across four of our hospitals in February 2019, including awarding the first 'outstanding' rating for a maternity unit in London – at both Queen Charlotte's & Chelsea and St Mary's hospitals. All eight services inspected received at least a 'good' rating, representing improvements for most. The Trust's overall CQC rating remains 'requires improvement'.

We have made good progress across our safety work streams and continue to have some of the lowest mortality rates in the country. In 2019/20, highlights included introducing our 'helping our teams transform' simulation and coaching programme to support safer surgery; improving hand hygiene compliance, achieving a 25 per cent reduction in falls in wards piloting an initiative to help patients mobilise safely; and reducing incidents involving high-risk medicines such as anti-coagulants and insulin.

Our key improvement area in the coming year is increasing incident reporting. Our rate of reporting is variable, we want to focus on learning from things that go well not just when they go wrong but we can only do that if we hear from our staff and patients.

Maintaining good operational performance

Our major development to improve the way we work is our 'keeping care flowing' programme, a whole range of initiatives led by staff across the organisation with the aim of providing the care our patients need as quickly and as smoothly as possible, from before their first contact, through every stage of their care with us and after they leave. This means our specialist care can be targeted where it will be most effective.

Key achievements in the past year include: a £7.2 million expansion and refurbishment of Charing Cross A&E; setting up new command centres at St Mary's and Charing Cross hospitals, with Hammersmith to follow, to improve the management of hospital capacity, with real time updates to help reduce delays and overcrowding; introducing care home liaison nurses to work in partnership with staff in care homes, reducing A&E attendances by 45 per cent in the nursing homes involved in the initial pilot; and enabling around a quarter of our urgent and emergency care to be provided in special day clinics, avoiding the need for patients to be admitted to hospital.

We also appointed a director for operational performance who brought together site operations and performance management and provided important oversight of how we work as effectively and efficiently as possible.

Better patient focus and more joined up working across our integrated care system

As part of the north west London integrated care system, we have been working particularly closely with our neighbouring acute NHS trust, Chelsea and Westminster Hospital NHS Foundation Trust. Between us, we run seven hospitals providing almost all the acute and specialist care for the one million people living in central and west London. We share an ambition to create more joined up clinical pathways and ways of working that better meet the needs of our patients, and our staff.

This year, our jointly led ICT teams rolled out the Cerner electronic patient record system implemented in our hospitals from 2015 to Chelsea and Westminster's hospitals. This is a major enabler of more joined up care and we have begun to make improvements, taking a service by service approach. With the input of patients and stakeholders, we began with HIV inpatient services and are currently reviewing dermatology and ophthalmology pathways.

With our academic partner, Imperial College London, we have also been progressing joint proposals we set out in 2018 in our 'Healthier hearts and lungs' paper for the development of an integrated children's service for north west London and associated academic centre for child health and a cardiovascular and a respiratory centre of excellence.

We've been working with primary care partners too, including co-designing a 'test

bed' with one of our local primary care networks – the Hammersmith & Fulham Partnership – to pool resources and share risks and opportunities arising from new ways of working. We had already begun to pilot more 'virtual' outpatient consultations before COVID-19 and so were in a good position to move as many appointments to telephone or video to avoid patients travelling in to our clinics. We're reviewing the impact and experience closely now to guide further developments as we will need to keep a strong focus on minimising the risk of infection over the coming year.

Our transformation work has been boosted by a new central team providing dedicated support to clinical teams as well as the continued expansion of our lay partner programme and wider patient and public involvement work.

Responding to COVID-19 has been an additional driver for a more joined up approach across our north west London care system and we are continuing to see the benefit of closer working with our partners.

Maximising the potential of digital

We are really benefiting now from our position as an NHS global digital exemplar. We have essentially gone 'paper free' – all information about adult patients is now available electronically, saving time and money but, even more importantly, opening up opportunities for safer and better care as well as the development of new insights.

A great example from the past year has been the introduction of a digital sepsis alert and treatment system. A peer reviewed study showed that, for our patients, its use has been associated with lower chances of death, shorter hospital stays and an increased likelihood of receiving timely antibiotics. We also had the first research output from the National Institute for Health Research Health Informatics Collaborative. This fantastic initiative allows research teams from several NHS trusts, including ours, to combine and analyse anonymised data from thousands of patients, creating completely new insights from existing information. Our paper drew on cardiovascular data of more than 250,000 patients and found that a small rise in heart attack protein is linked to increased risk of early death.

The most significant risks facing the Trust in 2019/20 were financial sustainability and estates redevelopment (see p120 for more detail)

Estates redevelopment

The traction we finally made in 2019/20 on a desperately needed redevelopment and refurbishment of all our estate, starting with St Mary's, was one of very few non-COVID-19 work areas we have continued actively to nurture. Our role in responding to the pandemic demonstrates the importance of all our main sites and we have to make our latest opportunity work. We are aiming to work up more detailed plans over the next few months, in partnership with our staff, local communities and wider stakeholders.

We begin 2020/21 with an ambition to continue to provide the best possible response to COVID-19 as well as looking at how we best adapt our previous plans for the year to take account of the ongoing demand and risks. We especially want to keep hold of developments that we have accelerated over the past few weeks that are providing real value for our staff and patients and taking us towards our strategic vision of 'better health, for life'. I would pull out four developments that it feels particularly important to build on: creating a greater sense of shared purpose amongst our staff and partners; strengthening collaborative working with GPs and other providers across our integrated care system; expanding patient access to specialist advice without having to come into hospital; and providing a better digital and physical working environment for our staff. Continued progress on our much bigger ambition of a full estate redevelopment programme will also be essential.

These developments will only be successful if we continue to deepen our partnerships with all of our stakeholders, value and invest in our staff and genuinely put our patients and local communities at the heart of everything we do, especially those who find it hardest to get the care they need for their individual needs.
The coming year is likely to be a difficult one. But we should take heart from the way we have come together to tackle the immediate challenges of COVID-19 and just how much we can achieve when we are focused on a common goal.

About the Trust

At Imperial College Healthcare NHS Trust we provide acute and specialist healthcare for around 1.3 million people a year. Formed in 2007, we are one of the largest NHS trusts in the country, with over 13,000 staff in north west London.

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

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

Our mission and strategic goals

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

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

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

Our values

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

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

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

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

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

Our hospitals

We provide care from five hospitals on four sites:

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

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

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

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

- **Western Eye Hospital:** a specialist eye hospital with a specialist A&E department.

Increasingly, we provide our services in community facilities and in partnership with GPs and community, mental health and social care organisations. We run eight renal satellite units.

Imperial Private Healthcare (IPH)

Imperial Private Healthcare is our private care division, offering a wide range of services across our sites. This includes the Lindo Wing at St Mary's Hospital, the Thames View at Charing Cross Hospital and the Robert and Lisa Sainsbury Wing at Hammersmith Hospital. In 2019/20 we treated over 17,000 patients privately, including many from overseas.

We work with over 500 consultants at Imperial Private Healthcare, covering every medical and surgical speciality.

The income from our private care is invested back into supporting all our services across the Trust.

Research, education and innovation

As well as being part of Imperial College Academic Health Science Centre, the Trust, with Imperial College London, hosts one of 20 National Institute for Health Research

(NIHR) biomedical research centres (BRCs). This designation is given to the most outstanding NHS and university research partnerships in the country, leaders in scientific translation, and early adopters of new insights in technologies, techniques and treatments for improving health.

The NIHR Imperial BRC currently supports 708 active research projects across 12 different disease areas.

The Trust is also part of the NIHR Health Informatics Collaborative (NIHR HIC) together with Oxford University Hospitals, Cambridge University Hospitals, University College London Hospitals and Guy's and St Thomas' NHS foundation trusts. This collaboration brings together clinical, scientific and informatics expertise to enable NHS clinical data to be catalogued and shared to enable new insights into care and treatment through research.

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

We are a major provider of education and training for doctors, nurses, midwives and allied health professionals including therapists, pharmacists, radiographers and healthcare scientists. In 2019/20, some 2,000 Imperial College London medical undergraduates trained with us. We had 640 student nurses in training in the year, many of whom gained their first job or qualification with us.

Our charity partners

We work closely with Imperial Health Charity which helps our five hospitals do more through grants, arts, volunteering and fundraising. In 2019/20, the charity invested over £1.8m in a wide range of initiatives for the benefit of patients and staff.

Imperial Health Charity funds major redevelopments, research and medical equipment, as well as helping patients and their families at times of extreme financial difficulty. Supporting the arts in healthcare, the charity also manages an Arts Council accredited hospital art collection and runs an arts engagement programme for patients and staff. It manages volunteering across all five hospitals, adding value to the work of staff and helping to improve the hospital experience for patients.

During 2019/20, the Trust also received generous support from COSMIC (Children of St Mary's Intensive Care), the Winnicott Foundation, which raises funds to improve care for premature and sick babies at St Mary's Hospital, and each of the Friends of St Mary's, Charing Cross, and Hammersmith hospitals.

Our lay partners

We are committed to increasing and deepening the involvement of patients and the public in every aspect of our work. An important element of our involvement approach is our community of lay partners – local people and/or patients who provide insight and oversight to help ensure that everything we do is focused on those we serve. They form a key part of our strategy, project and programme governance. As of the end of 2019/20, the Trust had 66 lay partner roles supporting

21 projects. Since we developed the lay partner role in 2016, we have engaged 104 lay partners on 39 projects. Read more about lay partners and our strategic lay forum on page 40.

Our commissioners

Almost half of our care is commissioned by north west London local clinical commissioning groups (CCGs), about 40 per cent is specialist care commissioned by NHS England and the remaining 10 per cent or so is commissioned by others, including CCGs beyond our local area.

The eight CCGs in north west London are:

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

In May 2019, North West London CCGs published their case for commissioning reform. This was in response to the recommendation in the NHS Long Term Plan that the number of CCGs be significantly reduced to align with the number of emerging integrated care systems (ICSs) across the country. Work is underway to merge into a single North West London CCG in April 2021 and to have four groups of CCGs working together during a transition year in 2020/21.

North West London Integrated Care System

Over 30 NHS, local authority and voluntary sector partners, including our Trust, are working together to improve health and care across north west London through one of London's five emerging integrated care systems (ICSs).

Our regulators

As an NHS provider, the Trust works with several different regulators. The main regulators are NHS England and NHS Improvement and the Care Quality Commission (CQC).

During 2019/20, NHS England and NHS Improvement came to work as a single organisation to better support the NHS and help improve care for patients.

The CQC is the independent regulator of health and adult social care in England. Our hospitals are regularly inspected by the CQC who award ratings against five quality domains: safe, effective, caring, responsive and well-led.

The Trust is currently rated overall as 'requires improvement'; made up of 'good' for the domains of caring and effective, and 'requires improvement' for the domains of safe, responsive and well-led.'

Our latest inspection report in July 2019 reported improvements in quality of care across a range of services that were inspected in February 2019, including London's first outstanding rating for maternity care at both Queen Charlotte's & Chelsea and St Mary's hospitals (see page 18 for more detail).

Trust in numbers 2019/20 *(all rounded)*

Patient contacts (including inpatients, outpatients and day cases)	1,294,000
Emergency attendees (including A&E and AEC)	305,000
Babies born	10,000
Operations (including day and inpatients)	38,000
Inpatients who would recommend us to their friends and family	97%

Our staff

Number of staff, including:	13,000
Doctors	2,800
Nurses and midwives	5,100
Allied health professionals	800
Scientists and technicians	1,200
Pharmacists	150
Medical students (years 3, 5 and 6)	2,000
Nurses in education, pre-registration	640
Admin and clerical	2,000

Our finances

Surplus	£8.7m
Turnover	£1,300.6m
Efficiencies	£43.1m
Capital investments including buildings, infrastructure and IT	£55.5m

Performance analysis

Introduction

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

We contribute to national monitoring programmes, which allow our performance to be benchmarked against similar NHS trusts.

Our executive management team regularly reviews a comprehensive set of quality and performance indicators known as our Trust scorecard. Our Trust board reviews a core set of indicators at our public meetings too. Our scorecard report is aligned with the CQC domains so we can see how we are meeting NHS-wide standards.

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

Assessing performance against our operational objectives

Assessing progress against our objectives is an important aspect of performance analysis. The following operational objectives underpinned our business plan for 2019-20:

- To enable more patients to get the right care and support, in the right place, at the right time – focussing this year on improvements in operational processes and use of data
- To expand and connect developments that enable better integration of care – focussing this year on establishing strong partnerships and involvement, new care models and systems to support collaboration
- To reduce unwarranted variations in care pathways – focusing this year on projects supported by Flow Coaching Academy Imperial and guided by external benchmarking on quality and efficiencies
- To develop strategic solutions to key challenges – focussing this year on staff recruitment and retention, reducing our underlying financial deficit and estates redevelopment
- To strengthen the connections between our service developments and our research – focusing this year on data and digital initiatives and expanding staff involvement
- To achieve a measurable improvement in our organisational culture – focussing this year on improvements in leadership, fairness and collaboration

Many of our major Trust initiatives in 2019/20 were intended to support more than one of our operational objectives. However, in this report we have set them out under the primary objective to which they most relate.

Objective 1: To enable more patients to get the right care and support, in the right place, at the right time – focusing this year on improvements in operational processes and use of data

Keeping care flowing

Since 2017, one of our main programmes of work has focused on helping patients move through our care pathways safely and promptly. We have seen that when care truly 'flows', patients have a better experience with us. Improved flow means fewer delays, giving patients faster access to the right specialists and avoiding unnecessarily long hospital stays that can impact independence.

Some of the key areas for the programme this year have included:

- how to support patients to access specialist advice and care outside of A&E
- how to reduce delays on inpatient wards
- safe and prompt hospital discharge
- planning for increased admissions over the winter period

This year we have made the following improvements:

- Set up a new command centre at St Mary's Hospital to improve the management of hospital capacity, with real time updates to help reduce delays and overcrowding.
- Introduced the comprehensive geriatric assessment for frail, older patients in A&E.
- Introduced care home liaison nurses to work with care homes and offer training. The aim is to prevent unnecessary hospital admissions and improve the discharge of patients admitted to hospital from care homes. Between April 2019 and February 2020 we ran a pilot project at St Vincent's Nursing Home and Chiswick Nursing Home, which saw A&E attendances from these homes reduce by 45 per cent, admissions to hospital reduce by 45 per cent and length of stay in hospital reduce by 40 per cent, saving 1,691 bed days.
- Enabled 25 per cent of our urgent and emergency care in the the first three quarters of the year to be provided as 'ambulatory emergency care', avoiding the need for patients to be admitted to hospital.
- Set up multi-agency discharge events that bring together Trust and community teams in one place to discuss how to manage complex patient cases.
- Improved ambulance handovers at Charing Cross Hospital. Since the opening of the rapid nurse assessment area in September 2019, over 95 per cent of handovers take place within 30 minutes. This year, Charing Cross Hospital was selected to be part of the Ambulance Exemplar programme and, in December, ranked second in north west London for its 30– minute handover performance.

- Introduced weekly multidisciplinary reviews of patients who have been in hospital for more than 21 days, looking at how to unblock any delays in their pathway.
- Developed an adult inpatient booklet with consistent information about hospital care and discharge processes for patients and their families.
- Used a 'modelling' process to predict the busiest times and help plan resources to match demand.
- Continued to roll out the national red to green (R2G) initiative, which helps teams identify and tackle delays in care.

Making our hospitals easier to navigate

We know that our patients and visitors often struggle to find their way around our complex hospital sites.

As a result, we have developed a new approach to wayfinding supported by Imperial Health Charity and designed following extensive engagement with patients, the public and our staff. The approach includes updating signage, improving the hospital environment to make it easier to navigate and implementing more patient-friendly terminology. We've looked at the user journey across patient pathways and what their touch points are – for example, using digital screens in our clinics to display essential information.

We piloted our new approach at St Mary's Hospital in March 2019. In the last year we have continued to test and develop our approach, including creating a set of guidelines to shape a full roll out of changes across all our hospitals in the next financial year.

To support patients with disabilities, we have introduced AccessAble information guides and video tours. This platform gives patients detailed information about how to navigate to our hospital departments – including whether there is step-free access, handrails and automatic doors.

An outstanding rating for our maternity services from the CQC

In February 2019, the Care Quality Commission inspected our services and published its findings in July 2019. We were delighted to receive an 'outstanding' rating for our maternity services at Queen Charlotte's & Chelsea Hospital and St Mary's Hospital – the first outstanding rating for a maternity service in London. The report noted that our maternity services provide compassionate, individualised care to women and families and are especially caring and responsive to parents who have suffered a loss, like a miscarriage, stillbirth or neonatal death.

We have also made progress in other areas. At our last inspection in 2014, our critical care services on all sites were rated as 'requires improvement'. Following the 2019 inspection, the Charing Cross and Hammersmith services are now rated 'good' and the St Mary's service 'outstanding'. We also saw the ratings for our children and young people's services at Hammersmith Hospital improve to 'good'.

In April 2019, we had a further inspection to assess our leadership, management and governance, under the CQC domain 'well-led'. We were pleased to see our

rating increase to 'good' from 'requires improvement'. The overall CQC rating for the Trust remains 'requires improvement'.

Our full CQC report is available on our website: www.imperial.nhs.uk

Improving patient transport

On 1 June 2019, the Trust began a new five-year contract with Falck UK Ambulance Service to provide non-emergency patient transport services. Falck, who took over from DHL, are anticipated to complete 330,000 patient journeys in their first year.

Falck is a leading international provider of ambulance and healthcare services. It currently provides non-emergency patient transport services for five other NHS trusts and for some clinical commissioning groups. Under the new contract, Falck is providing 126 new Falck patient transport vehicles, 237 trained crew members and a booking and transport system.

We faced several challenges during the transition from DHL to Falck. This included technical issues with the new control and dispatch system which regrettably caused some very poor experience for a number of patients over some time. We worked hard with Falck to resolve these issues and services are now running smoothly.

New A&E performance standards

Since May 2019, we have been one of 14 NHS trusts piloting new performance standards for urgent and emergency care as part of an NHS England initiative.

The main A&E target is currently the 'four-hour standard' – where 95 per cent of patients are expected to be reviewed, treated and discharged or admitted within four hours. The targets being piloted seek to consider advances in clinical practice and what patients say matters to them the most. They measure:

- **Time to initial assessment:** to ensure people don't wait too long to be assessed by a qualified professional
- **Treatment within the first hour for critically ill and injured patients:** to ensure patients who have had a stroke or heart attack, or have sepsis, for example, get the care they need as quickly as possible
- **Time in A&E:** to reduce long waits – including for patients who need to be admitted to hospital

During the first phase in the pilot (May to July), we tested the 'time in A&E' measure. In the second phase of the pilot we have:

- measured time to initial assessment
- collected data to see if it's feasible to measure how quickly critically ill or injured patients receive a package of care
- measured how long people who come to A&E experiencing a mental health crisis wait for psychiatric assessment or transfer to a mental health unit

As of March 2020, we are still testing the new standards. Along with the other Trusts in the pilot, we are not able to report publicly on new standards or the four-hour standard.

A new process for recording deaths and bereavement support for relatives

This year we introduced a medical examiner service, prompted by the Shipman Inquiry and changes to death certification nationally. Now every death in hospital is reviewed by a trained medical examiner who is a consultant. The medical examiner makes sure the correct cause of death is recorded on the death certificate and contacts bereaved relatives to respond to any questions or concerns. The aim of the medical examiner process is to improve the accuracy and quality of medical certification of cause of death, as well as ensuring coroners' referrals are appropriate. It also aims to provide the public with greater safeguards and reassurance, and to support bereaved families.

Based on feedback we received, this year we began developing a comprehensive guide for people experiencing a bereavement. It offers practical information to guide families through the process when a relative or close friend dies in hospital. It signposts to services like the medical examiner service that families may want to turn to for advice.

Cancer services co-locate

To maintain our excellent outcomes for cancer patients and improve their experience of care, we have brought together two of our cancer services into a new, specialist surgical unit at Hammersmith Hospital.

The oesophago-gastric cancer surgery team treats patients with cancer of the oesophagus and stomach. This year they moved from St Mary's Hospital to be located with hepatobiliary (liver, pancreatic, biliary and gall bladder disorders) surgery team. This has allowed surgeons to work together in one of the largest upper gastrointestinal units in the country.

Progressing our endovascular hybrid theatre

This year we progressed with the development of a new endovascular hybrid theatre at St Mary's Hospital, allowing patients with complex blood vessel problems to be treated with the most up-to-date procedures.

The hybrid theatre is due to open in 2020 and will allow surgery and high-quality imaging to be undertaken as a combined procedure in the same operating theatre. This means a team of vascular surgeons and interventional radiologists can work together to carry out endovascular procedures, treating problems with blood vessels without open surgery. Minimally invasive procedures, such as this, reduce physical trauma to the patient, are less painful and enable a faster physical recovery time, which reduces length of hospital stay.

Smartphone access to patient data for our clinicians

Since April 2014, our clinical staff have been able to access patient information in our electronic patient record system at any time, from any computer in our hospitals. Over the past year our staff have begun to be able to access this data securely from their mobile devices.

One of our approaches uses Streams, a mobile app developed by the British company Deep Mind and now owned and managed by Google Health. Initially the app showed blood test results and reports from scans such as x-rays. During the year, we have added vital signs such as temperature, blood pressure and oxygen saturation, together with flags for acute kidney injury, sepsis and the national early warning score.

The information can be accessed on the move, at the bedside and even at home for clinicians who are on call. Our clinicians report that Streams often allows them to make informed clinical decisions without leaving the bedside. These efficiencies mean more time for patient care.

Data security is ensured through a robust approach to mobile device management and a strict data processing agreement with the supplier Google Health. No data is stored on the mobile device and clinicians use their Trust login details to open the mobile app. In the event of loss of theft, the app can be remotely deleted from the phone.

By April 2020, around 350 clinical staff were using the app and there is a plan to increase this significantly during the coming year.

Objective 2: to expand and connect developments that enable better integration of care – focusing this year on establishing strong partnerships and involvement, new care models and systems to support collaboration

Global digital exemplar

For the last three years, we have been an NHS global digital exemplar. This means one of our main objectives is to introduce digital innovations and share our learning and guidance with other hospitals. This year, our biggest achievement has been helping neighbouring Chelsea and Westminster Hospital NHS Foundation Trust move to the same electronic patient record system as our Trust's. The two trusts are now delivering care using a single shared system. This has led to cost savings and, for clinicians, better access to information on patients who are cared for by both trusts. It has also made shared pathways and joint services easier.

Here are some of the highlights of our global digital exemplar work:

- **Going paper free:** all information about adult patients is now available electronically. In the two years since we moved away from paper, we have seen a £2.25m cumulative reduction in health records budget and a £225K annual reduction in our external printing costs.
- **Wireless recording of vital signs:** nurses on adult wards are now using monitoring devices to take routine observations, such as blood pressure, blood oxygen saturation, heart rate, respiratory rate and temperature. This data is updated wirelessly into the patient's individual record, saving time on the ward for nurses and reducing human error.
- **Monitoring mums and babies:** maternity staff can now view electronic graphical displays of heart rates and contractions for all mums and babies on our labour wards from anywhere in the Trust. They can spot signs of distress

and respond quickly, improving patient safety. All data is recorded in the electronic patient record.

- **Patient identification scanner:** to ensure safe administration of medication, we have introduced a bar code scanner linked to patients' individual records to ensure they receive the right dose of medication at the right time and in the right way. We are using the same technology for blood samples and transfusions and to ensure the right mother's milk goes to the right babies on our neonatal intensive care units.

Hammersmith and Fulham Primary Care Network test bed

In line with our strategic goal 'to help create a high-quality integrated care system with the population of north west London', we are reshaping our future working relationship with primary care colleagues and seeking to reduce growth in demand for acute services.

We have been co-designing a 'test bed' with one of our local primary care networks (PCNs) – the Hammersmith & Fulham Partnership – a 'super-practice' with a registered list of 67,000 patients.

Working together we are aiming to integrate the work of hospital, primary care and community clinicians, in partnership with patients and other local organisations. This will require a change to our contracting arrangements and to the sharing of risks and opportunities arising from new ways of working.

We are working with Imperial Health Charity and the not-for-profit organisation Social Finance as delivery partners, who contribute their expertise and additional project funding. If successful, we wish to expand the programme to other local partner PCNs.

Joining up acute and specialist care in 'inner' north west London

We have been working particularly closely with our neighbouring acute NHS trust, Chelsea and Westminster Hospital NHS Foundation Trust, to align our clinical pathways and ways of working. Between us, we provide almost all the acute and specialist care for around one million people living in central and west London.

Both our organisations want to develop more person-centred, joined up care that reduces inefficiencies. We also want to improve the opportunities and working lives of our staff.

Making the most of the opportunity of our shared electronic patient record system, we have begun by developing unified patient pathways and processes for three services: inpatient HIV services, dermatology and ophthalmology. Following engagement with stakeholders, patients and the public, we have consolidated inpatient HIV services at Chelsea and Westminster's purpose-built Ron Johnson ward, while ensuring common approaches to outpatient HIV services across both trusts. We continue to explore how care pathways in dermatology and ophthalmology can be better aligned for patients, reducing unnecessary variations.

Our two trusts have also been working in partnership with Imperial College London to progress the joint proposals we set out in November 2018 in the document 'Healthier hearts and lungs', including the development of an integrated children's service for north west London and associated academic centre for child health and a cardiovascular and a respiratory centre of excellence. These joint proposals were prompted by Royal Brompton & Harefield NHS Foundation Trust's own proposal to move all of its services to a site adjacent to St Thomas' and Evelina Children's hospitals in south London.

In January 2020, we welcomed the approach set out by NHS England for the development of cardio-respiratory services in London. It will allow us to preserve the long-established network of specialist respiratory and cardiovascular care, medical education and research in north west London that has led to significant improvements in patient care locally, nationally and internationally.

Our vision for how best to run, organise and develop care for children and young people in north west London is for the 'West London Children's Alliance' to create joint care pathways that make best use of our collective strengths and assets, organised around the needs of our patients and their families. We want to look at how we improve child health across our population and move towards 'life course' pathways rather than one-off interventions.

Pioneering software improves NHS imaging services across north west London

This year we became one of six NHS trusts in north west London to form a new network to improve imaging services, including X-ray, MRI and CT scans, for patients affected by cancer, stroke and a wide range of other conditions. The collaboration involved a £5.7 million investment in novel software that allows clinicians across the network's hospitals to share images and report on them rapidly. This development has allowed clinicians to work more collaboratively, speed up reporting and decision-making times, and reduce the need to duplicate scans. We are also expecting to see cost-savings as we have reduced the need for duplicate scans and transfer costs.

While images could already be shared between the network's hospitals, the previous system was both difficult to use and transferred only partial information. The new software integrates with our own imaging management systems, which helped to implement the solution more quickly.

Intergenerational care project holds 51 workshops in hospital

This year we have successfully connected local school children with our older patients at Charing Cross and St Mary's hospitals and a local care home. The intergenerational care project, led by Dr Elizabeth McGeorge, runs workshops in hospital to bring joy to both generations and teach children about dementia and communication.

Between January 2019 and March 2020, the Intergenerational Project held 51 in-hospital workshops involving over 90 children from five local schools and 180

patients. Activities at the workshops included music, art, drama and puppet-making sessions, as well as problem-solving games.

Patients who have attended workshops said they enjoyed spending time with the children while taking a welcome break from their beds on the wards. The children enjoyed getting to know patients in hospital while doing creative projects and playing games.

The impact of the project is currently being evaluated by the Royal Central School of Speech and Drama.

Objective 3: to reduce unwarranted variations in care pathways – focusing this year on projects supported by the Flow Coaching Academy Imperial and guided by external benchmarking on quality and efficiencies

Improving quality across the Trust

The aim of our quality improvement team is to create a culture of continuous improvement throughout our organisation, empowering staff to make improvements within their services and within individual patient pathways.

The team provides training on the improvement method as well as coaching. Over the past four years:

- 6,765 members of staff have attended beginner or awareness training on quality improvement
- 1,200 have had training to participate in improvement activity
- 237 have become improvement coaches

Currently there are 130 live quality improvement projects looking at pathway and local service changes. In 2019/20, the improvement team worked on 18 different clinical pathways with colleagues from multiple specialities to reduce 'unwarranted variation' in patient care

This year's quality improvement projects delivered impressive achievements including:

- The team organised a week of events In September 2019 to mark the World Health Organization's inaugural Patient Safety Day, as well as a patient safety conference in February 2020.

- In November 2019, the findings of a study on the impact of the sepsis digital alert system – developed as part of a quality improvement big room – were published in the Journal of American Medical Informatics Association (see page 34).

- In March 2020, the hand hygiene improvement programme was shortlisted as a finalist in the 2020 HSJ Value Awards. The project focuses on improving hand-hygiene compliance. In the wards where they have delivered a 90-day improvement cycle, compliance has increased from 38 per cent to 64 per

cent.

Imperial Flow Coaching Academy

Flow coaching is a best practice approach to improving inconsistencies in clinical pathways developed by Sheffield Teaching Hospitals and supported by the Health Foundation.

Imperial Flow Coaching Academy has taught and applied the flow-coaching methodology for three consecutive years and has trained 50 coaches. In 2019/20, 24 coaches completed the 12-month training programme. This included colleagues from Portsmouth Hospitals NHS Trust and Great Ormond Street Hospital.

The FCA trains pairs of coaches consisting of one clinical and one non-clinical coach, to facilitate a weekly 'big room ' – a collaborative, open space for staff, stakeholders and patients to develop, test and embed improvements to reduce unwarranted variations in particular clinical pathways.

The big rooms established in 2019/20 were for:

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

Reducing avoidable harm to patients

We continue to have some of the lowest mortality rates in the country and in 2019/20 one of our quality improvement priorities was reducing avoidable harm to patients. Increasing incident reporting rates among our staff was an area of focus and this year the percentage of moderate and above incidents we reported was below the national average – 1.6 per cent compared to 2 per cent,

In 2019/20 we declared 266 serious incidents, compared with 148 in 2018/19 – with the highest reported category being 'treatment delay', which refers specifically to delays for mental health patients in the emergency department. To improve patient safety in the areas where we know there is clinical risk – based on our most frequently reported serious incidents – in 2016 we established nine safety streams. This year we made progress with:

- Hand-hygiene: we have seen a significant, sustained improvement in the 12 wards where we focused our programme, with compliance rates increasing from 38 to 64 per cent.

- Reducing falls with harm: in wards piloting falls reduction interventions designed to help patients mobilise safely, we have seen a 25 per cent reduction in falls with harm.
- Safer medicines: this year we have seen a reduction in incidents involving high-risk medicines such as anti-coagulents and insulin.
- Responding to deteriorating patients: the focus of this programme is to enable clinical staff to identify patients at risk and this year we sustained a reduction in out of intensive care unit cardiac arrests across the Trust.
- Improving care for patients with mental health problems in the emergency department (ED): in 2019/20 we have focused on providing alternatives to admission for this patient group, reducing patient risks in the ED environment and improving training for the specialist staff involved in their care.
- Positive patient identification: this year we focused on reducing the number of incidents related to blood testing, and we saw a reduction in the number of wrong blood in tube incidents (WBIT) – this is where blood taken from a patient is mislabelled as coming from another patient.
- Improving fetal monitoring: this safety stream looks at reducing the number of infants delivered with poor outcomes due to a fetal heart rate being misinterpreted. This year we saw a reduction in the number of incidents resulting in harm thanks to the introduction of 'Fetalink' – a central monitoring system, alongside staff education and the 'fresh eyes' initiative where a second midwife confirms the fetal heart rate pattern.
- Endorsement of abnormal results: as part of a pilot in gynaecology, in 2019/20 we saw the time it takes to endorse results with 30 days, increase from less than 30 per cent to more than 90 per cent.
- Safer surgery: this year we rolled out a simulation and coaching programme, Helping our Teams Transform (HOTT), designed to support staff undertaking invasive procedures to carry out safety checks and to work effectively as a team.

Objective 4: To develop strategic solutions to key challenges – focusing this year on staff recruitment and retention, reducing our underlying financial deficit and estates redevelopment

Apprenticeships open new doors

Our apprenticeship programmes are designed to support existing staff by creating new career progression pathways, and to attract local people leaving education or seeking a career change.

Apprenticeship programmes offer people the chance to earn and learn in the workplace. In this financial year, 15 apprentices transitioned into substantive posts after completing our 'new entrant' apprentice programme.

Our apprenticeships offer development opportunities to our existing staff too – supporting them to build on their skills and experience. This year, 165 members of staff were enrolled on various apprenticeships.

This year, we also introduced a wider range of clinical apprenticeships. We now offer a band 7 advanced clinical practitioner apprenticeship. We welcomed our first three

midwife apprentices to the Trust in March 2020. Seven existing maternity support workers are also taking part in our band 3 maternity support worker apprenticeship.

In 2019/20 we have found affordable ways to increase the number of nursing associates and registered nurse apprenticeships. The nursing associate role is the bridge between healthcare support workers and registered nurses and delivers hands-on care for patients. This year, we had 19 trainee nursing associates – 10 of whom are now fully qualified.

New technology to improve our recruitment process

This year we have been working with a technology partner called Oleeo to improve how we recruit and on-board new staff. We are in the process of implementing an automated system called RECRUIT, which will replace our current applicant tracking system.

The new online platform will manage the whole recruitment process – from candidate applications to the on-boarding of permanent and fixed-term contract staff, as well as junior doctors, honorary and licence to attend contracts.

RECRUIT allows hiring managers to create job ads and post them across multiple free job boards and social media. The system then tracks each posting so ads can be optimised and hiring managers have a better indication of the return on investment, or the number of candidates the ad attracts.

RECRUIT also helps hiring managers to shortlist the most appropriate candidates based on the criteria they have entered. It generates automated emails to applicants to tell them whether they have been selected for interview.

For the candidate, RECRUIT is simple to use and allows you to search and apply for current vacancies. If a candidate applies for a role, they can check the status of their application and receive personalised updates throughout the selection and recruitment process. The platform will launch in 2020/21 and can be accessed via the Trust website.

Recruiting overseas

This year we partnered with King's Commercial to help us to recruit nurses internationally. We have explored this option because of a national shortage of nurses which has seen many NHS trusts extend their recruitment efforts beyond the domestic market. We are confident that our international nurse recruitment drive will reduce our vacancy rates while enriching our organisational culture.

Between November 2018 and March 2020, we have welcomed a total of 179 international nurses from the India and the Philippines. In 2019/20, 158 international nurses joined the Trust via this recruitment channel and are now working in every clinical division at the Trust.

To support our international nurses, we now offer an objective-structured clinical examinations (OSCE) training programme. This year we have had a 100 per cent pass rate. Once completed, nurses can receive their Nursing and Midwifery Council (NMC) registration within four to six weeks of joining the Trust.

We support our international nurses with relocation and sourced accommodation for them. To help them settle in, we arrange a 'buddy' for them and hold a welcome lunch on their second day with staff who have recently joined from overseas.

New career clinics and coaching programmes

In 2019/20 we developed and launched a new model of career clinic and targeted career coaching to support our staff.

At first, we ran monthly career clinics with career coaches at each of our main hospital sites. Despite positive feedback, attendance rates fluctuated. We realised that although short, individual coaching sessions had been well received, some of our staff really needed ongoing support as part of a programme.

Since August 2019, we have been running a quarterly career clinic with a newly designed career coaching programme – initially for midwives and nurses. Focussing on this group has allowed us to provide more targeted support. Working with the nurse education team, we have been able to connect with nurses and midwives at the beginning of their career. We have also incorporated career coaching into the Trust's development programme, 'Springboard', for nurses and midwives.

To launch this new career coaching programme, we recruited and trained volunteer career coaches. To date, over 60 members of our staff have volunteered to train to become career coaches, with more than 30 of these volunteers having completed the training. Nurses and midwives can now request a coach and be matched with a trained career coach who can provide ongoing support.

So far 56 members of staff have benefitted from our career clinics and coaching. We are planning to incorporate career coaching into the Trust's preceptorship programme and expand its reach to other staffing groups.

Patchwork – a one stop app for bank shifts

In January 2020, we introduced a new one-stop app called Patchwork that lets doctors see available bank shifts.

This digital system replaces paper-based processes which can be time-consuming. Instead of different parts of our organisation contacting multiple doctors and agencies, we can now advertise available shifts centrally in real time to a wider pool of doctors. For patients, the benefits are fewer appointment cancellations and delays to care.

As of April 2020, 1,990 doctors were registered on the Patchwork app. Doctors outside the Trust can also apply to be on our database too, following review by a Trust consultant in the relevant specialism.

Patchwork is a commonly used app, and many other north west London acute trusts have adopted it, as have many other trusts in London and further afield. The app has been rolled out across most of our NHS and private divisions. It is subject to a six-month and 12-month review.

Preparing for a challenging flu season

Our 2019/20 flu vaccination campaign produced the highest ever vaccine uptake among our healthcare workers, with just under 70 per cent of all staff vaccinated compared to 60 per cent in 2018/19.

This year, we made it as easy as we could for all our staff to have a flu vaccination, either in their own department or ward, at a drop-in clinic, or at meetings or local events they were already attending.

While it was very clear that we expected all our staff to have the vaccination, we understood that some of our colleagues were apprehensive and had questions about the vaccine. In response we launched a comprehensive communications campaign under the banner, 'be in*flu*ential'. It featured 52 well-known members of staff – influencers in their fields – who became our advocates for vaccination.

To dispel myths, we used clear evidence in all our communications about the safety of the vaccine and how effective it is in preventing serious illness. We created recognisable profiles of our influencers with photos and quotes that were published daily for several months across our channels and displayed in our buildings in areas where there was high footfall.

Understanding the reasons why people refuse vaccination, helped us to shape our communications campaign. We were supported by the respiratory specialists who work at the Trust who could explain first-hand the dangers of flu and how the vaccine works.

We gave our senior managers accurate information on the uptake of the vaccine in their areas and encouraged them to talk to their colleagues about flu and present the facts.

We plan to start vaccinating for the 2020/21 flu season in September 2020. Our target is to vaccinate 90 per cent of frontline healthcare workers by March 2021.

Expanded A&E opened at Charing Cross Hospital in October 2019

A £7.2 million refurbishment and expansion of Charing Cross Hospital's accident and emergency department (A&E) was completed in October 2019. We made these improvements to prevent overcrowding and long waits at times of peak demand, providing more space for patients to be assessed and treated.

We introduced:

- three additional cubicles for patients with serious illness or injuries, taking the number from 12 to 15
- three additional resuscitation bays, taking the number from five to eight
- additional space for patients to be assessed and treated including two additional urgent care rooms taking the number from seven to nine
- two new dedicated rooms for patients with mental health conditions providing them with a calm, quiet and safe space away from the busy A&E environment
- an expanded 'ambulatory emergency care' unit with additional treatment areas, consulting rooms and more staff, allowing patients with a wide range of

urgent health problems to get the treatment they need without being admitted to a ward or having an overnight stay

- a new common entrance and waiting area for all patients who walk-in, allowing a better patient experience and more joint working across the urgent care centre, ambulatory emergency care unit and emergency department.

Progress on a comprehensive redevelopment of our hospital sites

We saw the most significant progress in a decade on a much-needed strategy to redevelop our hospital sites. We have the biggest backlog maintenance liability of all NHS trusts – up to £1.3 billion – reflecting the age and poor quality of much or our estate.

In September 2019, the Government announced its 'Health Infrastructure Plan' – a rolling five-year programme of investment in healthcare infrastructure, including building new hospitals, modernising primary care buildings, and investing in diagnostics and technology. We were delighted that major developments at our three main hospital sites are included.

The Government's plan will see 40 new hospitals built across England over the next decade. Six hospitals have already been given approval to proceed with redevelopment, and another 21 new building projects, including ours, received £5million 'seed funding' to start their redevelopment schemes. This seed funding is supporting us to develop a business case and engage with our local communities, patients and stakeholders about our plans.

As quickly as possible, we want to begin the comprehensive redevelopment of St Mary's Hospital, which is our largest site in the most urgent need of repair and renovation. Located in Paddington, the St Mary's redevelopment will become part of a wider regeneration of the local area. Substantial new developments and a refurbishment of Charing Cross and Hammersmith/Queen Charlotte's & Chelsea hospitals will follow, and we plan for the Western Eye Hospital to be incorporated into one of these three developments.

The timetable we are working to sees the planning and business case approvals for St Mary's being completed by early 2022 and a new hospital built and fitted out by 2027. Significant improvements at Charing Cross and Hammersmith are currently slated to begin in 2022.

Making a major impact with minor improvements

In 2019/20 we launched a £2 million 'impact maintenance' fund to improve areas of our estate that cause the biggest issues for patient experience. Just under 500 proposals were submitted by our staff for small-scale, repairs and improvements, which cost no more than £5,000.

The funding focused on addressing issues that can be annoying for staff and patients, like repairing automatic doors in busy areas. So far over 200 improvements have been carried out across all five of our hospitals, including repainting, improving lighting, replacing worn flooring and upgrading patient and visitor toilets.

New surgical robot at Charing Cross Hospital

In 2019/20, patients with urological and throat cancers benefitted from the installation of a da Vinci X surgical robot at Charing Cross Hospital.

The latest generation robot will enable more patients to benefit from keyhole surgery.

The da Vinci system improves upon conventional keyhole surgery in which the surgeon is stood at the patient's side and uses hand-held instruments. Sitting at a master control console, the surgeon controls the system's robotic arms, equipped with jointed 'wrists' which exceed the range of motion of the human hand, while also reducing tremor.

This enhanced dexterity, along with the 3D high definition visualisation permitted by the da Vinci's cameras, makes it possible for surgeons to perform more minimally invasive procedures, leading to speedier recovery and an earlier discharge from hospital for many patients.

For prostate patients, the arrival of the surgical robot is the latest development in a range of innovations to offer a world-leading care pathway, including reducing cancer diagnosis times through the RAPID pathway, and a full spectrum of treatments for benign prostate enlargement including holmium laser enucleation, UroLift, prostate artery embolisation and the revolutionary Rezum steam treatment that was pioneered at the Trust on behalf of the NHS.

The da Vinci system is also set to improve outcomes for patients undergoing treatment for throat cancer. The robot's greater precision allows throat surgery to be approached through the mouth, speeding up recovery and avoiding disfiguring scars.

Cutting edge radiotherapy equipment installed at Charing Cross Hospital

Cancer patients are benefitting from the next generation of radiotherapy treatment as a result of two new state-of-the-art linear accelerator machines (LINACS) installed at Charing Cross Hospital this year.

The new machines use high energy X-ray beams to target and destroy cancer cells and are the most advanced of their kind. They include a high precision radiation delivery system, highly accurate imaging and a robotic patient couch which allows patients to be precisely positioned during treatment. This means that treatment can be adapted to the exact size, shape and position of the tumour, helping to deliver increasing levels of precision to target tumours.

The radiotherapy team at Charing Cross see up to 150 patients a day, sometimes more. By using the latest evolution of LINAC technology, we will be able to continue delivering excellent outcomes for patients and help people with smaller tumours that might have previously been treated elsewhere.

Specialty review programme

Our new transformation team took on leadership of our specialty review programme, helping clinical teams to develop and realise their strategic plans. Key progress in 2019/20 included helping the renal service to modernise their post-transplant pathway and initiate a larger dialysis at home service as well as supporting our work with Chelsea and Westminster NHS Foundation Trust to align our clinical pathways.

Objective 5: to strengthen the connections between our service developments and our research – focusing this year on data and digital initiatives and expanding staff involvement

Imperial College Academic Health Science Centre expands and is redesignated another five years

Our Imperial College AHSC (see page 72) was redesignated as a centre of excellence for health, research, education and patient care by the National Institute of Health Research and NHS England/Improvement in April 2020. As a university-NHS partnership, the AHSC aims to accelerate the translation of scientific breakthroughs into human health. Our strategy is to use the partnership's critical mass of clinicians and scientists to reduce the impacts of ill-health; preventing disease wherever possible, detecting disease earlier and developing better treatments.

Over the next five years, we plan to focus on six disease areas:

- Brain disease
- Cancer
- Cardiovascular disease
- Infection and antimicrobial resistance
- Metabolic disease
- Respiratory disease

The AHSC will take a multidisciplinary approach, bringing together Imperial College London's engineers, physical scientists and life scientists with biomedical scientists and NHS clinicians to generate new disease biomarkers, diagnostic tools, medical devices, imaging methods, artificial intelligence and digital healthcare tools. We will also trial new treatments including vaccines, gene and cell therapies.

Another ambition for the next five years is to enhance research and training opportunities for all staff across the AHSC, including enabling more nurses and allied health professionals to reach PhD level and beyond.

In 2019/20 the Institute of Cancer Research (ICR), London, joined the AHSC. The ICR was already working in close partnership with the AHSC to help create breakthrough cancer treatments, improve diagnosis, and find new ways to prevent the disease.

Imperial Health Knowledge Bank

This year we launched the Imperial Health Knowledge Bank, which is a database of patients interested in taking part in research studies, and who allow us to store small biological samples belonging to them for teaching and research purposes.

The aim of the knowledge bank is to get patients, researchers and clinicians working together to increase our understanding of health conditions. The more patients who join the database, the greater the volume of data and insight we will have, and this could help us detect diseases earlier and develop new tests and treatments sooner.

For several years we have been running a smaller version of the database and this year we have expanded it so more patients can join. Patients who join consent to us taking two extra blood samples at their next routine appointment. When a research study or clinical trial comes up relevant to their condition, we ask to share their contact details with the lead researcher.

Genomics

As lead partner for the West London Genomic Medicine Centre, we have gathered DNA samples from more than 3,000 patients with cancer or inherited rare diseases as part of the national 100,000 genomes project.

We have spent the past five years building genomic medicine into our everyday clinical practice. As of March 2020, the Trust offers 10 specialist clinics for patients with organ-specific genetic disorders, including genetic diabetes and genetic retinal disorders. GPs can refer patients to all of these clinics via NHS e-Referrals.

As part of a national NHS initiative, we now offer whole genome sequencing for a limited number of tumour types, including all tumours found in children, most sarcomas and acute leukaemia. From April 2020, whole genome sequencing will start to be commissioned as a diagnostic test in selected clinical areas at the Trust. We hope to make whole genome sequencing available as a routine clinical test by mid-2020.

New centre to fight drug-resistant bugs through improving use of antibiotics

This year we launched the £4 million Imperial Centre for Antimicrobial Optimisation (CAMO) to tackle overuse and inappropriate use of antimicrobials which is fuelling antimicrobial resistance (AMR) – leading to an increase in infections which are drug-resistant. AMR is a huge global health concern, as growing numbers of infections – such as tuberculosis, sepsis or those that cause infections in healthcare settings – are becoming harder to treat.

The CAMO aims to address these issues through research to optimise our use of antimicrobial drugs and preserve antibiotics. The centre is a partnership between the Trust and Imperial College London and one of the areas it will tackle is antimicrobial prescribing. Antimicrobial prescribing is typically based on a 'one dose fits all' model – where all patients receive the same recommended dose of an antibiotic for an infection. However, this approach does not account for wide variations in how patients process the drugs, or the nature of their infection – meaning treatment is

often not as effective as it could be, which has an impact on clinical outcomes and AMR.

To reduce the causes of AMR, the Department of Health and Social Care is providing funding to several UK organisations, including £4m to the CAMO.

Digital sepsis monitoring system helps save lives and improves care

This year a study led by researchers at Imperial College London, evaluating a digital sepsis alert system developed at our Trust, was published in the Journal of American Medical Informatics Association. The study showed use of the system was associated with lower chances of death, shorter hospital stays and an increased likelihood of receiving timely antibiotics.

We introduced the digital sepsis alert system to our hospitals in 2016 to monitor patients with sepsis – a blood poisoning which is life-threatening and accounts for an estimated 46,000 death a year in the UK. If diagnosed early, sepsis can be treated effectively with antibiotics but, before it develops, it can be difficult to spot because the symptoms are like those of flu.

The digital sepsis alert monitors a range of changes in patients such as temperature, heart rate and glucose levels, and alerts doctors and nurses if they fall outside safe parameters. When a patient triggers the alert, clinicians are notified through a pop-up warning on their electronic health records and/or dashboard.

As well as the alert, we also designed a multi-disciplinary care plan. Once a clinician confirms a diagnosis of sepsis, the electronic patient record system launches the care plan. This prompts the clinical team to determine the best treatment options and ensure they are given to the patient within one hour.

Researchers at Imperial College London analysed data from 21,000 hospital stays between October 2016 and May 2018 where patients had triggered the alert system. These patients were in emergency departments as well as acute and haematology wards at St Mary's, Charing Cross and Hammersmith hospitals. The team found that patients who triggered the alert had 24 per cent lower odds of in hospital death as well as a 35 per cent increased chance of receiving timely antibiotics than a group of patients who were receiving the usual standard care, where the digital alert system is not involved. They also found that patients who were admitted to hospital had a four per cent lower chance of staying in hospital for more than seven days than patients with similar symptoms where the digital alert system was not used and than the group of patients who were receiving standard care.

The research team also suggests the alert system has been able to alert clinicians to deteriorating conditions in patients and consequently investigations and treatment plans have been implemented more quickly.

Researchers are now carrying out a larger study with more NHS hospitals to see whether the results are the same in a bigger patient group.

A trial will look at new Parkinson's treatment for frequent falls

In 2019/20 researchers at Imperial College London and the Trust were awarded £1 million funding from the Medical Research Council (MRC) and JP Moulton Charitable Foundation, to trial a new treatment for frequent falls in patients with advanced Parkinson's.

In Parkinson's disease, some parts of the brain begin to deteriorate, leading to symptoms including balance problems, which can increase the chances of falls. Current treatments such as dopamine drugs and an invasive surgical procedure called deep brain stimulation, are effective in improving tremor and slow movement in the limbs. However, they are generally ineffective in reducing falls.

The £1 million award is to trial a surgical implant that alters nerve activity and could improve movement and reduce the number of falls. The spinal cord stimulation device works by sending a low-voltage electrical current to different areas of the spinal cord and it is already used to treat people with chronic back and nerve pain. Previous studies in mice have shown that it could be used to treat Parkinson's patients.

Five patients with advanced Parkinson's will take part in the trial at Charing Cross Hospital. During the study, patients will either receive spinal cord stimulation or placebo. They will be monitored for a year following the treatment to see if there is an improvement in their balance and a reduction in the number of falls they have. The researchers will also carry out tests to measure brain wave activities following surgery to see if spinal cord stimulation changes brain function.

If successful, the team hope that this treatment could be used to treat patients with advanced Parkinson's. They also hope the trial will help them to select the patients most likely to benefit from the treatment.

New hormone injection aids weight loss in obese patients

In 2019/20, findings from a small study showed that an injection helped reduce body weight and glucose levels in patients with diabetes and obesity in four weeks.

Patients in the study lost on average 4.4kg and the treatment led to substantial improvements to their blood glucose, with some patients' reducing to near-normal levels.

One of the most common types of weight loss surgery is a procedure known as gastric bypass surgery, which can be very effective in keeping excess weight off and improving blood sugar levels in diabetics. However, some patients decide against surgery and the procedure can cause complications such as abdominal pain, chronic nausea, vomiting and debilitating low blood sugar levels.

Previous research by Imperial College London suggested that one of the reasons why gastric bypass surgery works so well is because three specific hormones originating from the bowels are released in higher levels. This hormone combination, called 'GOP' for short, reduces appetite, causes weight loss and improves the body's ability to use the sugar absorbed from eating.

Researchers wanted to see if infusing patients with the GOP hormones glucagon-like peptide-1 (GLP-1), oxyntomodulin and peptide YY, to mimic the high levels seen after surgery, could aid weight loss and reduce high glucose levels. Fifteen patients were given the GOP treatment for four weeks using a pump that slowly injects the

GOP mixture under the skin for 12 hours a day, beginning one hour before breakfast and disconnecting after their last meal of the day. Patients also received dietetic advice on healthy eating and weight loss from a dietician.

Patients on the GOP treatment lost an average of 4.4kg, compared with 2.5kg for participants receiving a saline placebo. The treatment also had no side effects.

However, patients who received bariatric surgery or who followed a very low-calorie diet lost significantly more weight than GOP patients. The changes in weight were 10.3kg for bariatric patient and 8.3kg for patients who followed a very low-calorie diet.

The team also found that GOP was capable of lowering blood glucose levels to near-normal levels, with little variation in the blood glucose. Patients who received bariatric surgery also had an overall improvement in blood glucose, but the levels were much more variable, leaving them vulnerable to low blood glucose levels.

The team plan to carry out a larger clinical trial to assess the impact of GOP on more patients over a longer period.

MRI tool can diagnose difficult cases of ovarian cancer

Researchers at Imperial College London have developed an MRI tool that can identify cases of ovarian cancer which are difficult to diagnose using standard methods.

Ovarian cancer is the sixth most common cancer in women and usually affects women after the menopause or those with a family history of the disease. There are 6,000 new cases of ovarian cancer a year in the UK, but the long-term survival rate is just 35-40 per cent as the disease is often diagnosed at a late stage once symptoms such as bloating are noticeable. Early detection of the disease could improve survival rates.

In a clinical study, the MRI tool produced encouraging results and its impact on management and outcomes of women with ovarian cancer will now be evaluated in a major trial at 18 hospitals in the UK, including ours.

The MRI tool can distinguish between malignant and benign ovarian cysts with 90 per cent accuracy. It was developed by researchers led by Professor Isabelle Thomassin-Naggara at the APHP-Sorbonne Université, with Professor Andrea Rockall at Imperial College London.

Currently, to investigate potential cases of ovarian cancer doctors use ultrasound scanning and blood tests. However, in a quarter of cases these methods cannot identify with confidence whether a patient's cyst is benign or malignant. This leads to surgical investigations, which are invasive and carry risks, such as loss of fertility. In most cases women are then diagnosed as having benign cysts.

The team believes the new tool can be used as a triage test to decide whether patients need further follow up or treatment. They also believe that the findings from the study help stratify patients who are high risk so they can be given treatment at a much earlier stage.

A small rise in heart attack protein is linked to increased risk of early death

This year in a large new study, published in the British Medical Journal, researchers from the National Institute of Health Research Health Informatics Collaborative (NIHR-HIC) led by the Trust and Imperial College London, found that a raised troponin level was associated with an increase in risk of death in all age groups. This was seen even if the troponin result was slightly raised, with the increased risk of death occurring very early.

Troponins are a group of proteins that help regulate the contractions of the heart and skeletal muscle. The heart releases troponin into the bloodstream following an injury to the heart like a heart attack. High levels of troponin usually mean there is a problem with the heart. However, it has been unclear how to manage patients who have small troponin rises, particularly if they do not have other symptoms associated with heart disease or a heart attack.

The study showed that even a small increase in troponin is linked to an increased risk of death. It also showed that that regardless of age, the higher the amount of troponin in the blood, the higher the risk of death in patients with a heart attack. The results suggest that even a small rise in troponin in all age groups is clinically significant and can indicate underlying health problems.

The research team also found that, contrary to what they expected, very high levels of troponin in the blood in patients with a heart attack was associated with a lower risk of dying. They suggest that a possible reason is that patients with very high troponin levels are more likely to have a type of heart attack which can be treated by an operation to improve blood flow to the heart and therefore reduce the risk of dying.

During the study, the research team analysed the anonymised cardiovascular data of more than 250,000 patients who had troponin tests from 2010 to 2017. The data came from National Institute for Health Research Health Informatics Collaborative sites, including: our Trust, University College London Hospitals NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. The research team grouped the patients by age and compared their troponin results with their outcomes over a period of three years.

Research into leading cause of stillbirth awarded £2.4 million funding

Trust researchers have been awarded over £2.4 million this year to investigate the best technique to manage poor growth in babies during the later stages of pregnancy

Fetal growth restriction (FGR) can lead to stillbirth, accounting for half of the cases of stillbirth in the UK. The new international study, funded by the National Institute for Health Research (NIHR), will investigate the best time to deliver babies who are diagnosed with FGR in late preterm pregnancy.

FGR is caused mainly by problems with blood flow through the placenta, which supplies oxygen and blood to the baby, causing the fetus' growth to slow or stop and

leading to health complications. Fetuses with FGR often have to be delivered prematurely.

Currently there is no consensus for the optimal timing of delivering such babies in late preterm pregnancy (32-36 weeks) and babies are delivered at different times. Doctors make their decisions based on considering and balancing the risks of keeping the baby in the womb versus the risks of preterm delivery.

The TRUFFLE 2 study (The Trial of Randomised Umbilical and Fetal Flow in Europe 2) aims to clarify the decision process and move towards harmonising practice across Europe. The team will recruit over 1500 pregnant women from 11 UK hospitals, including ours, and 42 hospitals across Europe.

Staff who stepped into research celebrate 10 years of pioneering scheme

This year we marked the 10th anniversary of an innovative programme to encourage hospital staff to get involved in research.

The Research fellowships programme was set up in 2009 and gives all our healthcare professionals the opportunity to take a year out of clinical practice and focus on a research project supervised by academics at Imperial College London. Recipients also have the opportunity to develop their research skills and experience so that they can apply for a Master's or PhD and progress in their clinical academic career.

Some staff from the Trust have gone on to become clinical academics lecturing at Imperial College London and projects carried out by research fellows have had an impact on clinical care at the Trust. The fellowships are worth up to £65,000 and are jointly funded by Imperial Health Charity and NIHR Imperial Biomedical Research Centre. Since the launch of the programme, more than £3 million pounds have been given to over 50 Trust staff by the Imperial Health Charity and the NIHR Imperial Biomedical Research Centre to fund research fellowships at Imperial.

Focused ultrasound for essential tremor

In 2019/20 we used high-intensity, focused ultrasound waves for the first time to treat a patient with debilitating essential tremor (ET) on both sides of his body, avoiding traditional invasive brain surgery.

Around one million people in the UK are affected by ET, a brain disorder characterised by uncontrollable shaking. Tremor is thought to be caused by abnormal electrical circuits in the brain, which transmit tremors through the nervous system to the muscles.

Approximately, 100,000 people also have tremors caused by other movement disorders such as Parkinson's disease or multiple sclerosis. Currently, patients with ET or other types of tremor are offered anti-tremor medication. If the medication is ineffective or causes adverse side effects, some patients are offered deep brain stimulation (DBS), though this brings a risk of brain haemorrhage or even death.

The new treatment, known as 'MRI-guided focused ultrasound for brain' works by accurately applying heat energy from ultrasound waves to very specific parts of the brain to break the abnormal circuit causing the tremor. The procedure is performed under local anaesthetic with no need for invasive brain surgery. Trials in America and Japan have shown that it reduces the severity of tremor by at least 80 per cent. The treatment works immediately, and the results are expected to be long-lasting.

New equipment set to cut eye treatment time in half

Clinicians at the Western Eye Hospital will be able to treat patients for an eye disease called keratoconus in less than half an hour, thanks to a new piece of equipment introduced this year.

Keratoconus is a non-inflammatory eye condition. It occurs when the normally round dome-shaped clear window of the eye, the cornea, thins causing a cone-like bulge to develop. This eventually impairs the ability of the eye to focus properly and can lead to poor vison.

New 'crosslinking' equipment uses beams of ultraviolet light and drops of vitamin B2 to strengthen the cornea and stop the disease getting worse. With access to more powerful ultraviolet equipment, clinicians will be able to speed up the treatment, reducing the length of the procedure from around 45 minutes to under 20.

Holograms transform training for Trust radiologists

A medical simulation using interactive 'holograms' is allowing our radiology trainees to learn clinical skills using mixed reality.

Computed tomography (CT) guided interventions, which use CT images to help radiologists perform clinical procedures, are taught across the world, mostly using a traditional mentored approach on real patients. As the number of procedures grows and complexity increases there is a need for new approaches to teach and train medical practitioners.

The pioneering training session, launched this year, involved junior trainees from multiple centres in London. During the course, trainees practised image-guided needle biopsy through mixed reality simulations – a combination of 'real' and 'virtual' elements.

The simulation was developed by a team of experts from Imperial College London and is a pioneering example of using the Microsoft HoloLens2 for medical training.

Objective 6: to achieve a measurable improvement in our organisational culture – focusing this year on improvements in leadership, fairness and collaboration

Patient and public involvement

We want to be the most user-focused organisation in the NHS which means involving patients in every decision about their care as well as ensuring patients and local people have a voice in every aspect of our work from the start.

Here are two examples from 2019/20 of front-line staff co-producing improvements with patients, carers and lay partners:

- The carpal tunnel hand therapy team worked with patients and lay partners to plan a new clinic. They joined the physical 'walk through' of the new clinic design alongside managers, therapists, surgeons and radiographers and were able to make insightful improvements to patient information.

- Our inpatient neuro rehabilitation team developed a patient-centred approach in response to feedback and now have a weekly coffee morning, called 'Café Hab' at a local coffee shop to give inpatients real life experience of handling money, ordering food and traveling by public transport again supported by their therapists. Patients fed back that it was enjoyable and helped them to connect with fellow patients. The initiators of Café Hab were awarded the first Michael Morton patient and public involvement award in July 2019 at our staff awards.

Lay partner expansion

Our strategic lay forum, established in 2015, oversees the Trust's patient and public involvement strategy.

For the fourth year running, the forum has taken part in an annual planning away day with our executive directors to set involvement priorities and input into Trust business planning. Input that came from this year's session in January 2020, include prioritising:

- the Trust's values and behaviour work
- digital developments that to improve appointment bookings and wider patient administration
- patient experience and preventative care projects that support patients before and after their time with us.

Throughout 2019/20, the forum contributed significantly to the development of our refreshed organisational strategy, a number of service changes, estates redevelopment and integrated care.

We have developed our lay partner community this year too, by having regular networking meetings and four breakfast events.

In the coming year we plan to:

- measure lay partner impact, developing a new framework to understand the contribution
- increase diversity among our lay partners
- Increase learning from patient complaints and feedback.

Ensuring our hotel services staff are a full part of our team

All porters, cleaners and catering staff at Imperial College Healthcare NHS Trust moved to NHS basic pay rates, sick leave and access to the NHS pension scheme on 1 April 2020 following a review of options for the future management of 'hotel services' across our five hospitals. During the year, it had become clear that pay and other conditions were not fair. The move is intended to help ensure our hotel services staff can play their full role within our care teams and enable us to improve service quality collaboratively.

The Trust's decision in the autumn to explore changes to terms and conditions meant we had to halt the process we had begun to retender our contract for hotel services with external providers. As the external contract – with Sodexo – was due to expire at the end of March, we also decided to manage these services directly ourselves from 1 April 2020.

As part of our review of options – and drawing on the experiences of other NHS trusts and discussions with our staff and trade union partners – we concluded there was a case for making the direct management of hotel services a permanent move. However, the costs, benefits and risks were not sufficiently understood. Running the services in-house will enable us to make that judgement in full knowledge of the implications and opportunities. Therefore, we will undertake an evaluation after one year in order to decide whether to continue to employ hotel services staff directly – and bring all staff up to full NHS (Agenda for Change) terms and conditions – or re-tender the contract with a significantly amended specification.

Improving equality, diversity and inclusion

Our workforce is very diverse and we recognise that we have much to do to ensure that this diversity is reflected fairly in all aspects of our organisation. Importantly, we also need all our staff to feel included and fairly treated. We've made progress this year in establishing and resourcing a multi-year programme to achieve measurable improvements. We have strengthened and widened the programme governance and created a new dedicated role to co-ordinate actions across our teams. We have also supported the successful development of staff-led networks, ensuring each has at least one executive sponsor and access to communications expertise to help raise awareness and engagement.

On race equality, we:

- Established a reverse mentoring programme for our senior leadership team in July 2019 –supported by expert training and support, the programme pairs each of our 15 executive directors with a volunteer nurse or midwife from a black, Asian and minority ethnic (BAME) background to help raise awareness and understanding of culture, diversity and lived experience.

- Introduced diverse recruitment approaches – beginning with a new targeted training session, webinar and resources in December 2019 for panel members and hiring managers; our new applicant tracking system (see page 27) will make it easier for us to track and monitor the make-up of interview panels.

- Ran two pilot training sessions on unconscious bias – focusing on ward managers, the training builds understanding of how unconscious bias can impact on formal and informal people practices within teams; we have selected a supplier to deliver the training for us and will roll it out in 2020/21.

- Established a fortnightly WRES (workforce race equality standard) steering group including our four WRES experts – staff volunteers who have undertaken specific training as part of a national NHS programme to help lead the way in improving race equality.

- Made changes to our disciplinary procedures and policy to provide greater oversight in order to ensure decision-making is non-biased; at hearings that may lead to dismissals, we make sure panels are diverse and that more than one manager is involved in the decision-making and we have created a central investigations team to support managers with extensive and complex investigations to add extra rigour and reduce delays.

We now have an active and expanding BAME nurses and midwives network and a Trust-wide BAME network.

Looking ahead to 2020/21, we are undertaking a formal review of our new disciplinary processes with external funding and will roll out specialist race equality training for our employee relations team. We have also successfully applied to become part of the NHS Employers *Diversity and Inclusion Partners* programme which include developing one of our executives to become an equality, diversity and inclusion ambassador for our region and linking in with partner organisations to improve how we measure impact across the health and social care system.

On gender equality, we:

- Introduced standardised recruitment packs to make our flexible working offer clearer.
- Worked with our women's network to co-produce a national toolkit to support colleagues going on, or returning from, parental leave and developed best practice resources for managers on supporting staff who are parents, helping to ensure parents have equality of opportunity in their careers.

- Ran a communications campaign to highlight women in senior level roles who have caring responsibilities, work part-time or are part of a job share to help raise the profile of flexible working opportunities.

Our staff-led women's network is focusing on helping to improve career opportunities for women by supporting the promotion and development of leadership skills.

We are at an earlier stage in our action plan for disability equality and have focused on data gathering and analysis, as well as launching mental health first aid training for managers to help them support their staff.

Our 'I Can', staff-led network for people with disabilities, was established this year and is focusing on raising awareness of disability issues, the government's access to work scheme and the importance of disability data reporting.

Our staff-led LGBTQ+ network is working to connect LGBTQ+ staff, reduce health inequalities and improve experience for LGBTQ+ patients and staff. In June 2019, the LGBTQ+ network brought the NHS Rainbow Badge scheme to our Trust, making rainbow NHS badges available to all staff who wished to show their support to LGBTQ+ staff and patients.

Improving our organisational culture

This year, we have continued to transform the culture of our organisation and embed our four organisational values – kind, collaborative, aspirational and expert – to achieve our vision of 'better health, for life'.

This year we launched:

- one-hour *Living our values* workshop – a bespoke session for staff to reflect on the values and behaviours they live every day and those they need to work on
- values ambassador role training – a role designed to support the roll out of the values programme by developing the skills to deliver the *living our values* workshops
- active bystander training – a programme to empower staff to challenge behaviours
- revised performance development review forms with 50/50 ratings on objectives and values
- an asking and receiving feedback training pilot
- an unconscious bias training pilot – designed to highlight and adjust automatic patterns of thinking and eliminate discriminatory behaviours.

By 31 March 2020, over 100 values ambassadors, from across the organisation, had completed their training. Over 1,380 staff participated in the *Living our values* workshop and over 740 staff took part in the active bystander training. The pilot training programmes – unconscious bias and asking and receiving feedback – were also well attended with almost 120 staff members involved.

This year, our national staff survey also captured staff feedback on values and behaviours:

- 98 per cent of respondents are aware of the values and behaviours

- 76 per cent of respondents reported that values were discussed as part of the appraisal process.
- 64 per cent of staff who took part believe colleagues demonstrate the values at work, with a further 31 per cent stating "sometimes"
- 63 per cent of respondents believe that managers demonstrate the values at work, with a further 29 per cent of staff stating "sometimes"
- 39 per cent of staff who took part believe that poor behaviour is addressed effectively in the organisation.

In 2019 we achieved our highest ever staff engagement score with 52 per cent of staff participating in the national staff survey. This is over 2000 more responses than any survey we have run previously. Our overall engagement score increased from 7.0 to 7.2 which is above average and was the most improved engagement score in London.
This score incorporates staff recommendations, including:

- 67.4 per cent of staff said they would recommend the Trust as a place to work, up 6.5 per cent on last year and 4.9 per cent above the average
- 75.8 per cent of staff said they would be happy for their family or friends to receive our care, up 4 per cent on last year and 5.3 per cent higher than the average.

We received improved scores across all areas surveyed, with our results now above the national average in six out of eleven categories: immediate managers; quality of appraisals; quality of care; safety culture; staff engagement; team working. However, our scores remain below the national average for: equality, diversity and inclusion; health and well-being; morale; safe environment – bullying and harassment.

These staff survey results provide a baseline measurement for the programme over the next year. In 2020/2021 we will continue to build on the programme of action, including:

- rolling out our vision, values and behaviours programme, including our values workshops and active bystander training
- embedding networks for BAME, LGBTQ+, women and disability staff, supported by a dedicated equality, diversity and inclusion lead and executive director sponsors
- further changes to our staff disciplinary processes to make them simpler, fairer and more supportive
- improving staff health and wellbeing through workplace refurbishments, tailored training for line managers and expanded occupational health services
- investing further in security across our sites.

Freedom to speak up guardians encourage staff to raise concerns

The freedom to speak up (FTSU) programme promotes and encourages NHS workers, sub-contractors and volunteers to raise concerns about patient safety and to help make our organisation a better place to work. We are committed to an open and transparent culture, where staff members and volunteers feel empowered to raise concerns with confidence and know that they'll be acted on.

As of March 2020, we have four volunteer FTSU guardians in the Trust, with one vacancy. These members of staff are from a broad range of backgrounds and there is one guardian for each hospital. The FTSU role is a formal part of their job, with four hours protected time each week. One of the FTSU guardians has half of their time protected so that they can focus on the strategic direction of the function, freeing up the others to work on casework and awareness-raising.

The guardians and the FTSU agenda are supported by executive sponsorship from a non-executive director and the director of corporate governance and Trust secretary.

FTSU is introduced at Trust induction and is included in the 'active bystander' training package introduced in 2019/20. A FTSU strategy was agreed by the Trust board in January 2020. One aim is to deliver a more joined up way of working across the Trust.

The Trust's raising concerns policy details the different ways in which staff can speak up, including through their immediate management team (most concerns are resolved this way), people and organisational development, and FTSU guardians. The policy is being reviewed in 2020/21 to ensure it accurately represents the Trust's offer. In cases raised through FTSU, guardians will continue to liaise to ensure the response is satisfactory to the person speaking up.

Appraisals and performance development review

In 2019/20, 93.54 per cent of staff completed a performance development review (PDR), an improvement on the 2018/19 performance of 89.6 per cent.

In 2019/20, we ran 20 half-day training sessions for managers who are new to performance development reviews, and a full-day training session to enable productive conversations about improving performance. We also introduced a workshop on asking for, giving and receiving feedback, and produced new PDR templates and intranet information to support staff.

In the 2019 NHS staff survey, we scored above average on the staff survey theme 'quality of appraisals' with a score of 5.9 against an acute trust average of 5.6. This is an improvement on our 2018/19 score of 5.8.

We've seen an improvement in consultant appraisals and job planning in 2019/20. As of October 2019, 95 per cent of doctors had completed annual appraisals and we have maintained over 95 per cent compliance since then. Our aim is to ensure at least 95 per cent of consultants have an approved job plan in place and as of July 2019, the end of the 2019 job-planning round, 91 per cent did.

Core skills compliance increases

In 2019/20 we were proud to surpass 90 per cent of staff being compliant with core skills training. These are the skills that every employee needs to have and maintain to work at the Trust.

We have implemented a new, user-friendly learning management system called LEARN this year, which has helped to boost compliance. The core skills committee,

made up of senior clinicians and representatives from organisational development, makes sure it is clear which training modules members of staff need to complete

In 2020/21 we're aiming to improve the core skills compliance of junior doctors and doctors on honorary contract. We will focus on targeting staff groups whose compliance is below 90 per cent and work with new hotel services staff who have been on-boarded this year to make sure they have completed core skills training too.

Engaging with our junior doctor community

The Trust welcomed 1,000 junior doctors this year. It can be challenging for junior doctors to make their voice heard and we have worked hard to improve engagement to help ensure the best experience from the start.

The annual General Medical Council (GMC) national training survey measures the training experience for doctors in England, using red flags to identify negative outliers and green flags to mark positive outliers. The Trust-wide results of the 2019 GMC survey showed an improvement on the 2018 performance, with 48 green flags and 32 red flags – five fewer red flags and 21 additional green flags compared to the previous year – indicating an improvement in the overall experience we offer junior doctors while flagging areas we need to improve.

This year, we created a dedicated intranet area for junior doctors, including an induction section, so new starters can access training materials easily before they start work with us. As our intranet is mobile-optimised and accessible by an app on your phone, junior doctors can access vital information and contact details on the go.

In line with the 2018 contract changes for junior doctors, we've reviewed 140 rotas across the Trust to ensure doctors are not rostered for more than one weekend in three. Of the rotas reviewed, 133 have been aligned to the new terms and conditions.

The Trust has improved accommodation for junior doctors working long shifts or overnight shifts, as well as making the booking process and eligibility criteria clearer. We have developed a junior doctors' forum, the doctors' mess committee, a development programme for senior specialty trainees and an in-house leadership programme for junior doctors called Emerge.

Make a Difference

On 11 July 2019 the annual Make a Difference staff awards were held to celebrate the outstanding achievements of our staff and volunteers. We presented awards in six categories – Individual of the year, Team of the Year, Unsung Hero, Michael Morton patient and public involvement award, Chair's Award and the Charity's volunteering award. There were 300 staff and volunteers in attendance and Channel 4's health and social care correspondent Victoria Macdonald hosted the evening. Imperial Health Charity generously funded the awards alongside corporate sponsors.

At the ceremony a new patient and public involvement award was launched, to recognise improvements or developments that best demonstrated impact from working in genuine partnership with patients or local people. The award is named in honour of Michael Morton, the founding chair of our strategic lay forum who passed away in November 2018.

Over 110 nominations have been received for this year's in-year awards and over 725 instant recognition awards have been presented to staff, following nominations from both patients and colleagues. The Charity has also received 10 nominations for their volunteering award.

A connected, digitally enabled, workforce

Building on the successful introduction of a new Trust intranet last year, this year we launched a digital workplace programme to look at the opportunities and benefits that having a connected, integrated digital workplace could bring.

Working with NHS Digital and Microsoft, our programme has focused on areas where technology can break down physical barriers, improve productivity, and support integrated care pathways across the Trust and with partner organisations.

In November 2019, we started a pilot bringing together clinical and non-clinical teams to understand the challenges associated with introducing new, digital ways of working, and to plan for the technical roll-out, system and data governance.

In February 2020, due to the COVID-19 pandemic, we had to speed up our plan. Firstly, we enabled the Microsoft Teams chat, audio and video calls, and virtual meetings for all staff to reduce the need for cross-site travel and face-to-face meetings. By April 2020, 5,000 virtual meetings had taken place.

In 2020/21 the digital workplace programme will look at how information, learning and collaboration platforms can be further connected to offer a seamless experience for our staff and partners.

COVID-19: its early impact and our response

In the final month of 2019/20, everything changed in response to the COVID-19 pandemic. Very quickly, we had to more than double our intensive care capacity, redeploy hundreds of staff into new roles, and learn as much as we could about how to treat a new disease that continues to cause huge suffering around the world. At the same time, we did all we could to continue to care for all our patients, including transferring planned surgery and treatment to other NHS providers and private hospitals less impacted by COVID-19. We also transformed our outpatient appointments into primarily telephone and video consultations.

The scale of the effort can be seen in some of the operational data – between up to 14 May 2020:

- we cared for over 1,300 patients with coronavirus
- around 500 of our patients required ventilation in our intensive care units
- we helped over 700 people recover and be discharged home or to local care
- we reported just over 400 deaths of patients with coronavirus through central reporting to NHS England.

We were able to achieve so much, so quickly, thanks to the huge commitment and expertise of all of our staff, much closer working with our partners across our integrated care system, and the support and goodwill of many individuals and

businesses, boosted by the efforts of our closest partners, Imperial Health Charity and Imperial College.

There have been a whole raft of detailed changes and developments, some very positive while others have been more difficult to manage, including:

- establishing a daily clinical reference group led by the medical director to make decisions about changes to pathways and to establish new clinical protocols
- making temporary service changes, such as closing our specialist A&E at The Western Eye Hospital overnight to enable staff to be redeployed to support our intensive care expansion
- introducing a Trust-wide approach to the procurement and use of personal protective equipment (PPE) to ensure everyone's safety
- developing a patient and staff testing approach, drawing especially on the skills and expertise of North West London Pathology
- setting up a dedicated HR guidance line, alongside a staff welfare and wellbeing programme
- restricted visiting to our hospitals and introducing social-distancing measures
- putting in place new staff, patient and public communications, including a daily all-staff email and the roll out of Microsoft teams, allowing staff to work, engage and collaborate online

We have already begun a programme of work to learn lessons from our response so far, including finding out what changes have generated benefits for patients and staff that we should build on.

We are also analysing some of the unintended consequences of COVID-19 on wider health and care, including a decline in patients attending our A&Es, stroke unit and heart attack centres for care unrelated to COVID-19. We are supporting a national campaign to raise awareness that we remain open to provide safe care for anyone with urgent and emergency health needs. And we are working through the implications for patient waiting times and experience and how we can best resume planned care.

Sustainability report

In 2019, we launched *Care without Carbon*, a new Sustainable Development Management Plan (SDMP).

Care without Carbon is aligned to core healthcare strategies including: the NHS Long Term Plan, the Sustainable Development Strategy for the Health, Public Health and Social Care System, and our own work on becoming an anchor institution in our community.

The plan aims to get all Trust staff engaged with sustainability with measurable benefits by 2025. It aims to deliver a reduction of 27,500 tonnes of carbon by 2025 and cost savings of £29 million.

Care without Carbon has three aims:

- long-term financial sustainability
- minimising our impact on the environment – specifically to continue reducing our carbon footprint
- supporting staff wellbeing to enable a happy, healthy and productive workforce and to encourage them to embed sustainability in their day-to day-lives and in their decision-making at work.

Our plan sets out how we will meet our aims across seven key elements of NHS activity between now and 2025. It was created after extensive consultation with stakeholders across the Trust.

The plan will help to drive several projects at the Trust in 2020-21 alongside improving our reporting mechanisms. Projects for the coming year include: replacing under desk bins with centralised recycling bins and introducing food waste collections in all staff areas.

Progress against the plan will be managed internally through our Sustainability Programme Board. This group will report on progress on a quarterly basis and the results fed back to the Trust's board and staff.

The following sections highlight the progress we have made in 2019/20 and our plans for the coming year.

Our environmental impact

As one of the largest employers in north west London, we use a significant amount of energy and water and produce a large volume of waste. We are also one of the largest purchasers in the region. Transporting staff, patients and goods between our hospital sites contributes to our carbon footprint as well as the energy we consume. All these activities contribute to our carbon footprint which we are committed to reducing. Since our baseline of 2007/08, when our baseline value was 46,424 tonnes, we have reduced our absolute carbon footprint by 12,439 tonnes CO2e1 (26.8 per cent).

Our other key environmental impacts in delivering our services include:

- Waste: In 2019/20 a combined annual total of 5,001 tonnes of waste was recycled, an increase of almost 80 tonnes from 2018/19. This underlines our commitment to environmental best practice and operational savings. New processes, like the recycling of masks and plastic tubes, contributed 700 kg to our total recycled waste.

- Travel: our business miles were 213,281 miles between 1 April 2019 and 30 April 2020. This includes 47,160 miles travelled on the hopper bus which connects our sites and 21,187 passenger bookings on our transport providers.

- Gas and energy: Despite increased consumption of electricity and gas, we continue to reduce our emissions from energy use. In 2019/20 we used 33,985 tonnes – this is a two per cent reduction from 2018/19. This is mainly down to lower emission factors arising from a greener grid caused by increasing share of renewables like wind and solar.

Energy use and cost

Resource		**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Gas	Use (MWh)	86,702	86,716	84,814	92,297	100,436
	tCO_2e	15,992	15,956	15,619	16,979	18,465
Coal	Use (MWh)	0	0	0	0	
	tCO_2e	0	0	0	0	
Electricity	Use (MWh)	53,444	54,757	57,534	56,988	57,858
	tCO_2e	31,669	28,898	22,118	17,507	15,520
Green Electricity	Use (kWh)	0	0	0	0	
	tCO_2e	0	0	0	0	
Total Energy CO_2e		48571	45064	38085	34705	33985
Total Energy Spend		£ 9,012,756	£ 8,940,086	£ 9,242,247	£ 9,927,889	£ 10,028,345

- Water: our annual consumption of water was 404,650 cubic metres with a total spend of £831,510. In 2018/19, the consumption was 396,530 cubic meters and the spend was £586,105. The spend has been higher in 2019/20 because Hammersmith Hospital is relying on Thames Water for water supply

rather than the borehole, a source of free water, which is out of service at the moment.

Reducing our energy usage

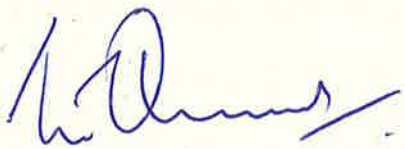
We have successfully completed the combined heating and power (CHP) plant integration project at the Hammersmith Hospital site. This means that the two CHP units at Hammersmith Hospital are now connected to our electrical infrastructure and the electricity generated is reducing our site demand from the grid by a third. The units have been fully operational in this mode since July 2019 and we are on track to deliver associated savings of £250,000 per year. In addition, the project will help achieve emission reductions of 2,616 tonnes per year.

In 2020/21 we aim to procure an energy performance contract (EPC). This will help enable us to benefit from cutting edge technology and deliver guaranteed savings. An EPC will help us to have an holistic overview of all the remaining avenues for energy efficiency and innovations and profit from big-ticket items such as CHP, power purchase agreements, battery storage and electric vehicle charging points (potentially even Vehicle2Grid if and when possible). We hope to integrate all these aided by intelligent controls, to benefit from improved resilience and commercially beneficial arrangements that would help reduce energy bills.

We have now delivered 35 energy efficiency projects. These were carried out at an investment of £10.4 million over the last nine years and they are contributing to a financial saving of £2.9 million and carbon reduction of 16,575 tonnes per annum.

Telehealth

The Trust has continued to develop telehealth technologies in several areas. These include By April 2021 we hope that video consultations will account for 30 per cent of all outpatient consultations.



Professor Tim Orchard

Chief executive officer

Quality account

Part 1: Priorities for improvement and statements of assurance from the board

1.1 Priorities for improvement

This section of the report provides an overview of our approach to quality improvement, our improvement priorities for the upcoming year and a review of our performance over the last year.

We are proud of our long-standing commitment to patient safety and continue to focus on improving the quality of care that we provide. We know that embedding our values enables our staff to demonstrate key behaviours that leads to safer care; listening to colleagues and patients, responding proactively where there are concerns, and being caring and supportive when things do go wrong. We will continue to focus on these actions to achieve demonstrable impact.

Our improvement methodology

We have a dedicated improvement team whose aim is to support us to embed a culture of continuous improvement in the Trust. The team continues to ensure the rigorous application of the Institute for Healthcare Improvement's methodology across the organisation by coaching individuals and teams in their area of work; for example, through our Coaching and Leading for Improvement Programme (CLIP) and our Imperial Flow Coaching Academy (FCA) which uses big rooms to engage a variety of diverse stakeholders in improvement work across patient pathways. We are also supporting the development of local capacity through a variety of novel education and training offerings aligned to a refreshed organisational 'dosing' model based on evidence that describes how to embed improvement in an organisation at scale and pace. Actively involving patients, relatives and carers remains central to our improvement approach; with patients as key participants in our big rooms and our lay partners as central to the success of our safety improvement programme.

Our 2020/21 improvement priorities

Each year we are required to define a number of quality priorities. This year, the Trust has undertaken a new approach – the Imperial Way Model – to ensure the successful delivery of our strategic goals and objectives set out in the wider Trust strategy. This method comprises annual objective setting, business planning and a management system (the Imperial Management and Improvement System (IMIS)). This business planning approach – which includes engagement with staff at all levels and across different groups – identifies a small number of key Trust-level focused improvements, designed to have a direct impact on our strategic goals or objectives within the course of a year. We have therefore aligned our 2020/21 improvement priorities with the six Trust-level focused improvements.

Priorities from this year that are not on this list will be transitioned to business as usual.

Our 2020/21 improvement priorities are listed below:

1. To improve the Friends and Family Test (FFT) response rate
2. To improve the percentage of staff who feel they are able to make improvements in their area
3. To improve incident reporting rates
4. To reduce temporary staffing spend
5. To reduce the number of patients with a length of stay of 21 days or more
6. To reduce avoidable harm to our patients

These priorities will be monitored through the integrated quality and performance reports.

Further information on these priorities and how we will measure our progress is included in the table below.

Improvement priority	Rationale for selection	Progress metrics
1. To improve the FFT response rate	Improving the quality of feedback provided in the FFT responses to feed the natural language processing tool will allow us to better understand the positive and negative experiences of patients.	• FFT response rates
2. To improve the percentage of staff who feel they are able to make improvements in their area	By understanding the primary drivers preventing staff from feeling able to make improvements in their area, we can better address engagement and target capabilities in key improvement initiatives.	• % of staff who feel they are able to make improvements in their area
3. To improve incident reporting rates	High rates of incident reporting is a strong indicator that staff value safety, feel able to raise safety concerns and can learn to continuously improve services.	• Incident reporting rates
4. To reduce temporary staffing spend	Targeting areas with high temporary staffing spend will help us to create a safe and sustainable workforce.	• Temporary staffing spend
5. To reduce the number of patients with a length of stay (LOS) of 21 days or more	Reducing the number of medically fit patients with a length of stay of 21 days, meaning patients are more likely to be cared for in the right place at the right time.	• Patient stays with LOS > 21 days

6. To reduce avoidable harm to our patients	Reducing avoidable harm will underpin our evolving Safety Improvement Programme, developed through a review and refinement of our current safety streams.	• % of moderate /major harm incidents (TBC)

It is important to note that these improvement priorities were defined and agreed prior to the outbreak of COVID-19 in the UK. In 2020/21 we will continue to deliver against these priorities wherever and whenever we can; however our primary focus will be our organisational, regional and national response to the COVID-19 pandemic.

Progress against our 2019/20 improvement priorities

Last year, we identified eight priority improvement areas based on analysis of progress with our previous goals, feedback from our listening campaign and Care Quality Commission (CQC) inspections, and a review of our operational objectives. The table below provides an overview of our progress.

1. To reduce avoidable harm to patients	Overall our harm profile is good, with some of the lowest mortality rates in the country. Our incident reporting rate remains above the national average. However, national comparison data is published six months in arrears; and if the national reporting rate also continues to increase we may fall below our target when the data is refreshed (this happened in 2018/19). Therefore we continue to focus on further increasing incident reporting, with an improvement programme addressing some of the recognised barriers whilst continuing to promote an open and supportive reporting culture across the organisation. The percentage of moderate and above incidents we have reported so far this year is below national average (1.6% compared to 2%). We have declared 266 serious incidents in 2019/20, with the highest reported category being 'treatment delay (availability of downstream mental health beds)'. Commissioners can raise queries with the Trust regarding submitted reports. To measure improvements in the quality of serious incidents, we aimed for a reduction in the number of reports returned from the commissioners with queries. In the past six months we have seen a decrease in the number of requests. This is due to a focus on reviewing and quality assuring these reports centrally before they get to panel and final submission. We have nine safety streams in place to focus on reducing harm in the most frequently reported serious incidents. Progress this year includes: **Improving hand hygiene** Significant sustained improvement in compliance with hand hygiene; for example, in phase II of the Hand Hygiene Improvement Programme, the 12 focus wards increased their mean compliance scores in the trust-wide IPC audit from 38% to 64%. We have maintained and increased our focus on hand hygiene as part of our response to COVID-19. There have been times where the supply and demand of hand washing materials has been challenging, but we have been able to maintain adequate supplies of soap or alcohol gel in our clinical areas at all times.

Reducing fall with harm
The new Falls Steering Group chaired by the director of nursing has been established, overseeing a 25% reduction in falls with harm in wards piloting falls reduction interventions such as the introduction of a falls care bundle.

Safer medicines
We have seen a reduction in incidents involving high risk medicines such as anti-coagulants and insulin, as well as a novel collaboration with partners in the Patient Safety Translational Research Centre that improves prescribing by providing real-time feedback to prescribers.

Responding to the deteriorating patient
We have sustained a reduction in cardiac arrests taking place outside of our intensive care units across the Trust.

Improving care for patients with mental health problems in the Emergency Department (ED)
This safety stream is focusing on alternatives to admission, reducing environmental risk for patients in the ED and better support, training and development for specialist staff caring for these patients. The work is closely aligned to the mental health 'big room' improving flow across the pathway as part of the Imperial Flow Coaching Academy. In responding to this safety stream we have continued to work closely with our colleagues in our local mental health services. However we continue to face challenges with the timely transfer of care for patients with mental health needs to more appropriate settings. We will continue to work collaboratively to improve our responsiveness to this potentially vulnerable group of patients.

Positive patient identification
Work has focused on defining policy as well as on reducing the number of incidents related to blood testing. In response we have seen a reduction in the number of wrong blood in tube incidents. We have undertaken a pilot of the use of technology during medicines administration. We anticipate once this pilot rolls out that it will reduce harm related to misidentification during medicines administration.

	Improving fetal monitoring The introduction of 'Fetalink' and 'fresh eyes (a second check of fetal monitoring) alongside staff education and strengthened governance to learn from incidents has resulted in a significant reduction in the number of incidents resulting in harm. **Endorsement of abnormal results** We have seen success in improving the time it takes to endorse results as part of a pilot in gynaecology (with endorsement within 30 days increasing from <30% to >90%). Due to the scale of the pilot this has not translated to a reduction in incidents at Trust level; therefore work continues to understand the locations, themes and level of risk associated with clinical incidents related to a delay in reviewing and acting upon test results. **Safer surgery** The successful roll-out of the Helping Our Teams transform (HOTT) for teams undertaking invasive procedures, which includes human factors training, simulation and in-situ coaching. In 2019/20 over 1000 staff have participated in the programme. With our partners, we marked the inaugural World Patient Safety day in September 2019 and hosted our first Imperial Patient Safety Conference in February 2020, providing a dedicated forum to reflect on our safety priorities and actions.
2. To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation	The Trust has established the Imperial Flow Coaching Academy to reduce unwarranted variation by understanding and delivering best practice. We have trained 50 flow coaches supporting teams to deliver improvement across 20 clinical pathways, including: *Sepsis pathway* • A 35% increase in the likelihood of receiving antibiotics within 1 hour of admission with suspected sepsis, a 24% reduction in mortality with a 7% reduction in length of stay (meaning patients get back to their

	home much sooner). *Vascular elective pathway* • Weekly discharges have increased from a mean of 11 to 16 patients and length of stay has reduced by an average of 2 days; this means patients are more likely to be cared for in the right place at the right time. *Diabetic foot pathway* • Reduction in mean length of stay to 18 days. *Theatres pathway at St Mary's Hospital* • 24 hour stays have been reduced from an average of 17 per month in 2018 to an average of less than six per month in 2019. • Theatre lists are more likely to start on time with over 80% of theatre lists now starting with the patient who has been identified as needing to go first.
3. To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow	Our Care Journey and Capacity Collaborative is how we are delivering this priority across four specific areas of the emergency pathway: • Front door – implementing and operationalising urgent and emergency care (UEC) standards; provision of same day emergency services (SDEC); ambulance handovers; and patients in mental health crisis in the emergency department. • Giving the best start – getting inpatients to the right place (time to move and right bed); and timely specialist input. • Perfect ward day – reinforcing the SAFER patient flow bundle. • Discharge – improving patient and family communications around the patient choice policy; and long length of stay reviews. Performance is monitored through the executive operational performance committee.
4. To improve access for patients waiting for elective surgery	In March 2020, due to the COVID-19 pandemic, all non-urgent elective inpatient procedures were stood down and clinical reviews were completed by the services. Through these review processes, a large number of appointments deemed non-urgent were cancelled or postponed for up to three months. Inevitably this will have a serious effect on the size of our

	waiting lists and associated performance and data quality metrics. Therefore commentary for this priority focuses on performance up to quarter three (Q3). The Trust over performed against the Referral to Treatment (RTT) target agreed with commissioners, which is throughout Q3 when viewed as a number (63,100). However, we did not meet the percentage target in Q3 which is mostly influenced by winter pressures and patient choice during this time of the year but is being investigated at specialty level to ensure that recovery action plans are in place. Standards set by NHS England state that no patient should wait more than 52-weeks for their treatment to start following referral. In Q3 we have seen a rise in 52 week waiting patients, with 14 patients being reported in the period. The increase is multifactorial and related to capacity; surgeon, theatre and bed availability; patient choice to defer until January 2020 and a high number of cancer patients taking priority over routine elective surgery. Notably, no cases of clinical harm were identified in the quarter due to elective waiting times in the 44+ week cohorts.
5. To improve compliance with the equality and diversity standards	We want to provide a better working environment for our staff, free from all unfair discrimination. The results of our staff survey continue to show we have more work to do to improve equality, diversity and inclusion across the Trust, with performance lower than we would want. We are delivering on our workforce equality, diversity and inclusion work programme with four elements that cover the main protected characteristic groups, including ethnicity, gender and disabilities. This work programme is overseen by a governance structure that includes our Equality, Diversity and Inclusion (EDI) committee chaired by the Trust chief executive. The EDI Committee includes representatives from divisions and staff networks.

The committee delivers on its objectives via five staff networks. These networks are anchored by staff leads and cover disability, black, Asian and minority ethnic (BAME), lesbian, gay, bisexual and transgender (LGBT) and gender diversity issues. Executive sponsors give each network's agenda board level visibility. The networks are working with staff and executives to open channels of communication, to agree priorities for our equality, diversity and inclusion agenda and to recognise that everyone has a role to play in delivering it.

Our 2018-19 Annual Equality and Diversity (E&D) report was agreed by the board and published on 26 September 2019. The annual report includes the workforce race equality standard (WRES) and workforce disability equality standard (DES) metrics and report, as well as data on our gender pay gap.

Area: Gender Pay Action Plan							
Objective	**Metric**	**Baseline annual**		**2019/20 quarterly**			
		17/18	**18/19**	**Q1**	**Q2**	**Q3**	**Q4**
Improve female workforce representation at Band 8A+	Increase % of workforce at Band 8A+ (female)	54%	53.42%	53.74%	53.72%	53.47%	54.53%
Area: Disability (WDES action plan)							
Objective	**Metric**	**Baseline annual**		**2019/20 quarterly**			
		2017/18	**2018/19**	**Q1**	**Q2**	**Q3**	**Q4**
Improve quality of disability data on ESR	Reduce % of disability data in 'unspecified' category	37.10%	33.20%	32.98%	32.30%	33.40%	30.98%
Area: Race Equality (WRES action plan)							
Objective	**Metric**	**Baseline annual**		**2019/20 quarterly**			

		2017/18	2018/19	Q1	Q2	Q3	Q4
Improve workforce representation of BME people at Band 7+	Increase % of workforce at Band 7+ (BME)	33.57%	34.38%	34.48%	33.68%	34.52%	33.91%

Area: Race Equality (WRES action plan)

Objective	Metric	Annual		
		2017/18	2018/19	2019/20
Reduce the differential in the relative likelihood of BAME and White people receiving D or E ratings in their personal development review (PDR)	Reduce the likelihood of BAME staff receiving D or E ratings (PDR)	1.51	1.45	1.33

Area: Gender pay action plan

Objective	Metric	Gender Pay Gap Report Results		
		March 2017	March 2018	March 2019
Reduce the differentials of bonus pay gap (LCEAs) between female and male	Mean difference	26.60%	28.00%	29.00%
	Median difference	40.00%	46.00%	44.80%

6. To improve the behaviours across the Trust related to safety	Safety culture (or 'the way we do things round here to keep patients and staff safe') has been a focus since 2016, and we have increasingly recognised the importance promoting our values, and ensuring that these translate into the safety behaviours as part of our safety improvement programme. We have seen a year on year improvement in staff survey questions relating to safety culture; for example staff feeling safe to raise concerns. The new national NHS Patient Safety Strategy was launched in July 2019 and the aims of our

safety improvement programme were reviewed over the summer of 2019 to ensure that they remain aligned to national policy and our evolving Trust strategy. As part of the review we have established a new safety improvement group (SIG) group to provide strategic oversight of delivery of the safety improvement plan. This is chaired by our medical director and they report exceptions to the executive quality committee. We are delighted to continue to have attendance at the group by our lay partners in safety improvement.

Incident reporting
We concluded a pilot of 90 day improvement cycle to increase incident reporting, which demonstrated an increase in reporting in many of the wards involved. One of the key outcomes of the evaluation was around feedback and learning. Staff in all the pilot wards reported that they did not have regular and easy access to their incident reporting data. Following this programme, a review was established to (a) improve how incident reporting data are presented, (b) to work to make it meaningful to clinical teams, and (c) to improve how incident reporting data is presented and disseminated to staff. A proposal has also been agreed for a pilot to present data in a more engaging way using existing software. Incident reporting is increasing overall.

Communications
We are working with corporate communications to launch a Trust-wide communications campaign in 2020/21 to improve incident reporting, and to raise the profile of the Freedom to Speak Up guardians and speaking up more generally. In addition we continue with our bi-monthly safety briefings and safety alerts.

Learning from Excellence
We have asked our staff to use Datix, our electronic incident reporting system, to record Learning from Excellence. We have now conducted a review into our use of Learning from Excellence comparing the use of Datix with other

	models, including those used in other trusts. It was proposed to move away from Datix in a future pilot, therefore the next phase of this work will explore alternative software options for Learning from Excellence. This pilot would be cross site and would involve lay-partners in co-production.
7. To improve staffing levels for permanent nurses and non-consultant doctors	By the end of 2019/20, we had achieved our overall vacancy rate targets for all staff and for nursing and midwifery staff. We have ensured staffing meets planned safe levels. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses taking the following actions: • Using the workforce flexibly across floors and clinical areas • The nurse or midwife in charge of the area working clinically and taking a case load • Specialist staff working clinically during the shift to support their ward based colleagues We are also achieving our vacancy rate targets for career grade and trust grade doctors. Other highlights include: • We have secured 90% of our student nurses who have trained with us and qualified this autumn. • The international nurse recruitment work was on track to realise 160 nurses by the end of March 2020 however, the COVID-19 pandemic has led to delays. • The nursing associate apprenticeship recruitment and development and graduate nurse apprentice numbers are increasing and the schemes are gathering momentum. We are also running recruitment and retention campaigns for areas and staff groups with high vacancy rates, including cardiac physiologists and locally employed doctors.
8. To review our approach to inspection, accreditation and reviews	Our approach has been strengthened over the last twelve months with improvements evidenced by CQC inspections. Our quality ratings have improved for a range of services inspected across four of our hospitals in February 2019.

As noted above, these include maternity at Queen Charlotte's Chelsea Hospital and St Mary's Hospital which were the first maternity units in London to be rated as outstanding. Recently the CQC published its report from the inspection of GP services at Hammersmith Hospital and Charing Cross Hospital, with the trust achieving a 'good' rating in all domains. The CQC also completed a re-inspection of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), following the service of an improvement notice in June 2019. They commended the progress the trust had made in response and were satisfied that we are now compliant with regulatory requirements. The Improving Care Programme Group oversees this work and plans in place with our core services for their inspection preparation.

1.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2019/20. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

Review of services

In 2019/20, Imperial College Healthcare NHS Trust provided and/or sub-contracted 104 NHS services.

We have reviewed all the data available to us on the quality of care in all of these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2019/20 represents 81 per cent of the total income generated from the provision of NHS services by the Trust for 2019/20.

The income generated by patient care services associated with the services above in 2019/20 represents 97 per cent of the total income generated from the provision of services by the Trust for 2019/20.

Participation in clinical audits and national confidential enquiries

Clinical audit drives improvement through a cycle of service review against recognised standards, implementing change as required. We use audit to

benchmark our care against local and national guidelines so we can put resource into any areas requiring improvement; part of our commitment to ensure best treatment and care for our patients.

National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

During 2019/20, 49 national clinical audits and two national confidential enquiries covered NHS services that Imperial College Healthcare NHS Trust provides. During that period, we participated in 90 per cent of national clinical audits and 100 per cent of national confidential enquiries in which we were eligible to participate.

The Trust did not participate in four out of the five British Association of Urological Surgeons (BAUS) audits in 19/20 but a benchmarking exercise using alternative data has been conducted to provide assurance. The outcome of this exercise has been reviewed through existing governance arrangements and assurance provided. The Executive Quality Committee agreed that we would not undertake four of the five BAUS audits. This decision was based on concerns raised by the clinical team regarding the level of assurance available from these audits. The urology team have produced a number of local audits to provide assurance in areas where we do not participate in BAUS work.

The national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible to participate in are included in the table below with the number of cases submitted presented as a percentage where available.

Participation in national clinical audits and confidential enquiries 2019/20

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
Assessing cognitive impairment in older people/care in emergency departments	Royal College of Emergency Medicine	√	**120 cases submitted percentage not available**
BAUS urology audit – cystectomy	British Association of Urological Surgeons	X	**Did not participate *See commentary above***
BAUS urology audit – female stress incontinence (SUI)	British Association of Urological Surgeons	√	**100 per cent**
BAUS urology audit – nephrectomy	British Association of Urological Surgeons	X	**Did not participate** *See commentary above*
BAUS urology audit – percutaneous	British Association of	X	**Did not participate**

nephrolithotomy (PCNL)	Urological Surgeons		*See commentary above*
BAUS urology audit – radical prostatectomy	British Association of Urological Surgeons	X	**Did not participate** *See commentary above*
Care of children in emergency departments	Royal College of Emergency Medicine	√	**Ongoing collection**
Case Mix Programme	Intensive Care National Audit and Research Centre	√	**Ongoing collection**
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	**100 per cent**
Elective Surgery (national PROMs programme)	NHS Digital	√	**77.1 per cent**
Endocrine and Thyroid national audit	British Association of Endocrine and thyroid surgeons	√	**Not available**
Falls and Fragility Fractures Audit Programme (FFFAP) – fracture liaison service database	Royal College of Physicians London	√	**100 per cent**
Inflammatory Bowel Disease Registry – biological therapies audit	Inflammatory Bowel Disease Registry	√	**Ongoing collection**
Major trauma audit	Trauma Audit and Research Network	√	**97.6 per cent**
Mandatory surveillance of bloodstream Infections and Clostridium Difficile Infection	Public Health England	√	**100 per cent**
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRACE-UK	√	**Ongoing Collection**
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	**100 per cent**

Mental Health – care in emergency departments	Royal College of Emergency Medicine	√	**186 cases submitted Percentage not available**
National Asthma and COPD Audit Programme	Royal College of Physicians	√	**Ongoing collection**
National Audit of Breast Cancer in Older People	Royal College of Surgeons	√	**100 per cent**
National Audit of Cardiac Rehabilitation	University of York	√	**773 cases**
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	√	**100 per cent**
National Audit of Dementia (Care in General Hospitals)	Royal College of Psychiatrists	√	**100 per cent**
National Audit of Pulmonary Hypertension	NHS Digital	√	**Ongoing collection**
National Audit of Seizure Management in Hospitals	University of Liverpool	√	**100 per cent**
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	√	**Not available**
National Bariatric Surgery (NBSR)	British Obesity and Metabolic Surgery Society	√	**Ongoing collection**
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	√	**100 per cent from April to December Data to end of March not available until end of May**
National Cardiac Audit Programme	Barts Health NHS Trust	√	**Ongoing collection**
National Diabetes Audits – adults	NHS Digital	√	**Ongoing collection**
National Early Inflammatory Arthritis Audit	British society for Rheumatology	√	**Ongoing collection, 119 records submitted so far**

National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	√	**100 per cent Charing Cross Hospital** **74 per cent St Mary's Hospital Ongoing collection**
National Gastro-Intestinal Cancer Programme	NHS Digital	√	**Ongoing collection**
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	√	**Ongoing collection**
National Lung Cancer Audit (NLCA)	Royal College of Physicians	√	**Ongoing collection**
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	√	**Not yet started**
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	√	**100 per cent**
National Ophthalmology Audit	Royal College of Ophthalmologists	√	**Ongoing collection**
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	√	**Ongoing collection**
National Prostate Cancer Audit	Royal College of Surgeons	√	**Ongoing collection**
National Smoking Cessation Audit	British Thoracic Society	√	**100 per cent**
National Vascular Registry	Royal College of Surgeons	√	**Ongoing collection**
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	√	**Ongoing collection**
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	√	**100 per cent**
Perioperative Quality Improvement Programme	Royal College of Anaesthetics	√	**Not available**

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England	√	**Ongoing collection**
Sentinel Stroke National Audit Programme (SSN/AP)	King's College London	√	**98.2 per cent up to February 2020 Ongoing collection**
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion	√	**Ongoing collection**
Society for Acute Medicine's Benchmarking Audit	Society for Acute Medicine	X	**Did not participate**
Surgical Site Infection Surveillance Service	Public Health England	√	**100 per cent**
UK Parkinson's Audit	**Parkinson's UK**	√	**100 per cent**

National clinical audit

We reviewed the reports of 46 national clinical audits and confidential enquires in 2019/20. These clinical audits linked with our focused improvement work have identified a number of areas of excellent practice as well as opportunities for development and improvement.

Paediatric Intensive Care Audit Network: annual report 2019
We have performed extremely well in all of the key domains of this recurring national audit. The one area for improvement is against the recommended overall ratio of trained nurses to inpatient beds, although this is improving year on year as a result of a focused recruitment programme and staffing review. The unit underwent an extensive redevelopment and refurbishment this year as a result of a generous donations from Imperial Health Charity and Children of St Mary's Intensive Care (COSMIC). The new unit is much larger and provides more space and better facilities for patients, families and staff.

The Learning Disabilities Mortality Review
The Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 across England to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice. The Trust has care pathways for inpatients, outpatients, emergency departments and some specialist services with a full time learning disability coordinator, to support the care and management of patients with learning disabilities. There is also a clear pathway in relation to learning from deaths and the structured judgement review (SJR) process that links with the LeDeR review process. The Trust reported 18 deaths of patients with learning disabilities to the LeDeR programme in the last financial year. The learning disability coordinator routinely reviews the records of all patients with

learning disability, which includes do not attempt cardio-pulmonary resuscitation (DNACPR) status. Where there is any doubt on the basis of the decision or where inadequate capacity assessments/best interest decisions have been made this will be followed up with the responsible consultant and investigations undertaken.

National Diabetes Insulin Pump Audit (NDIPA) 2017-2018
This audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump. The Diabetes Technology Centre was set up earlier this year and since July 2019, all pump starts at the Trust take place here in a dedicated pump initiation clinic run by our type 1 diabetes educators. 19.7 per cent of people with type 1 diabetes being seen at the Trust were receiving insulin pump therapy compared to 17.7 per cent of patients nationally. 91.3 per cent of our pump users had their HbA1c recorded appropriately, which is on par with the national average (94.9 per cent), but only 43.5 per cent achieved all eight care processes compared to the national average of 52.6 per cent. We have developed a new Type 1 diabetes clinic template to improve data capture and ensure that the key eight care processes are undertaken and recorded.

Royal College of Emergency Medicine Vital Signs in Adults National Report
The Vital Signs Standards were originally developed and published in 2010 through a partnership between the Royal College of Emergency Medicine, the Royal College of Nursing, the Faculty of Emergency Nursing and the Emergency Nurse Consultants Association. This is the second time this audit has been conducted at the Trust. Senior decision maker oversight, and evidence that doctors acknowledged abnormal vitals, were on the whole very good. The Trust, however, is implementing an action plan to improve communication between reception and triage, implement an early warning score action card, and to devise a written escalation policy for triage surges.

National Pregnancy in Diabetes Audit Report 2018
The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant. It presents national data that shows that seven out of eight diabetic women were not well prepared for pregnancy. Stillbirth rates and other complications of pregnancy were demonstrably higher for diabetic mothers. The audit presents a challenge to all stakeholders to participate in the challenge to improve pre-gestational diabetic pregnancy outcomes. We have developed a new endocrinology/ diabetes pregnancy clinic to offer specialist care based on the St Mary's Hospital site.

National audit of cardiac rhythm management devices and ablation 2016/2017 - summary report
The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK. The Trust is a major national centre for this work and the report reflects this, showing that the unit is performing in line with or better than peer units. In addition, a strong research programme means that patients are often able to benefit from new and developing techniques and technology in advance of formal approval by the National Institute of Clinical Excellence (NICE) as part of collaborative research programmes.

State of the Nation – England report – using national clinical audit to improve the care of people with falls and fragility fractures in England
This national audit has been reported with acceptable risk/reasonable assurance. It represents improvements in performance in most areas but demonstrates that achieving early and timely surgery for patients with hip fractures remains challenging. This has been recognised by the Trust and is the focus of a dedicated multidisciplinary improvement group including orthopaedic surgeons, anaesthetists and ortho-geriatricians. A business case including additional theatre capacity has been made although no decision has yet been made. This will be kept under review through approved governance structures. One area of improvement has been the implementation of a new fracture liaison service since January 2020, which aims to risk assess patients presenting with fragility fractures and to advise and intervene to reduce future fracture risk.

National Paediatric Diabetes Audit Spotlight reports - workforce and structure
The Trust offers a mature and well-developed service that is well ahead of many peers. We are able to offer the recommended four appointments a year for all children and young people with diabetes. We have a well-established Young Adult Transition clinic, where paediatrician, adult physicians and other professionals involved work with young adults and their parents to provide the necessary support for this age group. This audit showed that our specialist staffing is better than other units in London, the South-East and nationally.

National Paediatric Diabetes Audit spotlight reports – diabetes-related technologies
This audit is specifically aimed to determine the prevalence of use of diabetes-related technologies amongst children and young people with Type 1 diabetes across England and Wales. It also aims to establish the type of support children, young people and their families receive when utilising diabetes-related technology. The Trust is well ahead nationally in this area and the audit demonstrated that the paediatric diabetes unit is performing in line with or better than peer units in all key audit domains.

Perinatal Mortality Review Tool – first annual report (2019)
We were able to demonstrate reasonable assurance against the recommendations of this audit; however, there were opportunities for improvement. We have reviewed the processes for our perinatal mortality reviews so that we can learn and improve. Some of the actions we are taking to achieve this include improving our record keeping about who is involved in reviews. We have identified two obstetric leads; a neonatal lead is already in post. We are actively engaging and seeking the views of parents during reviews to make this a more useful process and to ensure that they are given every opportunity to ask questions, feedback and express their views and concerns.

Local clinical audit
Over the year, the Trust has identified a number of areas for targeted audit work across the organisation. These have been selected as areas of potential risk or in order to support a strategic aim. Audits conducted in these areas have been coordinated centrally and reported to the trust audit group and to executive quality

committee for oversight and monitoring of actions and to provide assurance. Many of these audits form part of our safety improvement programme, with the results being used to inform specific quality improvement work. In addition, specialties within directorates conduct local audit activity. Over 2019/20 there were 337 local audits registered in the Trust. The report, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Some examples of the actions to improve the quality of healthcare provided include:

- **Audit of compliance with the World Health Organization's five steps to safer surgery, including the Trust Count Policy:** Substantial assurance that surgical teams are complying with the five steps to safer surgery with some local variation in practice around the count which is being addressed through the development of a single unified policy as part of the Trust invasive procedure group. The HOTT programme is the key intervention to improve and maintain compliance.
- **Audit of our consent policy (part 4 - specifically for adults who are unable to consent to investigation/treatment):** Overall completion of the consent form for patient details, name of procedure and signature of health professional was completed to a satisfactory level. Documentation for assessment of mental capacity and best interests was generally poorer, with a lack of explanation to attempts made and reasoning for failed attempts. Education that includes teaching the importance of using justified reasoning and completing sections fully has commenced.
- **Audit of the chest pain pathway:** carried out by the cardiology team, this audit found that appropriate referrals were being made but that the times for transfer were found to be longer than the trust target but this data was collected during a time of high bed pressure. Improvements are being made to the pathway to the heart attack centre (HAC) and to downstream beds.
- **Audit of compliance of documentation of operative notes after hip replacement surgery against newly released 'getting it right first time' (GIRFT) guidance:** carried out by the trauma and orthopaedic team, this audit demonstrated good compliance which could be further improved by the introduction of a standardised operation note template in the electronic patient record which is being taken forward.
- **Re-audit of the assessment for delirium and cognitive impairment in adult general surgical patients over 65 years admitted to the Trust:** carried out by the general surgical team, this audit has shown an improvement demonstrating that of the 85 per cent of patients with a positive indicator for delirium, 74 per cent received a formal assessment for delirium or cognitive test and of those with clinically suspected delirium, 82 per cent of patients received a formal assessment.

Our participation in clinical research

We continue to contribute to world-leading programmes of clinical research, partnering closely with Imperial College London through the Imperial College

Academic Health Science Centre (AHSC). In collaboration with industry, the charity sector and government, this partnership drives our biomedical and clinical research strategy. It ensures we remain at the forefront of scientific discovery and can apply these new advances to benefit of our patients and the wider population.

Through the AHSC we also work closely with the Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust to coordinate our efforts and align our priorities across North West London.

Much of our innovative clinical and biomedical research is made possible because of significant infrastructure funding, awarded through open competition by the National Institute of Health Research (NIHR). This includes our NIHR Biomedical Research Centre (BRC), Clinical Research Facility (CRF), Patient Safety Translational Research Centre (PSTRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). Funding from our own Imperial Health Charity ensures this work not only benefits our NHS patients, but also provides career development opportunities for our staff.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2019/20 that were recruited to participate in research approved by a research ethics committee was 13,801. 11,760 patients were recruited into 402 NIHR portfolio studies in 2019/20. This included 757 patients within 89 studies sponsored by commercial clinical research and development organisations.

More detail on our translational research work can be found on the NIHR Imperial Biomedical Research Centre website: https://imperialbrc.nihr.ac.uk/research/.

Our CQUIN performance

Commissioning for Quality and Innovation (CQUIN) is a quality framework that allows commissioners to agree payments to hospitals based on the number of schemes implemented and a proportion of our income is conditional on achieving goals through the framework. We signed up to a total of ten CQUIN schemes for 2019-20, five Clinical Commissioning Groups (CCGs) schemes and five NHSE schemes with a proportion of our income in 2019/20 being conditional on achieving quarterly scheme targets. The total value of the schemes we signed up to is 1.55 per cent of the contract value for NHS acute healthcare services as agreed with NHS England and 1.25 per cent of the contract value for agreed CCG schemes.

Submissions have been made for Q1-3 and we are on track for our Q4 end of year submission in April 2020. All ten schemes had strong clinical and service leadership engagement with the aim to bring as many schemes into business as usual at the end of the financial year. Our CQUIN goals for 2020/21 have not yet been agreed, however they are likely to focus on similar issues to our current goals.

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the CQC at all of our sites and our current registration status is 'registered without conditions'.

The Trust's overall CQC rating remains requires improvement.

All trusts participate in CQC patient surveys; the outcomes of three surveys carried out during 2018 were published during 2019/20. Overall, the Trust's performance in the surveys was relatively unchanged and was "about the same" when compared to other trusts.

- The outcomes of the adult inpatient survey showed no significant change. The Trust performed better than other trusts in relation to patients being asked to give their views on the quality of care.
- The outcomes of the urgent and emergency care survey identified dissatisfaction with the availability of food; however, there was significant improvement in relation to privacy, cleanliness, waiting times and knowing who to contact for advice after discharge.
- The outcomes of the children and young people survey showed no significant change; parents raised concerns about the availability of hot drinks, the quality of food and cleanliness of the environment.

We did not participate in any special reviews carried by the CQC during 2019/20, nor were any reviews published that the Trust participated in which were carried out in previous years.

The CQC inspected four core services at the Trust in February 2019:

- Critical care at St Mary's and Charing Cross and Hammersmith hospitals
- Services for children and young people at St Mary's and Hammersmith hospitals
- Maternity at St Mary's and Queen Charlotte & Chelsea hospitals
- Neonatal services (the neonatal ICU) at Queen Charlotte & Chelsea Hospital.

The outcomes of the inspections were published in July 2019 and we are very proud of our performance overall. In summary:

- Maternity at St Mary's Hospital and QCCH were the first maternity services in London to be rated "Outstanding" overall.
- Services generally improved to good, or maintained existing good ratings, for both domains and overall.
- Three ratings remained Requires Improvement:
  - The safe domain in services for children and young people at St Mary's Hospital.
  - The well-led domain for services for children and young people at Hammersmith Hospital (the David Harvey Unit).
  - The well-led domain for critical care at Hammersmith Hospital.
- The overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remained requires improvement, although some of these issues, such as poor physical estate, are largely outside our control. We will need more services to be inspected and improve to influence our overall ratings at these sites.

- The Trust's overall CQC rating following these inspections remains requires improvement.
- The overall rating for Queen Charlotte's & Chelsea Hospital improved to outstanding.

Following the CQC's inspection of well-led at Trust level domain in April 2019, the Trust level rating for well-led improved to good.

Compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) in the imaging department at St Mary's Hospital was inspected by the CQC in June 2019. Following this inspection the CQC took enforcement action against the Trust in the form of an improvement notice, which required that the Trust address the areas of non-compliance identified during the inspection which in the main related to our overarching governance structures, procedures and policies related to IR(ME)R. The CQC re-inspected in August 2019 and confirmed the imaging department at St Mary's Hospital had become fully compliant with IR(ME)R.

The GP practice operated by the Trust, Hammersmith & Fulham Centres for Health, is located at Charing Cross and Hammersmith hospitals. The practice was inspected by the CQC at both sites in July 2019; this was the first ever inspection of the practice. The outcomes of the inspection were published in September 2019; all domains and the practice overall at both sites, were rated good.

Routine CQC inspections have been suspended during the COVID-19 pandemic however, an unplanned (focused) inspection of any service could be carried out in response to changes in CQC intelligence, where serious concerns are identified. When routine inspection recommences we will expect the Trust's next round of core service inspections and the inspection of well-led at Trust level. We look forward to this opportunity to have our other services re-inspected and our ratings updated.

Our data

High quality information leads to improved decision making, which in turn results in better patient care, wellbeing and safety. Data quality and security are key priorities for our trust and essential to our mission.

NHS number and general medical practice code validity

The Trust submitted records during 2019/20 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:

- 97.7 per cent for admitted patient care;
- 99.3 per cent for outpatient care; and
- 93.2 per cent for accident and emergency care.

The percentage of records in the published data which included the patient's valid general medical practice code was:

- 100 per cent for admitted patient care;

- 100 per cent for outpatient care; and
- 100 per cent for accident and emergency care.

Data security and protection toolkit

The data security and protection toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems to provide assurance that they are practicing good data security and that personal information is handled correctly.

We met all the mandatory standards of the toolkit and therefore produced a 'satisfactory' return. This was published to the Department of Health and verified as 'low risk' and 'reasonable assurance' following independent audit.

Clinical coding quality

Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

The Trust was not subject to the payment by results clinical coding audit by NHS Improvement during 2019/20 by the Audit Commission.

Data quality

We continued to focus on improving the quality of our performance data via the Data Quality Improvement Programme (DQIP). The aim of the DQIP is to prioritise areas for improvement and provide intensive support within these areas for a period of time, before returning metrics to business as usual internal frameworks. The Data Quality Steering Group (DQSG) oversee progress with the DQIP, reporting to the Executive Operational Performance Committee (ExOp) on a monthly basis and to Audit Risk and Governance Committee (ARG) bi-annually.

In 2019/20, we chose 20 data quality indicators (DQIs) identified as key priorities for improvement across waiting times (10) and income/activity (10). Highlights and achievements for 2019/20 include:

- Four out of the five waiting time audits have continuously reported within the agreed five per cent threshold recommended by NHS Improvement.
- The average RTT error rate has improved to eight per cent for 2019/20, as compared to ten per cent for 2018/19.
- Of the ten priority waiting time DQIs, five have shown sustained improvement when compared to baseline.
- Outpatient check-in and outpatient check-out waiting times DQIs have shown a 42 per cent improvement against baselines, after operational teams implemented a targeted action plan across the year.

In March 2020, due to the COVID-19 pandemic immediate changes were put in place for the provision of outpatient services across the Trust. To reduce the number of face-face contacts in the outpatient departments, clinically appropriate services were transferred to telephone or video consultations. For inpatient procedures, all non-urgent elective treatments were stood down and clinical reviews were completed by the services. Through these review processes, a large number of appointments deemed non-urgent were cancelled or postponed for up to three months. This change will affect the waiting lists and associated performance and data quality metrics.

With the normal processes affected due to the current situation, a clear governance process is required to provide assurance across the Trust for the management of our elective care waiting lists. The Trust is developing a five-step 'COVID-19 waiting list data quality framework'. This will replace the business as usual Data Quality Improvement Programme. A number of measures and mitigation reports are being implemented to track data quality throughout the Trust's COVID-19 response; this includes six key priority data quality indicators.

The COVID-19 waiting list data quality framework will be proposed to the executive team in mid-April and work on the implementation will begin after this, with a dedicated scorecard reported on a routine basis. When the Trust returns to business as usual, the expectation is to return to the Data Quality Improvement Programme and continue as per the original plan.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures reported up to Trust Board. Through this process, 75 per cent of deaths which occurred at the Trust between April 2019 and March 2020 have been reviewed so far. Of these, 198 have gone forward for structured judgement review (SJR). This is a validated methodology and involves trained clinicians reviewing medical records in a critical manner to comment on phases of care and determine whether the death may have been due to problems with the care the patient received.

As noted on page 20, in 2019/20 we implemented our medical examiner (ME) service in line with national guidance; we are pleased to say that our service was fully operational before the 1 April 2020 deadline. The ME service has fundamentally changed how we learn from deaths. Our ME service now identify cases where a SJR should be conducted, this is based on a review of clinical notes and most importantly a conversation with the bereaved. Our ME service now reviews every death that occurs in our hospitals and: a) ensures that the proposed cause of death is accurate, b) the bereaved understand the cause of death and have an opportunity to raise any concerns and c) identify any cases that should be referred for SJR.

We have changed our SJR process to ensure that it is aligned with our other clinical governance process, as part of this we have moved away from an SJR declaring a death avoidable or unavoidable. Rather the SJR now focusses on identifying learning and care/service delivery issues. Where care/service delivery issues are

identified these are reviewed via our serious incident framework and are subject to more in depth investigation as appropriate.

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

Patient deaths, April 2019-March 2020

	Q1	Q2	Q3	Q4	Total
Number of patients who died ***Based on date of death***	442	441	436	598	1917
Number of deaths subjected to case review or investigation ***Based on date of death***	59	69	56	14	198
Estimate of the number of deaths where some level of care concerns were identified but were still deemed to be unavoidable	7	1	5	0	13

Our rate of referral to SJR reduced in Q4, and our rate of death increased significantly because of COVID-19. We believe that the reduction in cases referred to SJR is representative of the fact that the ME service started reviewing all deaths in Q4. This means that family concerns are dealt with quickly and transparently, and other issues are explored and understood at the point of death, rather than referring cases to SJR for further review as would have happened previously. In order to assure ourselves that the correct cases have been referred to SJR we will audit all cases in Q4 in order to provide further assurance that the correct cases have been referred.

Deaths which occurred in 2019/20

Of the 1917 deaths that occurred during 2019/20, 1440 were subject of case record reviews, 164 SJRs and 18 serious incident investigations. Of those reviewed, 13 of the deaths were identified with level of care concerns. Which represents 0.67 per cent of the deaths that occurred during that financial year.

In six of these cases, the issues were not found to have contributed to the outcome and the deaths were deemed to be totally unavoidable. The themes for these were poor documentation of clinical decision making and records of discussions with patients and/or their families when the prognosis of their current condition was poor.

In seven cases some opportunities for learning were identified but none were deemed to be avoidable deaths. The potential learning from these have been fed into two of our safety streams: 'responding to the deteriorating patient' and 'fetal monitoring'. An additional theme was not following the recommendations in the Trust guidelines of referring patients with a history of multiple miscarriages and foetal

concerns to an obstetrician-led antenatal clinic. Cases are shared with the safety stream leads to ensure the improvement work covers the findings of the SJRs.

Individual action plans are also developed in response to each case. Examples of these actions include:

- Review of pathways of care for head injury patients in the trauma service
- Raise awareness of the guidelines for referral to consultant led antenatal clinics
- Carry out an audit on a representative sample of patients of the documentation of National Early Warning Score (NEWS) and escalation of triggers in line with *Recognising the Deteriorating Patient – Management and Escalation of Adult Patients* and implement the appropriate actions in response to the findings

We expect that the impact of these actions will be improvements in the overall quality and safety of care provided to our patients. On a trustwide level, we have seen a reduction in avoidable deaths compared to last year.

Seven day hospital services

The seven day services programme is designed to reduce the discrepancy in care quality provided by Trusts to patients admitted during the week or those admitted during the weekend. We are currently meeting three of the four priority standards, those numbered: (5) seven-day access to diagnostic services; (6) 24 hour, 7 day a week access to consultant directed interventions; and (8) twice daily consultant review for patients with high dependency needs.

We continue to fall below the target in Standard 2 that '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'. Given the way we organise our specialist services, we continue to have confidence that our medical model provides appropriate expertise should patients require it. We are clear that the forecasted recurrent cost of delivering such rotas (circa £2million) would not make significant enough impact on improving care quality to justify this spending. This approach has previously been well understood by our CCGs and NHS Improvement.

Although not formally audited as priority standards, we continue to make good progress in improving the areas of care that relate to the experience, safety and flow of patients through our services (which are represented by the non-priority standards 1,3,4,7,9 and 10).

Speaking up

Freedom to Speak Up (FTSU) promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. We are committed to embedding an open and transparent culture in which staff members and volunteers feel empowered to raise concerns, with confidence that these

concerns will be acted upon and without fear of detriment for speaking up. To this end, we have enhanced our processes and structures to support speaking up and ensure that all staff members demonstrate the values and behaviours required to deliver this in practice.

At present we have five FTSU guardians in the Trust, with one vacancy. They are all volunteers and from a broad range of backgrounds. They perform their guardian role in conjunction with their primary employment, with protected time of 0.1 whole time equivalent (WTE) for their FTSU role. A 0.5 WTE guardian was recruited in 2019 to lead on the strategic direction for the Trust, freeing other guardians to focus on raising awareness and casework.

Responsibility for FTSU has moved from the people and organisational development directorate to the corporate governance team, part of the CEO's office. A non-executive director and the director of corporate governance & Trust secretary actively support the FTSU agenda, and the guardians have direct access to all of them.

FTSU is introduced at Trust induction and is included in the 'active bystander' training package.

A FTSU strategy was passed by the Trust Board in January 2020, giving direction to the service for this year. One aim is to deliver a more 'joined up' way of working across the Trust.

We also have a raising concerns policy, which details the different ways in which staff can speak up, including through their immediate management team (most concerns are resolved this way), HR, and our FTSU guardians. This is being reviewed at present to ensure it represents our current offer and best practice.

Rota gaps

We have 785 doctors in training working at the Trust, with 50 gaps on the rota. Twenty-five of these gaps have been filled by locally employed doctors. We have 14 unfilled posts, 11 of which are being recruited to. The remaining 11 are going through the approval to recruit process. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan targeted campaigns for hard to recruit specialties and the use of locums where necessary.

1.3 Reporting against core indicators

All acute trusts are required to report performance on a core set of eight quality indicators. An overview of the indicators is included below, with our performance reported alongside the national average and the performance of the best and worst performing trusts, where available. This data is included in line with reporting arrangements issued by NHS England.

Mortality

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates. We do this by using two measurement methods: SHMI (Summary Hospital-level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio). Both of these data sets allow us to understand our mortality rate when compared to our peers. However, the two measures differ slightly in methodology. SHMI measures all deaths that occur in England, including those that occur within 30-days of discharge from hospital and is the official mortality measure for England. HSMR measures more variables than SHMI, such as patients receiving palliative care, deprivation and whether the patient has been transferred between providers. We believe using both measures gives us the best picture of our mortality rate across our hospitals:

SHMI

	National performance 19/20*			Trust performance			
	Mean	**Best**	**Worst**	**2019/20***	**2018/19**	**2017/18**	**2016/17**
SHMI	100	69.09	119.57	69.09	73.21	74.13	75.54
Banding**	-	-	-	3	3	3	3
% deaths with palliative care coding	36.79%	N/A	N/A	57.86%	57.7%	56.7%	54.9%

*Most recent available data range 01 Dec 2018 to 30 Nov 2019; next update available 14 May
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital

HSMR

	Trust performance*		
	2017/18	**2018/19**	**2019/20**
HSMR	67.37	64.0	66.97
National performance	2nd lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers

*Dates cover January-December performance

Source: Dr. Foster

We believe the reasons for these results are as follows:

- It is drawn from nationally reported data
- We have reported a lower than expected SHMI ratio for the last three years.
- We have the lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (1 Nov 2018-31 Oct 2019).

- We have the lowest HSMR of all acute non-specialist providers across the last available year of data (66.97 from January – December 2019).

We intend to take the following actions to improve our SHMI rate, and so the quality of our services, by:

- Continuing to work to eliminate avoidable harm and improve outcomes.
- Reviewing every death which occurs in our Trust and implementing learning as a result, as described above in the 'Learning from Deaths' section.

Patient reported outcome measures (PROMs)

PROMs (patient reported outcome measures) measure quality from the patient perspective and seek to calculate the health gain experienced following surgery for hip replacement and knee replacement. Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. The Trust is responsible for ensuring completion of the first questionnaire (part A) pre-surgery. The number of pre-surgery forms sent to NHS Digital is compared to the number of surgical procedures performed at the Trust and it is this which provides the Trust's participation rate.

An external agency is responsible for sending patients the second questionnaire (part B) post-surgery. Analysis of any differences between the first and second questionnaires is used to calculate the overall health gain. If insufficient part B questionnaires are returned to the external agency, and in turn to NHS Digital who publish the results, they will not publish an organisation's health gain score.

The below table reports on patients who have had a hip replacement or knee replacement, where significant numbers of surveys were submitted. Hernia repair and varicose vein treatments outcome data is not included as they were removed as indicators but are still listed in the quality account guidance document from NHSE.

	National performance*			Trust performance		
	Mean	**Best**	**Worst**	**2018/19***	**2017/18**	**2016/17**
Hip replacement surgery (EQ-5D)	0.457	0.546	0.348	0.480	0.464	0.443
Knee replacement surgery (EQ-5D)	0.337	0.406	0.262	0.310	0.298	0.276

Source: NHS Digital
*2018/19 data is latest full year of data available

We believe that our performance reflects fact that:

- we have a process in place to collect, collate and calculate this information on a monthly basis, which is then sent to NHS Digital.
- data is compared to peers, highest and lowest performers, and our own previous performance.
- we are preforming above the mean for hip replacement surgery, and slightly below the mean for knee replacement surgery; however we have continued to improve our performance in this area year-on-year since 2016/17. We will continue to focus on improving our performance in these areas.

We intend to take the following actions to improve this percentage, and so the quality of our services:

- We now have a dedicated nurse in post to oversee the process and continue to put patient experience and improvement at the top of our quality agenda.

28 day readmissions

	National mean	2019/20*	2018/19	2017/18	2016/17
28-day readmission rate (Patients aged 0-15)	9.87%	4.72%	4.88%	4.92%	5.15%
28-day readmission rate (Patients aged 16+)	8.87%	7.43%	6.75%	6.92%	6.64%

*Last full year of data available (November 2018 – October 2019)

We believe our performance reflects that:

- We have a process in place for collating data on hospital admissions from which the readmission indicator is derived
- We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission.
- working to tackle long-standing pressures around demand, capacity and patient flow.

Patient experience

One way in which we measure patient experience is by collating the results of a selection of questions from the national inpatient survey focusing on the responsiveness to personal needs. Our performance, compared to peers as well as our previous performance, is listed in the table below.

	National performance 2018/19*			Trust performance				
	Mean	**Best**	**Worst**	**2018/19**	**2017/18**	**2016/17**	**2015/16**	**2014/15**
Score	67.2	85	58.9	65.2	68.8	67.3	67.6	68

*Latest data available from NHS Digital.

We believe our performance reflects that:

- we have systems and processes in place to collect this data
- we are performing slightly below the national mean drawn from the nationally reported data from the National Inpatient Survey, which was published in August 2019.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- Increasing the FFT response rate is one of our key priorities for this year
- Improving response rates will allow us to better understand the experiences of patients and to identify areas for improvement
- Better utilizing our Patient Led Assessments of the Care Environment (PLACE) data, including creating a formal action plan for 2020.

Staff recommendation to friends and family

The extent to which our staff would recommend the Trust as a place to be treated is another way to measure the standard of care we provide. Our performance, compared to our peers and our previous performance, is listed in the table below.

	National performance			Trust performance			
	Mean	**Best**	**Worst**	**2019/20**	**2018/19**	**2017/18**	**2016/17**
Percentage of staff who would recommend the provider to friends and family needing care	70.5%	87.4%	39.7%	75.8%	71.7%	73%	70%

We believe our performance reflects that:

- We utilise nationally reported and validated data from the national staff survey.
- Our results are slightly above average for acute trusts.

The 2019 staff survey saw our biggest ever response rate with 52 per cent (5659) of staff participating. This is over 2000 more responses than any previous survey we have run. Our overall engagement score increased from 7.0 to 7.2 which is above average and was the most improved engagement score in London. The score for all ten themes within the survey have improved since 2019.

The Trust launched its people strategy in 2019 where we introduced a number of significant initiatives to improve staff experience including:

- The launch of our Living our Values culture programme.
- Almost 3,000 staff involved in the development of the Trust's behavioural framework – designed by our people, for our people.
- People processes such as corporate welcome (induction) and PDR (appraisal) have been redesigned to support the Living our Values programme and the behavioural framework.
- Over 1,300 staff have experienced the Living our Values programme (which has at the core of it a one-hour workshop) with a commitment that all our #ImperialPeople will be touched by the programme by the end of the year.
- The launch of the active bystander programme (we are the first NHS trust to run this) which supports staff to challenge negative behaviours in the workplace.
- A reverse mentoring scheme for BAME nurses and midwives and the executive team.
- New staff networks launched including BAME, LGBT, Women's and disabilities.
- New leadership development programmes for junior doctors, consultants and general managers launched in 2019.
- Two major wellbeing initiatives launched; mental health first aid for managers and a fast track physio service.
- An impact maintenance fund where staff can apply for funding to improve the state of our estate.

In 2020/2021, we intend to take the following actions to improve this percentage, and so the quality of our services, by:

- Consolidating these initiatives, while continuing to pay attention to priority areas of the staff survey: bullying and harassment and health and wellbeing.
- Implementing a programme of pulse surveys to monitor staff experience and engagement in major Trust-wide initiatives or campaigns.

Patient recommendation to friends and family

The Friends and Family Test (FFT) is a key indicator of patient satisfaction which asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

We collect feedback through a range of different methods including text messaging; paper surveys; our website and our real time patient experience trackers. This system also means we can accurately track key protected characteristics (gender, age, ethnic group, religion and disability) and work to implement improvements based on any concerns that impact on one group more than another. We also have an "easy read" version of the survey.

A&E Friends and Family Test

	Trust performance			
	2019/20	**2018/19**	**2017/18**	**2016/17**
% would recommend	93%	94.26%	94%	95%

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We have actively monitored our performance throughout the year.
- We have almost met our target for the percentage who would recommend our A&E services (average 93 per cent) and met our target for the response rate of 15 per cent.
- We are better than the national average for our A&E response rates and similar for our likely to recommend score.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- Continuing to take steps to improve and ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed.
- Continuing to improve our environment with improvements made to our Charing Cross Hospital A&E services in the past year.
- Reviewing how we support patients to access food and drinks when waiting in our A&E departments by setting up a working group. We will focus in St Mary's Hospital A&E in the first instance.

Inpatient Friends and Family Test

	Trust Performance			
	2019/20	**2018/19**	**2017/18**	**2016/17**
% would recommend	97%	97.42%	97%	97%

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We have actively monitored our performance throughout the year.
- Our average inpatient FFT likely to recommend rate was 97 per cent, above our 94 per cent target and similar to last year's performance.

For patients reporting a positive experience, interaction with staff continues to be the most significant factor. We are continuing to build upon this relationship by actively encouraging staff to understand and act upon patient feedback.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- Continuing to improve our volunteering service building on the successful introduction of patient support volunteers (kindly sponsored by Imperial Health Charity).
- Continuing our improvement project called 'eat and drink, move and sleep' (MOVE) which was launched in 2018/19 in response to patients telling us that noise at night and the quality of our food is a problem. In response, we will implement a malnutrition screening tool in our patient electronic records and introducing 'sleep easy' boxes across 18 wards as part of the 'sleep' element of the project. Over the next year we will focus on implementing the 'Time to Eat' guidelines across the inpatient areas and have begum bespoke projects in areas such as paediatrics. We have seen improvements in patient activity with more patients sitting out of bed as part of the 'move' element of the work. This has also helped to promote the 'eat' element as we encourage patients to sit out for meals.
- Increasing deaf awareness by introducing the use of blue deaf awareness bands for patients and the use of deaf awareness cards. This project is driven by feedback from one of our patients who suggested the use of blue bands.
- Improving how we use patient experience data. Work is continuing to develop the natural language processing tool. This helps us to learn how to extract comments and themes from patient feedback so we can use this to continue to make improvements across our services.
- Our Learning Disability and Autism Policy has been updated and will be published in April 2020. We have incorporated our new learning disability 'purple pathways' that include learning from incidents to highlight the risk of aspiration pneumonia and constipation to staff.
- Working to improve care for young people moving from paediatric to adult services. We have introduced the HEADSS Risk Assessment tool (home; education, employment, eating and exercise; activities and peer relationships, social media; drug use, including prescribed medications cigarettes, alcohol and other drugs; sexuality and gender; Suicide and depression (including mood and possible psychiatric symptoms), spirituality and safety. This gives a structured approach to understanding young people's needs, enabling the clinical teams to provide appropriate support.
- We have held two adolescent transition clinics to date and expect to expand upon this next year. The clinics have been well-received by young people and their parents.
- The patient affairs and bereavement services have relocated to the nursing directorate. We are looking at how we can improve our end of life care across the Trust with the new end of life big room starting this year and an end of life nursing lead being developed.
- The Patient Experience Network (PEN) has been launched. This provides a forum whereby staff can meet to share best practice and ideas.

Venous thromboembolism

Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission.

	National performance*			Trust performance			
	Mean	Best	Worst	2019/20 *	2018/19	2017/18	2016/17
Percentage of patients risk assessed for VTE	95.47%	100%	71.83%	96.27%	95.39%	93.87%	95.33%

Source: NHS Improvement; 2019/20 includes only Q1-Q3; Q4 unavailable (published on 4 June).

We believe our performance reflects that:

- We utilise nationally reported and validated data published quarterly by NHS England.
- We have monitored VTE risk assessments on a monthly basis throughout the year. While we did not meet the 95 percent target during the first quarter, our improved performance across the second and third quarter contributed to an average compliance across the year of 96.27 per cent.

We intend to continue to work to improve this percentage, and so the quality of our services, by:

- Working with the areas that are below target to support staff to complete the assessment;
- Reviewing our compliance with national guidance and are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of root cause analysis into VTE cases.
- Continuing to take part in the Getting it Right the First Time (GIRFT) thrombosis survey.

Clostridium difficile

For 2019/20, Public Health England changed the surveillance definitions for *Clostridium difficile*. From April 2019, any cases of *C. difficile* within 48 hours of admission have been classed as hospital acquired (previously this was 72 hours). This means we are unable to compare our performance in 2019/20 with the previous year. It also means that our target for *C. difficile* was increased accordingly from 68 to 77.

	National performance			Trust performance			
	Mean	**Best**	**Worst**	**2019/20**	**2018/19**	**2017/18**	**2016/17**
Rate of *Clostridium difficile* per 100,000 bed days	48 cases	0 cases	147 cases	19.6 (72 cases)	14.3 (51 cases)	17.6 (63 cases)	18.03 (63 cases)

*National performance does not include March 2020

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting.
- In 2019/20, we reported 101 cases of *C. difficile* attributed to the Trust; 72 of these cases were hospital onset, and 29 were community onset. This is above our target of 77.1 of these cases were related to lapses in care, compared to 11 last year.

We intend to take the following actions to improve this percentage, and therefore the quality of our services:

- continuing to work on reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates (as described above).

Patient safety incidents

An important measure of an organisation's safety is its willingness to report incidents affecting patient safety, to learn from them and deliver improved care. A high reporting rate reflects a positive reporting culture.

	National performance*			Trust performance			
	Mean	**Best**	**Worst**	**2019/20**	**2018/19**	**2017/18**	**2016/17**
Patient safety incident reporting rate per 1,000 bed days	Apr-Sep 19: 49.8	Apr-Sep 19: 103.8	Apr-Sep 19: 26.3	Apr-Sep 19: 50.7 Oct 19 – March 20: 50.4	Apr-Sep 18: 50.4 Oct 18 – March 19: 45.8	Apr-Sep 17: 47.96 Oct 17 – March 18: 51.26	Apr – Sep 16: 42.3 Oct 16 – Mar 17; 46.82

*Latest data available from NRLS reports

We believe our performance reflects that:

- We utilise the nationally reported and verified data from the National Reporting and Learning System (NRLS).
- The data shows all incidents reported by us for the period April – September 2019: our incident reporting rate for this period was 50.7 against a median peer reporting rate of 49.8.
- Our individual incident reporting data is made available by the NRLS every six months, and we have performed slightly better than the national mean during both six-month reporting periods.

We intend to take the following actions to improve this percentage, and therefore the quality of our services, by:

- improving how we report, manage and learn from incidents. See further detail outlined in our 2020/21 improvement priorities.

Percentage of patient safety incidents reported that resulted in severe/major harm or extreme harm/death

We investigate all patient safety incidents, which are reported on our incident reporting system, Datix. Those graded at moderate harm and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be serious incidents or never events then undergo an investigation which involves root cause analysis (a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened).

	National performance			Trust performance			
	Mean	**Best**	**Worst**	**2019/20**	**2018/19**	**2017/18**	**2016/17**
Percentage of severe/ major	Apr-Sep 19: 0.23%	Apr-Sep 19: 0.00%	Apr-Sep 19: 1.22%	Apr-Sep 19: 0.03%	Apr-Sep 18: 0.05%	Apr – Sep 17: 0.06%	Apr – Sep 16: 0.08%

harm incidents ***(# of incidents)***	*(15)*	*(0)*	*(17)*	*(2)* Oct 19 – Mar 20: 0.04% *(3)*	*(4)* Oct 18 – Mar 19: 0.04% *(3)*	*(5)* Oct 17 – Mar 18: 0.12% *(9)*	*(6)* Oct 16 – Mar 17: 0.06% *(5)*
Percentage of extreme harm/death incidents ***(# of incidents)***	Apr-Sep 19: 0.08% *(5)*	Apr-Sep 19: 0.00% *(0)*	Apr-Sep 19: 0.7% *(24)*	Apr-Sep 19: 0.06% *(5)* Oct 19 – Mar 20: 0.06% *(5)*	Apr-Sep 18: 0.05% *(4)* Oct 18 – Mar 19: 0.01% *(1)*	Apr – Sep 17: 0.09% *(7)* Oct 17 – Mar 18: 0.05% *(4)*	Apr – Sep 16: 0.03% *(2)* Oct 16 – Mar 17: 0.12% *(9)*

*Latest data available from NRLS reports:

We believe our performance reflects that:

- We utilise nationally reported and verified data from the NRLS
- Between April and September 2019 (most recent national data available), we reported 0.03 per cent severe/major harm incidents (two incidents) compared to a national average of 0.23 per cent and 0.06 per cent extreme/death incidents (5 incidents) compared to a national average of 0.08 per cent.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- continuing to work to eliminate avoidable harm and improve outcomes. See "Our 2020/21 Improvement Priorities" section for more detail.

Part 2: Other information and annexes

This section of the report provides further information on the quality of care we offer, based on our performance against the NHS Improvement Single Oversight Framework indicators, national targets, regulatory requirements, and other metrics we've selected.

Our performance with NHS Improvement single oversight framework indicators

NHS Improvement uses a number of national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues. We report on most of these monthly to our Trust Board through our integrated quality and performance report (IQPR).

Key performance indicators

As anticipated, performance against the operational standards has been impacted as a result of COVID-19. Patients are being tracked and managed according to clinical priority and a harm review process in place. All safe options for treating patients are being reinstated as part of recovery planning.

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	82.01 %	85.45%	83.67%	80.4%	77.74%
Diagnostics	Maximum six week wait for diagnostic procedures	1%	1.53%	0.88%	0.81%	1.17%	3.27%
Cancer access initial treatments	Two week wait	93%	89.0%	91.97%	84.40%	90.13%	89.85%
Cancer access initial treatments	Breast symptom two week wait	93%	93.6%	93.83%	94.80%	94.37%	90.5%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	85.8%	88.7%	86.83%	86.73%	78.05%
Cancer access initial treatments	% patients treated within 62 days from screening referral	90%	78.8%	81.47%	81.07%	79.87%	69.8%
Cancer access initial treatments	% patients treated within 62 days (upgrade standard)	85%	84.5%	87.20%	87.67%	82.13%	79.4%
Cancer access	% patients treated within	96%	97.1%	97.67%	97.17%	96.97%	96.55%

initial treatments	31 days of decision to treat						
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	96.9%	97.69%	97.90%	95.70%	95.9%
Cancer access subsequent treatments	Chemotherapy treatments within 31 days	98%	99.9%	100%	99.60%	100%	100%
Cancer access subsequent treatments	Radiotherapy treatments within 31 days	94%	97.9%	97.17%	100%	96.77%	97.6%
Infection control	C. difficile acquisitions	77	101	25	28	27	21

In May 2019, the Trust began testing proposed new A&E standards as one of 14 hospital trusts in England. Like other trusts involved in the testing, figures on the A&E four-hour access will not be published for the pilot period and are therefore not included above.

Our performance in other key areas

In addition to our core 2019/20 improvement priorities described above, we have made progress in a number of other quality areas and initiatives. We have included this information as it represents a broad spectrum of our quality activity across various parts of our organisation; the below include patient led initiatives such as PLACE, as well as developments in our clinical services and our on-going clinical information technology programme.

Pressure ulcers

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue. They are caused when the skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We reported twenty one category three and un-stageable Trust acquired pressure ulcers in 2019/20, which is one less than last year. We have not reported a Trust acquired category four, the most serious of pressure ulcers, since March 2014. We have nominated skin champions in each of our clinical areas and we run quarterly study days for our staff in the prevention of pressure ulcers and wound care.

PLACE

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE began in 2013 as an annual patient-led initiative to monitor and score the environment based on six criteria. The assessments provide a clear message, from patients, about how the environment or services might be enhanced. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are carrying out their roles.

In 2019, we introduced a number of changes to PLACE, including: changing when we complete the assessment to later in the year; the questions asked; and the scoring/weighting mechanisms. As such, results are not directly comparable with previous years.

This year's assessment still contained the six areas listed below, and the Trust performance is summarised against each:

- Cleanliness – all hospitals scored above national average.
- Food and hydration – Trust scored above average, with only one site slightly below.
- Privacy, dignity and wellbeing – each hospital was below average, as a Trust <three per cent below national average score.
- Condition, appearance and maintenance – all scores were above national average.
- Dementia – all sites scored above national average.
- Disability – Trust scored above average, with only one site slightly below.

It is difficult to compare to last years' standings due to changes in the PLACE system in 2019. However, advances in wayfinding and a steady improvement programme, including small impact works, have contributed to a generally good picture. The PLACE Steering Group is now taking this work forward with a formal action plan for the 2020 round of assessments.

Genomic medicine service

The NHS genomic medicine service went live in April 2020 and is available as a routine test, in the right circumstances, to our patients. The service includes single gene testing, whole genome sequencing (WGS), gene sequencing and personalised treatment plans and has the potential to change the way we deliver health care by providing consistent and equitable care to patients. As a new service we will operate to common national standards, specifications and protocols using a single national testing directory and building up a national genomic knowledge base to inform academic and industry research to help new drug discovery. Consolidating existing services such as lab testing, genetics and multi-disciplinary meetings and improving access to these tests will continue to transform how the NHS will diagnose, treat and care for patients.

'Streams' results viewing

We have partnered with Google Health to implement Streams, an app which allows Imperial clinicians to view patient's blood results, radiology results and observation

data securely on their own mobile device. This will allow better access to key clinical data at the bedside or while on-call and should reduce time taken to take clinical decisions should a patient's condition change. Implementation across the Trust will continue in 2020.

App developments for 2020/21 include displaying deteriorating patient flags (National Early Warning Score, acute kidney injury and sepsis) and clinical documentation. The partnership will also explore the practical implementation of A.I. and machine learning into clinical services, such as breast screening.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

The following organisations were invited to provide statement on our quality account:

North West London Collaboration of Clinical Commissioning Groups
NHS Brent CCG
NHS Central London CCG
NHS Ealing CCG
NHS Hillingdon CCG
NHS Harrow CCG
NHS Hounslow CCG

Central and West London Healthwatch
Brent Healthwatch
Ealing Healthwatch
Barnet Healthwatch
Hounslow Healthwatch
Hillingdon Healthwatch

City of Westminster
London Borough of Hammersmith and Fulham
London Borough of Ealing
London Borough of Brent
Royal Borough of Kensington and Chelsea
London Borough of Harrow
London Borough of Hillingdon
London Borough of Hounslow

Due to the COVID-19 pandemic the draft quality account was shared with stakeholders electronically and staff from the Trust were not available to attend meetings or overview and scrutiny committees to answer questions in person. Stakeholders were invited to share any questions via email with a named individual from the Trust. The Trust received the following written responses:

Hammersmith and Fulham response Health and Social Care Policy and Accountability Committee response to Imperial Health Care Trust Quality Account 2019-2020

1 Introduction

1.1 We thank Professor Tim Orchard and his staff for their continuing dedication and compassion, performing so well during the COVID crisis and send our condolences for those Trust staff who have died. This has been an unprecedented time and the Trust's staff at all levels have shown great leadership and commitment to supporting local people and engaging with partners. We are impressed by much in the report especially:

- Those areas where the Trust is performing above average against national indicators [paediatrics, cardiac care];

- The achievement of good outcomes on all the services audited by CQC this year; and
- the achievement of outstanding ratings in the recent CQC audits.

1.2 There are also several areas that we have highlighted which we believe would benefit from further attention and some that we would like to review as part of HISPAC's work next year

2 Improvement Methodology

2.1 The Improvement Team

The Trust has a dedicated quality and improvement team, implementing Institute for Health Care Improvement methodologies. A new Imperial Management and Improvement System has identified this year's priorities. There is a significant culture change programme in place, that should itself be a focus, as it provides impetus for a Trust wide organisational change

2.2 Benchmarking

We expect Imperial to be a leader in this area and the significant investment in quality improvement reflects this. It would be useful to benchmark the team itself against best practice elsewhere, including the level of resourcing.

2.3 Programmes

The report summarises several innovative improvement initiatives. Going forward the scope and effectiveness of the such key programmes as the Living our Values, the Imperial Flow Coaching Academy, Improving Care Programme Group as well as more targeted initiatives such as HOTT (Helping Our Teams Transform), the Falls Bundle, Connecting Care for Children, Connecting Care for Adults, would all benefit from being highlighted in detail.

2.4 Reporting
A clearer view of the overall work programme and its objectives would be more effective. An understanding and evaluation of results is integral to informing the Trust's culture change programme.

Overall a different form of reporting is required. Whilst we appreciate that the Quality Account is written according to a specific remit and is meant to be a summary, we feel that its format could be improved for next year to be more user friendly. Suggestions would be to allow greater consistency year on year with the format of the tables to enable clearer comparisons, extended timelines for the Committee to provide input, and clarification about protected data.

3 This year's programmes

3.1 COVID-19 impact

Clearly the Trust's attention has been focused on the COVID-19 crisis and it has made a massive commitment to manage the new situation. Going forward it will impact on Trust performance at every level and it may be worth revisiting the improvement targets and consider adjustments.

Potential refinement of several key areas will need to be addressed

• Treatment backlog

The backlog of planned non-COVID 19 treatment is likely to put pressure on the system as it attempts to return to normality. It would be helpful if plans could be shared when they are available [see also below].

• Staff exhaustion

Staff have worked remarkably hard, under enormous pressure facing a serious and uncompromising threat to their own health and that of their families, friends and neighbours. When the pandemic finally retreats, staff who may already be physically and nervously exhausted, will face an enormous deferred treatment backlog. The trust will need to develop a support programme for very tired staff.

• Learning from the crisis

Assessing lessons learned will need a critical view point to distinguish improvements that can be mainstreamed, for example, a significant improvement in collaborative working and faster decision making, from improvements that are the product of significant extra resources combined with a significant reduction in demand.

3.2 Patient engagement involvement

the Trust as well as the Local Authority are developing their engagement with the public to improve services. The engagement with patients is visible across the Quality Audit but should also be highlighted in its own right. In addition, there has been an upsurge of volunteering across the public sector which represents a unique opportunity for a step change in public engagement and co-production.

3.3 Improvement Priorities for 2020/2021

• COVID-19 impact

Clearly the Trust's attention has been focused on the COVID-19 crisis and it has made a massive commitment to manage the new situation.

Across the board targets will be impacted by COVID 19 which will distort staff and patient responses, and impact on activity at all levels.

There will be a need to review the improvement targets altogether

• Five Improvement Targets

. The current five key improvement targets have the advantage of addressing areas that staff across the trust can contribute to. Family and friends' response rates; rates for staff feeling able to make improvements and improved incident reporting rates are enablers for change; reducing agency costs is a key staffing measure. Patients waiting over 21 days is an index of flow effectiveness, and therefore of partnership working

Flow issues have received a lot of attention within the COVID guidance and there will be a significant opportunity for stakeholders across the system to contribute to improved performance

• Older people

This is not an area addressed in the report. Covid-19 has demonstrated the particular vulnerability of older people to such epidemics which may recur.
We would appreciate some detail on the performance of older people's services in the Trust, and in particular a discussion about possibilities for deeper planning for this age cohort. We note, for example, that delays to hip and knee replacement continues to be a concern. These conditions disproportionally effect older people and delays may have serious consequences for that group's ability to participate in the life of their community, undertake caring commitments, result in increased social isolation and the risk of further deterioration. A designated action plan is required, and the Committee would welcome further engagement in developing this. Its production presents major opportunities for public engagement and co-production.

• Capital programmes and use of resources

Use of resources is now one of the CQC priorities and made the difference in the Trust being able to achieve a Good rating overall. The physical environment also impacts significantly on patient and staff's assessment of the service, both in A&E

and in the hospital overall and is a particular quality issue for Imperial given its significant maintenance backlog, which should also be focused on going forward. Given the significant backlog repairs and modernisation work the Committee would like the Trust to share an action plan which addresses the impact of the physical infrastructure limitations and how this would affect the CQC rating.

4 **Progress against last year's priorities**

4.1 Reduce avoidable harm

In general, there has been considerable work against last year's priorities, but a number of areas suggest that further follow up work may be required, and we would like to highlight the following:

It would be helpful to have areas where incidents have occurred tabulated to clearly emphasise their relative significance. Improvements are not quantified in several areas [safer medicines, deteriorating patient mental health in ED patient, fetal monitoring]. It would perhaps be helpful to have a dashboard against this priority.

Particular issues are:

• Incident reporting
The Trust reports that incident reporting rates are below national average, and this remains a priority in 2020/2021. It would be helpful to have better tabulation of the causes of reported incidents going forward.

• Improving hand hygiene
Compliance has increased but this is in one of the areas that we would expect to improve radically following COVID-19 requirements.

• Reducing falls with harm
This is a key programme that would benefit from further highlighting particularly on the scope objectives and effectiveness of the new Falls Bundle

• Responding to the deteriorating patients with mental health problems in the emergency department
This pathway continues to face challenges, and this is an area of concern which suggests that further work with the mental health trust, local authority and commissioners to manage flow outside the hospital is required. This would be a useful area for the Committee to scrutinise.

On page 6, the target "reduce harm to patients" mentions "treatment delay (availability of downstream mental health beds)." This needs considerably more detail given the importance of mental health in our community which leads the Committee to ask the following questions:

1. What are the numbers of patients affected or involved?
2. Does the lack of beds mean that beds were simply not available locally or across London? This is important as there is much evidence of patients being sent to beds far from their families and communities.
3. Is the lack of suitably the qualified mental health staff a factor?

4. Do we have detail on the social background, age groups and gender of the affected patients?
5. What liaison is there on this matter (Q4) with local authorities?
6. Most important, if this situation is not "one off" what mitigations are planned for what may be an ongoing situation.
7. The Committee would like to know what work the Trust is doing on this area with local mental health trusts (West London Mental Health Trust).

It is encouraging to hear that the Flow coaching academy is focusing on mental health including in ED and this may provide the opportunity to address this in more detail.

4.2 Reducing unwarranted variation

This is a significant area of work with 50 flow coaches supporting 20 clinical pathways of which four are highlighted. A consistent measure of variation is not used. It would be helpful to have a dashboard to get an understanding of the overall programme and an assessment of its effectiveness. 4.3 Improving access to services across the Trust through a focus on increasing capacity and improving emergency flow.

London Borough of Brent Community and Wellbeing Scrutiny Committee's response to the draft Quality Accounts for 2019/20

Imperial College Healthcare Trust: Quality Accounts 2019/2020

The scrutiny committee again welcomes the publishing of the Trust's Quality Accounts because of the transparency and public accountability they provide. Overall, the Accounts have helped the committee to understand the Trust's focus on quality improvement in 2019/2020 and the Trust's ambitions to deliver better outcomes for its patients in the year ahead.

The Quality Accounts clearly set out the six areas for improvement in the next year. However, it is not clear why reducing temporary staffing spend is one of the priorities and we would have liked for the relationship between temporary staffing and improvements in quality to have been more clearly set out. In addition, the table setting out the six areas does not identify clear metrics for improvement, which would help us to better understand the scale of your ambitions for the next year. For example, while we welcome the inclusion of the Family and Friends Test it could be made clearer what target for progress metrics you aspire to in 2020/2021; and how performance will be monitored by the Board. It would also be useful to have benchmarking on such a measure, against other comparable Trusts or national statistical averages.

We also welcome that the Trust has identified a key priority for improvement as the percentage of staff who feel they are able to make improvements in their area. Engaging with the views of staff is very important and helps to deliver high-quality care. It is also right for the Trust to emphasise values and behaviours and for the Trust to promote these values at all levels of the organisation. The Quality Accounts

make it clear that the leadership and the Board are committed to an open organisational culture in which staff feel they can raise concerns and we note the commitment to the Freedom to Speak Up initiative and a Raising Concerns policy. However, the scrutiny committee would have liked to have seen more evidence of how these initiatives and policies have led to learning and quality improvements in the last year, by citing examples.

Views of the Care Quality Commission as the regulator of the Trust are very important. The Quality Accounts consider that last year there was the publication of the outcome of three CQC surveys of patients: Adult Inpatient Survey, Urgent and Emergency Care Survey, and the Children and Young People Survey. However, while it's a good practice that areas of dissatisfaction or negative experiences are recorded; they are not described in great detail, and it's not clear from the Accounts how these will be areas for improvement or what improvements were made in these areas. The Quality Accounts identify the results of four inspections and highlight where it has been rated Good, but it would also be useful for the purpose of the Quality Accounts to focus on the areas which were identified as Requires Improvement, and how this will be taken forward next year.

Over the eight core quality indicators it is very welcome that the Quality Accounts have applied the rigour of stating the Trust's performance over a period of time, and also giving the benchmarking information of national averages, using averages from the best to the worst, using data where it is available. We can clearly see how the Trust ranks against others, and how performance has changed over time across these important indicators, or in other words 'the direction of travel'. It is also clear from the Quality Accounts how the Trust intends to improve on its targets in the next year and what actions it will put in place – and it is a good practice that these are clearly listed under each of the core indicators.

More generally, the committee welcomes the Trust's commitment to using high-calibre data. It is not enough to say that an organisation is committed to data quality in principle. The committee appreciates that the Quality Accounts set out how the Board and leadership have sought assurance that the data they work with is robust and fit for purpose through the Data Quality Improvement Programme (DQIP), and reporting of any improvements or areas of concern to the Audit, Risk and Governance Committee.

Last year a priority for improvement in the Quality Accounts was to improve compliance with the equality and diversity standards, and metrics were set out. We would expect all healthcare Trusts to be committed to reducing inequalities in access to care and outcomes of care. This is especially so for the Trust's patients who live in the London Borough of Brent which has one of the most diverse populations in London and one of the highest percentages of Black and Minority Ethnic (BAME) groups of any London borough.
Increasingly, many of these communities are experiencing widening health inequalities, and early evidence suggests this has been a factor in the Covid-19 pandemic. The Quality Accounts for 2019/20 do make reference to Covid-19 throughout the document and the committee would like to see how this area of inequalities and BAME populations will be taken forward in the next year in more detail.

Finally, the scrutiny committee would like to thank formally all the staff at Imperial College Healthcare Trust for the care they have provided to many people in the London Borough of Brent in the last year and especially in their response to the Covid-19 pandemic which has placed great pressures on staff and healthcare services at the Trust.

Cllr Ketan Sheth, Chair
Brent Council Community and Wellbeing Scrutiny Committee

Response from the Westminster Adult's and Children's Services Policy and Scrutiny Committee

Introduction
The Westminster Adult's and Children's Services Policy and Scrutiny Committee welcomes the opportunity to comment on the Imperial College Healthcare NHS Trust Quality Account 2019/20.

Quality progress 2019/20
We are pleased to see progress in reducing avoidable harm to patients. We note that the Trust incident reporting rate is above the national average. We welcome its continued commitment to identifying barriers to reporting and promoting a supportive reporting culture. This was also an area of success for the Trust in 2018/19, and we commend the continued focus in this area.

We note that there have been 266 serious incidents, with the highest category being the result of treatment delay due to availability of downstream mental health beds. While we are pleased that the percentage of moderate and above incidents is below the national average, we encourage the Trust to continue to review and learn from its serious incidents, particularly those resulting from treatment delay, to help reduce the numbers in future.

Improving care for patients with mental health problems in the Emergency Department was a focus for the Trust during 2019/20. We note that the Trust continues to face challenges with the timely transfer of these patients to more appropriate settings. We are pleased the Trust is committed to working collaboratively with colleagues in mental health services to improve in this area and we hope that this work leads to a more responsive service.

We are pleased that significant progress was made in 2019/20 towards improving hand hygiene, especially as this will continue to be an important area of focus during the COVID-19 pandemic. This was also an area of improvement in 2018/19 and we commend the Trust for maintaining improvements in this area.

The Imperial Flow Coaching Academy was established to reduce unwarranted variation and promote best practice. We are pleased about the improvements this has led to across different clinical pathways; for example, in the Sepsis Pathway a 24% reduction in mortality and a 7% reduction in length of stay.

Improving access to patients waiting for elective surgery was an area of focus for the Trust in 2019/20. We acknowledge that the COVID-19 pandemic has affected the size of waiting lists due to all non-urgent elective inpatient procedures being stood down in March 2020. We are pleased to see that in Q3 the Trust overperformed against the RTT target agreed with commissioners. However, we do note that the Trust did not meet its percentage target and encourage continued investigation of this at a specialty level.

Standards set by NHS England state that no patient should wait more than 52-weeks for their treatment to start following referral. We are concerned that in Q3 there was a rise in 52 week waiting patients, with 14 patients being reported in the period.

We are concerned that the Trust's staff survey results indicate that more needs to be done to improve equality and diversity. We encourage the Trust to continue to do work in this area and to ensure that staff at all levels are engaged with about this.

In 2018/19 the previous committee noted the Trust had not achieved its 4 hour wait target for A&E. We note that in 2019 the Trust was one of 14 hospitals to test new A&E standards. We will be interested to see the results of this test.

We were pleased to see that the Trust's quality ratings from the CQC have improved for a range of services inspected across its hospitals in February 2019.

Priorities for 2020/21

We note that for 2020/21 a new model (The Imperial Way Model) has been established to drive the delivery of strategic goals and objectives set out in the Trust's wider strategy. We are pleased to see this new approach includes engagement with staff at all levels. The model has identified six priority areas for improvement. However, since these priorities were identified, the Trust's primary focus has moved to responding to the COVID-19 pandemic. While the COVID-19 response is now the Trust's central focus it is still important that the Trust continues to look for ways to drive improvements in its service and that it keeps patient safety and quality service at the centre of its decisions.

Conclusion

Overall, the progress that the Trust has made over the last year is welcomed. We appreciate the Trust's collaborative approach towards engaging with the committee, in particular the regular meetings between Committee Chair and the Chief Executive to keep abreast of issues that are affecting the Trust. We hope to continue to work closely with the Trust in 2020/21. Lastly, we want to offer our sincere thanks and appreciation to the Trust and its staff for their continued work as part of the COVID-19 response.

Councillor Iain Bott
Chairman Adult's and Children's Services Policy and Scrutiny Committee.

Annex 2: Statement of directors' responsibilities for the 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 has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. While we are not an NHS foundation trust in line with guidance from NHS Improvement we are following the NHS foundation trust regulations in relation to quality accounts.

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 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from Clinical Commissioning Groups
  - the annual governance statement May 2020
  - feedback from local Healthwatch and local authority overview and scrutiny committees
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the national inpatient survey 2019
  - the national staff survey 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment May 2020
  - CQC inspection report dated July 2019
  - The General Medical Council's National Training Survey 2019;
  - Mortality rates provided by external agencies (NHS Digital and Dr Foster).

- the quality report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's

annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our Audit, Risk and Governance Committee held in May 2020, where the authority of signing the final quality accounts document was delegated to the chief executive officer.

By order of the board

Professor Tim Orchard

Chief executive officer

Accountability report

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

- The corporate governance report explains how the composition and organisation of the Trust's governance structures, developed in line with good governance standards, support the Trust's objectives, and provide assurance that the Trust's risks are appropriately identified and managed.

- The remuneration and staff report sets out the Trust's remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce.

- The Trust's external auditor also provides a report on the audit of the financial statements.

Corporate governance report

Director's report

The Trust board and its committees

The Trust board is accountable, through the chair, to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board as of 31 March 2020 consisted of the chair, five non-executive directors, the chief executive officer, the medical director, the director of nursing, and the chief financial officer, as outlined below. In addition, we have two additional non-voting non-executive directors who provide additional expertise to the board.

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

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

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

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

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

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

During the year, there have been some changes to Board members:

- Victoria Russell stepped down as non-executive director from 30 June 2019, upon completion of her term of office. This role remained vacant from 1 July to 31 August 2019.
- Kay Boycott joined the Trust as non-executive director on 1 September 2019.
- Nicola Horlick joined the Trust as non-executive director for a brief period from 1 to 24 September 2019, before she stepped down to take up political interests.
- Dr Mahiben (Ben) Maruthappu joined the Trust as associate non-executive director on 1 September 2019.
- Dr Andreas Raffel's term of office extended to 31 December 2021.
- Sir Gerald Acher's term of office extended to 30 November 2020.
- Richard Alexander transferred his chief financial officer responsibilities to Jasbir Kaur (Jazz) Thind as the interim chief financial officer on 6 January 2020.

The Trust board as of 31 March 2020 was as follows:

Paula Vennells	Trust chair
Sir Gerald Acher	Vice chair
Professor Andrew Bush	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Kay Boycott	Non-executive director
Nick Ross	Designate non-executive director
Dr Ben Maruthappu	Associate non-executive director
Professor Tim Orchard	Chief executive officer
Professor Julian Redhead	Medical director
Professor Janice Sigsworth	Director of nursing
Jazz Thind	Chief financial officer (interim)

There was one vacant non-executive position and one vacant executive position on the board as at 31 March 2020.

Attendance at Trust board meetings: 1 April 2019 to 31 March 2020

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

Member	**Attendance (actual/possible)**
Non-executive directors	
Paula Vennells, Trust chair	7/7
Sir Gerald Acher, vice chair	7/7
Professor Andrew Bush, non-executive director	3/7
Peter Goldsbrough, non-executive director	7/7
Dr Andreas Raffel, non-executive director	7/7
Victoria Russell, non-executive director (to 30 June 2019)	2/2

Kay Boycott (from 1 September 2019)	4/4
Nicola Horlick (from 1 to 24 September 2019)	0/0
Nick Ross, designate non-executive director	5/7
Dr Ben Maruthappu, associate non-executive director (from 1 September 2019)	3/4
Executive directors	
Professor Tim Orchard, chief executive	7/7
Professor Julian Redhead, as medical director	7/7
Richard Alexander, chief financial officer (until 5 January 2020)	4/5
Jazz Thind, chief financial officer (from 6 January 2020)	2/2
Professor Janice Sigsworth, director of nursing	6/7

* Changes to the board membership are outlined above

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

Audit, risk and governance committee

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

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

The committee met four times in regular session during the reporting period, and also held two meetings to review the annual accounts and related issues only.

Member	Attendance (actual/possible)
Sir Gerald Acher, non-executive director (chair)	6/6
Professor Andrew Bush, non-executive director	1/6
Kay Boycott, non-executive director (from 1 September 2019)	3/3
Dr Andreas Raffel, non-executive director	4/6
Professor Tim Orchard, chief executive officer	5/6
Professor Julian Redhead, medical director	6/6
Richard Alexander, chief financial officer (until 5 January 2020)	2/5
Jazz Thind, interim chief financial officer (from 6 January 2020)	0/1
Professor Janice Sigsworth, director of nursing	6/6

Deloitte LLP acted as the Trust's external auditors in 2019/20, having been appointed in April 2017 for an initial three-year period. Pricewaterhouse Coopers LLP (PwC) continued as the Trust's internal auditors, having been appointed for an initial period of three years from April 2018.

During 2019/20 the committee has retained oversight of the key financial, operational and strategic risks facing the Trust through review, and ongoing development, of the board assurance framework (to gain on-going assurance of risk and internal control processes), the corporate risk register, and through internal sources of validation and triangulation with the quality committee and finance, investment and operations committee.

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

The corporate risk register is also reviewed regularly, together with themes from key divisional risk registers and the key divisional risks profile. These give the committee visibility of the overall Trust risk exposure and how effectively risks are managed at the Trust. The committee has undertaken several in-depth reviews where specific risks were identified. These included cyber security, and data quality, North West London Pathology, hotel services and non-emergency patient transport. It also included an initial review of the management of the emerging risks around COVID-19 at its meeting in March 2020.

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

Quality committee

The quality committee is responsible for seeking and securing assurance that the Trust's services are delivering, to patients, carers and commissioners, the high levels of quality performance expected of them by the Trust board. It also seeks assurance

in relation to patient and staff experience, and health and safety; performance is monitored in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the Care Quality Commission, and ensures that there is a clear compliance framework against these.

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

Member	Attendance (actual/possible)
Professor Andrew Bush, non-executive director (chair)	5/6
Sir Gerald Acher, deputy chair	6/6
Victoria Russell, non-executive director (to 30 June 2019)	1/1
Kay Boycott, non-executive director (from 1 September 2019)	3/4
Ben Maruthappu, associate non-executive director (from 1 September 2019)	2/4
Professor Tim Orchard, chief executive officer	5/6
Professor Julian Redhead, medical director	5/6
Professor Janice Sigsworth, director of nursing	5/6

Regular discussions included review of divisional quality risks, the Trust's quality and performance report, the infection prevention and control report, serious incident monitoring report, claims and complaint data, the health and safety report and progress updates on the improvement workstreams across the Trust. The committee also received regular reports on actions and processes relating to Care Quality Commission (CQC) compliance, including the results of both the Trust self-assessment process which seeks to support continual improvement and outcomes from CQC inspections.

The committee undertook several in-depth reviews in areas of potential quality concern, including the number of never events declared during the year. Close attention was also paid to the progress in improving the staff influenza immunisation rates. The committee considers findings versus recommendations from external quality reviews and oversees the Trust's response. This has included review of the Trust's response and self-assessment against the Gosport inquiry report and monitoring until all actions had been completed.

The committee receives and considers a range of assurances regarding quality of services, including findings from the national cancer patient experience survey, outcomes of the ward accreditation programme, as well as various patient and staff survey results, including the friends and family test (FFT), General Medical Council national training survey, adult inpatients and NHS staff survey. The committee also receive assurance reports on the nursing and establishment review to ensure safe, sustainable and productive nursing and midwifery staffing levels.

Finance, investment and operations committee

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

2019, the committee expanded its remit to include operational performance and transformation. The purpose of this change was to bring as sharp a focus on our operations and transformation activities as we have on finance; to monitor progress, add support and understand risks and opportunities in these areas which are so important in achieving our strategic goals.

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

Member	Attendance (actual/possible)
Dr Andreas Raffel, non-executive director (chair)	6/6
Peter Goldsbrough, non-executive director	4/6
Victoria Russell, non-executive director (to 30 June 2019)	0/1
Dr Ben Maruthappu, associate non-executive director (from 1 September 2019)	1/4
Professor Tim Orchard, chief executive officer	6/6
Richard Alexander, chief financial officer (up to 5 January 2020)	2/4
Jazz Thind, interim chief financial officer (from 6 January 2020)	2/2

The committee regularly considered reports in relation to the Trust's performance against agreed corporate and divisional budgets, cost improvement plans, and the capital programme. The committee reviewed and agreed the financial recovery plan before submission to NHS Improvement. Discussing COVID-19 at the end of the year, committee members considered the financial risks arising from the pandemic.

The committee received assurance on the progress of the transformation plan which focuses on larger-scale and longer-term change programmes to deliver our strategic goals, including financial sustainability. These updates included progress updates on the specialty review programme and the approach for the development of the Trust's winter plan.

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

The committee reconsidered summaries of business cases approved by the executive during the year. It also reviewed and commended for Trust board approval business cases for major investment, including the business case to bring hotel services in house and the strategic imaging asset management business case.

Redevelopment committee

The committee was suspended at the start of the year due to a pause in the redevelopment programme but re-established in October 2019 in the form of a programme board, when activity around redevelopment resumed, and chaired by the Trust chair. In March 2020 alongside the programme board, a board redevelopment committee was established as a decision-making committee of the board. The programme board and board committee oversee all aspects of the redevelopment

programme, including achievement of workstream milestones and deliverables, and risks associated with the overall programme and support to any commercial negotiations or procurement processes required for redevelopment.

The programme board met four times, and the board committee met once in the reporting period:

Member	Programme board attendance (actual/possible)	Board committee attendance (actual/possible)
Paula Vennells, Trust chair and committee chair	4/4	1/1
Peter Goldsbrough, non-executive director	2/4	0/1
Nick Ross, designate non-executive director	4/4	1/1
Professor Tim Orchard, chief executive officer	4/4	1/1
Professor Julian Redhead, medical director	2/4	0/1
Richard Alexander, chief financial officer (until 5 January 2020)	1/2	0/0
Jazz Thind, interim chief financial officer (from 6 January 2020)	2/2	1/1
Professor Janice Sigsworth, director of nursing	3/4	0/1
Matthew Tulley, director of redevelopment (from 3 February 2020)	1/1	1/1

The programme board received progress updates from the programme director at each of its meetings followed by updates from the workstream leads for finance, estates and regulatory; communications and engagement; and clinical academy strategy. It received updates on key risks and the wider strategic plan. It noted the 'look back exercise' of work undertaken prior to re-establishing the programme board and considered next steps following a bespoke Trust board seminar regarding redevelopment.

It considered and recommended to the board, a period of exclusivity agreement with the developer for the programme. The committee also noted the private patients ambitions and implications for the redevelopment programme. The January and March 2020 meetings discussed the development of the outline business case for redevelopment of St Mary's Hospital.

Remuneration and appointments committee

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

The committee met four times during the reporting period:

Member	Attendance (actual/possible)
Peter Goldsbrough, non-executive director and committee chair	4/4
Paula Vennells, Trust chair	4/4
Nick Ross, designate non-executive director (member from September 2019)	2/2
Professor Tim Orchard, chief executive officer	4/4
Kevin Croft, director of people and development	4/4

Discussions included chief executive and executive performance reviews including objectives, the process and pay review for very senior managers, changes within the senior management level of the finance function, and impact of NHS pensions lifetime allowances.

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

The committee met five times during the reporting period. The Trust has been represented at each meeting by the medicine and integrated care divisional director along with other colleagues:

Member	Attendance (actual/possible)
Dr Frances Bowen, divisional director	4/5

During 2019/20, the integrated care partnership consolidated and strengthened its workstreams to focus on the delivery of three new models of care: compassionate communities, the acceleration of Primary Care Network integration and the development of integrated community teams.

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

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

identified in relation to matters to be discussed by committees or Trust board, these are recorded and the individual excluded from the discussion.

In addition, the Trust seeks annual declarations from all staff graded band 8a and above. Returns for 1971 staff, approaching 79 per cent, had been returned at the end of March 2020. The Trust publishes on its website a list of those staff considered to hold clear decision-making roles; of these 152 staff, 86 per cent had declared at the end of March 2020.

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

Professor Tim Orchard

Chief executive officer

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

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

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

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

Signed.....**Chief executive officer**

Date 22 JUN 2020

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Trust board

22 Jun 2020 **Date** ..... **Chief executive officer**

22 June 2020 **Date** ..... **Chief financial officer**

Annual governance statement

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

The structure for the Trust's annual governance statement for 2019/20 follows the format required by NHS England and NHS Improvement.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Imperial College Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Imperial College Healthcare NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

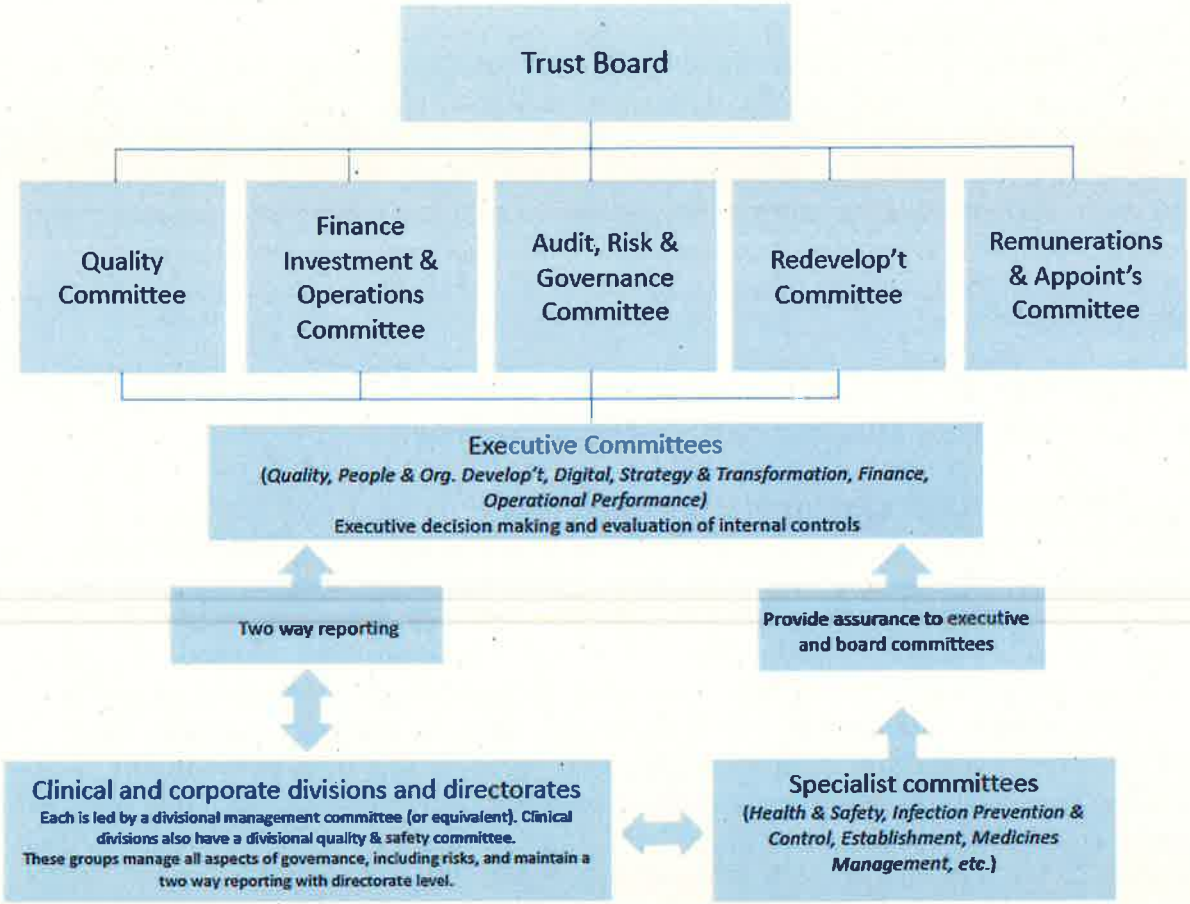
Capacity to handle risk
Risk is managed at all levels in the organisation, from ward to board. Given the size and complexity of Imperial College Healthcare NHS Trust, there are three main level of leadership in risk management: directorate, divisional and corporate. These mirror the Trust organisational structure and risks are escalated to the next management level based on the impact they can have and the capacity to manage them.

Risk management training is available via e-learning to all managers across the organisation, while ad hoc workshops are organised with divisional and corporate management teams.

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

The Risk and control framework
The Trust has a systematic framework for internal control, ensuring effective reporting and escalation mechanisms. This includes divisional management and divisional quality groups, as well as the specialist committees (for example the health and safety

committee and infection prevention and control committee). This framework is outlined below:



The Trust control framework is in continuous evolution and grows with the risk management culture of the organisation.

Aligned with the control framework is the Trust risk management framework, which consists of:

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

The risk management framework supports the development of an organisational approach to risk management whereby effective risk management is an integral part of providing healthcare and day-to-day decision-making.

The Trust risk appetite statement is agreed by the Board and cascaded to the whole organisation via an operational framework. It interlinks with the existing risk registers

and board assurance framework, forming an illustration of the Trust's current risk exposure.

The Trust board approved the following statement in March 2019:

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

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

The Trust risk appetite will be further reviewed after the Trust objectives for 2020/21 are agreed. This has been delayed due to the Trust's response to the current COVID-19 pandemic, but it will be addressed as part of the Trust's recovery programme.

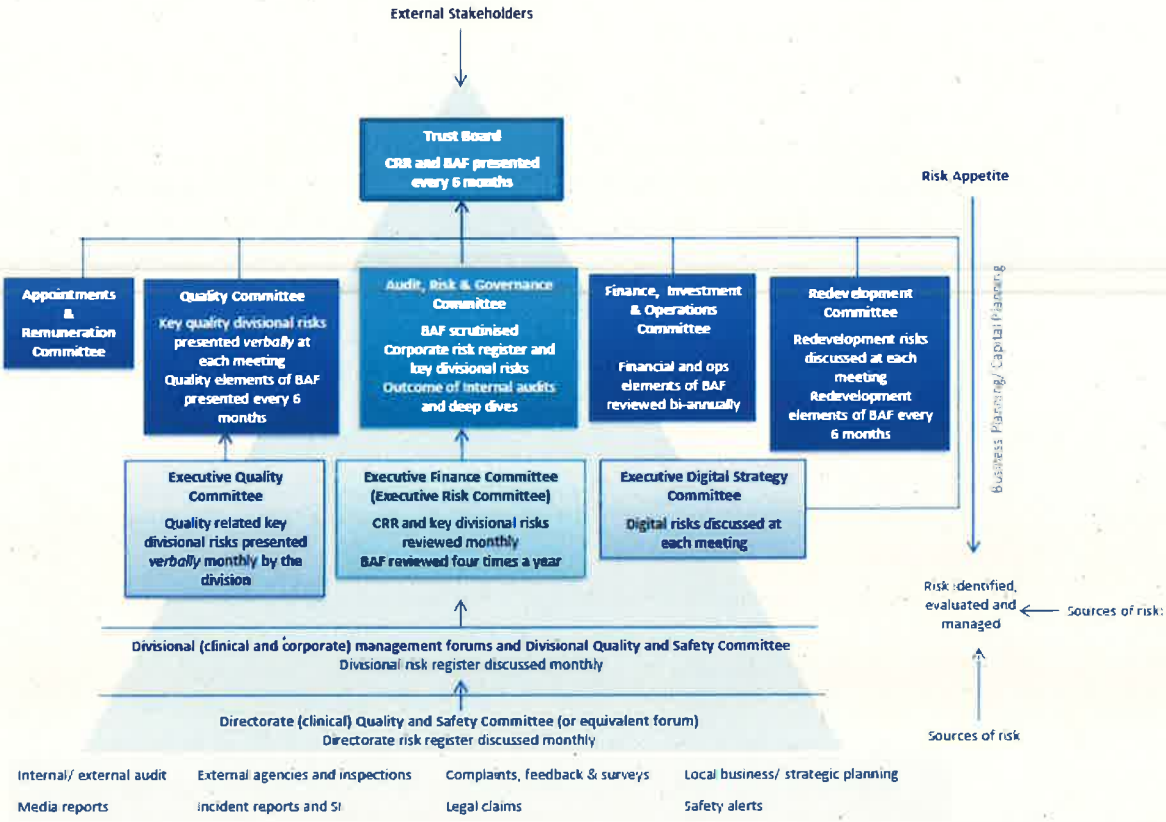
The risk management policy describes the approach that the Trust takes to identifying, managing and mitigating risk. Each directorate and division maintain a risk register with clinical and non-clinical risks. The divisional management committees ensure that operational staff identify and mitigate risk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

Risks are identified from various sources including proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback,

whistleblowing, stakeholder/partnership feedback and internal and external assurance from stakeholders such as the Care Quality Commission and NHS Improvement.

Risk management is embedded within the organisation through the corporate, divisional and directorate structures and it is actively included in key business processes, such as business and capital planning, and quality impact assessment for cost improvement programmes.

The reporting and feedback mechanisms are in place as outlined below:



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

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

The audit, risk and governance committee oversees and monitors the performance of the risk management system, informed by internal auditors undertaking reviews

and providing assurance to the committee on the systems of control operating within the Trust.

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

The following have been identified as the significant risks facing the Trust through 2019/20 and as it enters 2020/21, further detail on each is provided later in the report:

- Impact of COVID-19 on our ability to deliver business as usual
- Ability to deliver financial recovery plan
- Reliability of Trust estates critical equipment to support Trust operations.

As part of the continuous improvement of practice that the Trust is committed to, several changes have been made to the Trust's risk management framework to strengthen the Trust's approach to risk management, including:

- The guidance used to score risks at the Trust has been reviewed and new metrics introduced that are more relevant to the size and culture of the organisation.
- The risk appetite was actively used during business planning process, where it was considered to support decision making.
- Fraud and project risk management have been included in the Trust risk management framework and reporting is being reviewed to further support monitoring.
- A compliance and assurance framework was developed to systemise central oversight of compliance to all regulations (other than CQC) at the Trust.
- A revised approach to the board assurance framework has been agreed by the audit, risk and governance committee for implementation in 2020/21, including the assurance role of board committees.
- Regular deep dive reviews of the corporate risk register have been extended to reviews of divisional and directorate level risk registers.

Care Quality Commission regulatory framework

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The Trust was compliant with the requirements of its CQC registration and was not subject to any enforcement action during 2019/20.

During 2018/19 four of the Trust's core services were inspected: critical care at St Mary's, Charing Cross and Hammersmith hospitals; services for children and young people at St Mary's and Hammersmith hospitals; maternity at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital (QCCH), and neonatal services at Queen Charlotte's & Chelsea Hospital (the neonatal intensive care unit). The Trust had its annual CQC inspection of the 'well-led' domain at Trust level in April 2019. Reports from these inspections were published by the CQC in July 2019. Additionally, the Trust had its first 'use of resources' assessment by NHS Improvement in February 2019, the rating from which is used by the CQC to inform an overall combined well-

led rating for the Trust. This report was published alongside the CQC inspection reports.

- The overall rating for critical care remained the same at St Mary's Hospital, which was 'good', and improved to 'good' at Charing Cross and Hammersmith hospitals.
- The overall rating for services for children and young people remained the same at St Mary's Hospital, which was 'good', and improved to 'good' at Hammersmith Hospital.
- Following the inspection, enforcement action was taken in relation to this service in the form of a requirement notice to ensure suitable management of the risk of cross infection in the paediatric intensive care unit (PICU) at St Mary's Hospital.
- The overall rating for maternity improved at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital to 'outstanding'. This was the first maternity service in London to achieve an 'outstanding' CQC rating.
- The overall rating for neonatal services at Queen Charlotte's & Chelsea Hospital improved to 'good'.
- The rating for well-led at Trust level improved to 'good'.
- The Trust's first use of resources rating was 'good'.
- The overall ratings for all sites remain the same, all of which are 'requires improvement', apart from Queen Charlotte's & Chelsea Hospital which improved to 'outstanding'. This is because the core services inspected do not involve changes to enough underlying ratings to affect the overall ratings aggregations.
- The combined well-led rating is a summary of the sustainability and quality of care; the Trust's combined rating is 'good'.
- The CQC's overall quality rating is the summary of the CQC's judgement of the quality of care. As far as the CQC is concerned, it is their overall quality rating which is the Trust's overall rating. This means that a trust's combined rating may be different from the CQC's overall rating for the Trust, as is the case for this Trust – the combined rating is 'good' but the CQC's overall rating remains 'requires improvement'.
- The overall rating for the Trust remained 'requires improvement'. This is because the core services inspected do not involve changes to enough underlying ratings to affect the overall ratings aggregations.

The CQC is the authority for the Ionising Radiation (medical exposure) Regulations 2017 (IRMER) and inspects services which use ionising radiation to treat patients. In June 2019 the CQC inspected the main imaging department at St Mary's Hospital. Following the inspection, the Trust was issued with an improvement notice, which is a form of enforcement action, in relation ensuring procedures and governance were in line with the regulations and ensuring practice was in line with procedures. The Trust was required to become compliant with the regulation by a deadline set by the CQC and a follow up inspection was carried out in August 2019, at which time the CQC considered that the Trust had become fully compliant with the regulation as required. Reports are not published following IRMER inspections, nor are ratings awarded.

The GP practice operated by the Trust at Charing Cross and Hammersmith hospitals had its first CQC inspection in July 2019 and the report was published in September 2019. The overall ratings and all underlying ratings for both sites were 'good'.

The Trust has not participated in any special reviews or investigations by the CQC during the year. However, all trusts are captured in CQC patient surveys, four of which were published during 2019/20:

- The 2018 adult inpatient survey, published in June 2019, reflected the views of inpatients who were discharged in July 2018. The Trust's performance was about the same as other trusts and showed no significant change from the previous survey. The Trust did perform better than other trusts in relation to patients being asked to give their views on the quality of care.
- The 2018 urgent and emergency care survey, published in October 2019, reflected the views of patients who received care in these areas during September 2018. Overall, the Trust's performance was about the same as other trusts. Dissatisfaction with the availability of food was identified; however, there was significant improvement in relation to privacy, cleanliness, waiting times and knowing who to contact for advice after discharge.
- The 2018 children and young people survey, published in November 2019, reflected the views of patients and parents for patients who received care during November and December 2018. Overall, the Trust's performance was about the same as other trusts, with no significant changes compared to its performance in the previous survey.
- The 2019 maternity survey, published in January 2020, reflected the views of patients and partners whose delivery took place in February 2019. Overall, the Trust's performance was about the same as other trusts. There was a significant change to the Trust's performance compared to the previous survey, in relation to two questions: we are performing better on communicating with patients, but worse for providing hot drinks.

Performance management and oversight

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

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

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

is reflected in the integrated performance framework and other performance monitoring processes.

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

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

Throughout 2018/19, the Trust had been placed in segment three, relating predominantly to financial position and performance on constitutional standards, and as part of enhanced oversight by NHS Improvement, the Trust agreed a series of undertakings to address these areas. During 2018/19 these undertakings were revised by NHS Improvement to reflect the progress made by the Trust in achieving the undertakings and the Trust's improved operational and financial performance. In September 2019 NHS Improvement revised the Trust's categorisation to segment two and closed the Trust's undertakings.

Review of economy, efficiency and effective use of resources

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

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

Trust board, and shared with our commissioners; this also includes information on schemes that were not approved for progression.

Key risks

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

Financial sustainability

2019/20 has been a challenging year financially for both the Trust and the wider NHS. The Trust increased its focus on financial improvement including, but not limited to, a three per cent reduction in pay run rate, mainly through a decrease in the use of agency staff and the development and mobilisation of savings plans at pace. This was set against a backdrop of rising inflation and a growth in activity, driving an of 8.1 per cent increase in our cost versus a 6.5 per cent growth in our income; and saw us needing to balance delivering £57m of savings against the need to continue to provide high quality care and manage ever increasing demand.

Notwithstanding these challenges, the Trust was able to deliver its key financial targets for 2019/20, in respect of its control total and remaining within both the external financing and capital resource limits. A continuation of its performance for the previous four financial years.

The year ended with the outbreak of the COVID-19 pandemic, which required us to significantly change our clinical and business operating models to meet the challenges it presented. For 2019/20, and for at least the first four months of 2020/21, all costs incurred to manage COVID-19 have been or will be underwritten by the Department of Health and Social Care (DHSC). This reflects the national commitment to ensure trusts are not impacted either in terms of cash or their impaired ability to deliver the usual levels of services and savings expected each year. Our regulator, NHS England/Improvement (NHSE/I), has not yet confirmed the formal contracting arrangements for the remainder of the 2020/21 financial year, however it does provide assurance that funding will continue to flow, and advises that providers prepare cash flow forecasts on this basis. The Trust has also benefitted from the national announcement regarding the write off of debt with £15.8m of cash (previously earmarked to repay the loan) being retained in 2020/21 thereby further strengthening the Trust's liquidity position and its ability to support capital investment.

Estates and redevelopment

The Trust's capital plan for 2020/21 is once again extremely challenging due to the level of backlog maintenance, ICT infrastructure, and medical equipment replacements required to mitigate Trust level risks. This is in addition to divisional capital projects which are essential for the quality and safety of our services.

The Trust has the largest backlog maintenance liabilities of all NHS or foundation trusts, principally due to the age of its estates. Estates Return Information Collection

(ERIC) data published in 2016 showed the Trust had nearly 25 per cent of all NHS risk adjusted backlog maintenance costs, with a fully built up backlog liability of £1.3bn. The Trust is part way through a board-approved plan to spend a minimum of £131m over eight years on the highest priority backlog items. The amount in the 2020/21 plan is consistent with this.

The CQC stated in a recent report that, "in some areas, the premises and equipment were unsuitable" and urgent action is needed to improve the on-site facilities. This is reflected in the safety projects in our plan, geared towards improving clinical areas, wards and theatres. The Trust has numerous instances where equipment is now obsolete which means there is prolonged downtime if the equipment fails. Medical equipment in the 2020/21 plan represents the most urgent replacements.

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

The core, depreciation, element of the Trust's capital resource limit (CRL) is planned to cover the essential capital expenditure in 2020/21. In addition to this Public Dividend Capital (PDC) allocations of £12.9m are expected to fund the HIP 2 redevelopment costs, National imaging replacement for MRIs and the London Care Information exchange.

While the capital programme is primarily focused on essential quality and safety-related projects, prioritisation of capital projects is also informed by the specialty review programme and the Trust's organisational strategy, and how that shapes our redevelopment work.

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

In addition to the immediate challenges of maintaining our infrastructure and estate, it is widely accepted that in the longer term the Trust needs to fully redevelop its sites. A redevelopment programme is on-going and in autumn 2019 the Trust was included within the DHSC Health Infrastructure Plan. The highest priority is to deliver a new hospital on the St Mary's Hospital site. To this end the Trust entered a six - month exclusivity agreement with Great Western Development to examine the feasibility of delivering a new hospital within the context of a wider redevelopment and regeneration of the Paddington Basin area. The Trust will submit a business case supporting the investment to the Department of Health and Social Care in mid-2020. Detailed estates plans will be developed for Hammersmith and Charing Cross Hospitals during 2020/21.

The continuing deterioration in the condition of the estate, while addressed in part by an eight-year essential backlog maintenance programme, gives cause for material concern in that estate failures can cause significant delays to service provision and

significant loss of income. There can also be very significant costs to rectify such estate failings.

Emerging risk – impact of COVID-19 on the Trust

A key risk that emerged at the end of the financial year was the emergence of COVID-19 and the subsequent pandemic, and the impact that this had on the Trust at the end of 2019/20.

COVID-19 is a high consequence infectious disease spreading worldwide, which has put the NHS under unprecedented pressure since the beginning of March 2020, presenting it with major safety, demand, capacity, staffing and financial challenges.

The Trust initial response was supported by its pandemic influenza, major incident and other business continuity plans. The Trust has also implemented, and at times anticipated, national guidance in its response to managing the crisis, and while many risks have been mitigated, others are still being managed while planning for the recovery phase.

In order to create capacity for the increased level of emergency and intensive care demand, and to minimise the risk of contracting the virus for other patients, the Trust has reduced its elective capacity to carrying out only those procedures that are time critical. The benefit of having a procedure done during the escalating pandemic has been weighted against the risk of contracting the virus for all patients booked within a 12-week period. This harm review, completed by consultants, is being recorded in the relevant clinical records and this is being used to prioritise patients during the recovery phase. We recognise that patients will have suffered psychologically as well as in terms of pain and symptoms due to this decision. The established harm review process in place to assess harm for patients with long waits has been extended to include all patients rescheduled during the pandemic. Any harm will be recorded in our incident reporting system, reviewed at the medical director's incident panel and investigation completed as appropriate. Capacity in the independent sector has also been repurposed to enable time-critical treatment to proceed in some specialties according to an agreed criteria.

Similarly, telephone and video-conference appointments have replaced outpatients appointments where possible. An audit of the documentation of harm reviews for elective and out-patients has commenced.

Visitor attendance has been minimised to end of life patients, while further effort has been made to keep other patients in contact with their families with virtual media. We recognise that the psychological effects of this will have caused distress to patients and relatives. Our medical examiner service has worked hard to speak with all families of patients who have died, we hope this has given additional support to the bereaved and we have picked up a number of issues we have been able to solve during this time.

Critical care capacity has been extended from 68 to 143 beds and super-surge capacity of up to 300 critical care beds has been planned. Nursing cover has been reviewed in line with national guidance and staff from all clinical and non-clinical

groups have been trained and redeployed to critical care and to general and acute wards. Incidents are being monitored to pick up any themes related to care delivery using significantly different nursing skill mix.

Patients have been delayed in the emergency department due to availability of appropriate beds due to acuity or infectious status. We have seen a large increase in the number of patients spending over 12 hours in the departments which are all being investigated using normal governance processes.

To support staff dealing with these new ways of working and decision making, the Trust's medical director chairs a daily meeting of key clinicians – the clinical reference group (CRG) – to advise and oversee the development of clinical policy and practice in relation to the COVID-19 response. A 24-hour decision support team are in place led by an associate medical director to provide support and advice for consultants when making difficult decisions. The team include members of our ethics committee, palliative care, respiratory and intensive care unit consultants.

Incidents are monitored daily and our teams have been encouraged to continue to report with additional support in place for them to do so. Infection data is being used to track potential transmission and identify hot spots that might require additional support. A new role of personal protective equipment (PPE) helper was developed to support staff with choices and use of PPE. This will be crucial during the duration of the pandemic to ensure staff and patients are protected.

Mortality data is closely monitored with any potential issues identified in care referred on for a structured judgement review. The number of patients who have died in our care has increased during the pandemic but apart from deaths related to the virus there are no other issues identified as giving cause for concern.

The virus has put at risk both the physical and mental health of Trust's staff. The Trust has been following national guidance for the use of personal protective equipment (PPE) and on-site dedicated areas for testing have been available to Trust staff. However availability of equipment has been an issue and although we have never run out, our staff have faced anxiety that we might. Emotional wellbeing groups meet at dedicated spaces on the Trust main sites and individual counselling is also available, to help staff deal with the challenges presented by the COVID-19. Other initiatives are being carried out, including the distribution of free lunches, out of hours food options and the provision of other essentials at on-site free 'shops', to improve staff experience and their emotional wellbeing.

Lock down, isolation requirements for staff and their households and the virus itself have posed issues for staffing levels. To ensure staff are supported dedicated helplines have been set up, hotels sourced and parking options accessed.

To deal with this unprecedented crisis, the Trust has been able to access special funds and pass business cases at a much faster pace than usual. This, of course, has also exposed the organisation to a higher risk of fraud, as well as the risk that changes to the financial regime will lead to insufficient visibility of costs and a deterioration of financial performance and financial sustainability of the Trust in the longer-term period. Strong financial monitoring, reporting and governance have been

maintained to mitigate this risk, while more information on the plans to ensure financial sustainability is achieved are available in the paragraph of this report that elaborates the financial risk in more details.

While ongoing focus remains on managing the impact of COVID-19 on Trust's patients, staff and operations, work was initiated at an early stage to mitigate the impact of the pandemic on the Trust, after the crisis will have passed.

Even though NHS Digital has suspended collection of some performance data from NHS organisations, the Trust has maintained tracking of those patients whose appointments have been cancelled or delayed, to ensure they are prioritised as appropriate and there is capacity to treat all patients after the crisis period, which will also allow safe recovery of areas and services.

An incident recovery group has been established to develop a comprehensive recovery strategy.

Data security and protection
The Trust has a published data protection framework designed to deliver compliance with the General Data Protection Regulations (GDPR) and the NHS digital data security and protection toolkit.

The data security and protection committee (DSPC) is responsible for oversight of Trust data protection and security policies. It is further responsible for monitoring the mitigation plans identified in the information and communications technology (ICT) risk register including key risks and ICT risks listed in the corporate risk register.

The chief information officer (CIO) acts as the senior information risk officer (SIRO), a role designed to take ownership of the Trust's information risk policy and as advocate for information risk on the Trust board, with overall accountability for data protection and cyber security. A SIRO action plan has been generated to manage and mitigate information threats and risks.

The chief clinical information officer (CCIO), as Caldicott Guardian, is the appointed senior clinician with ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key advisory role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information.

The data protection officer is a role assigned in compliance with, and duties outlined in, the Data Protection Act 2018. In summary these are:

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

The NHS digital data security and protection toolkit is an online self-assessment tool that enables organisations to measure and publish performance against the National

Data Guardian's ten data security standards. It consists of three leadership obligations, 10 data security standards, 44 mandatory assertions and requires 112 mandatory evidence items, mandatory standards are either *"met"* or *"not met"*.

One mandatory evidence requirement is 95 per cent of staff to complete annual mandatory data security and protection training. This target was achieved on 31 October 2019

The Trust data security and protection toolkit return was subject to an independent audit which returned an overall rating of low risk. The audit report also placed the Trust as above average when compared to similar organisations.

Data security and protection incidents 2019/20
The Trust is mandated to report all incidents via the data security and protection toolkit. In cases where there is a risk to the rights and freedoms of data subjects the toolkit incident reporting tool will automatically notify the Information Commissioners Office and Department of Health and Social Care. There were no data security and protection incidents in 2019/20 requiring a report, to the ICO and Department of Health and Social Care. In lower level incidents the Trust records these on the data security and protection toolkit but these are not automatically forwarded to other authorities but should be collated and used to assess risk of recurrence and take mitigating action as appropriate.

Table of data security and protection incidents 2019/2020

Grade of incident	**Number**
Incident reported to the ICO and Department of Health	0
Trust level incident	51
Total *	**51**

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

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

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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

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

Annual quality account

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.

Chief Executive Officer's review of effectiveness

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

In support of this:

- The head of internal audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal audits carried out have provided assurance from substantial assurance to limited assurance; following the audit reports, management have accepted, and taken action to address, recommendations made. Management improvement plans for all audits given limited assurance are reviewed by the audit, risk and governance committee.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that each has taken all the steps that

they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

- The Trust board reviews risks to the delivery of the Trust performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety and quality, and workforce.
- The board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed. Internal audit has rated the framework as providing substantial assurance.
- The audit, risk and governance committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed recorded and escalated as appropriate. The committee regularly receives reports on internal control and risk management matters from the internal and external auditors.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- During 2019/20, the Trust has continued to engage with the CQC through regular engagement meetings. The CQC conducted a regulatory inspection of the Trust's compliance with IRMER at St. Mary's Hospital and served the Trust with an improvement notice. This was removed in August 2019, following remedial action and re-inspection.
- NHS Improvement's NHS oversight framework provides a structure for overseeing trusts and identifying potential support needs. The framework looks at five themes: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability (well-led). Trusts are then rated from one to four, according to these themes, with a four being those who need the most support. During 2019/20, NHSI has reviewed the Trust's progress in delivering the regulatory undertakings and the Trust's rating and have moved the Trust from segment three to segment two, and removed all regulatory undertakings.
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; reports from external assessments; Deanery and Royal College assessments; accreditation of clinical services; and patient led assessments of the care environment.

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

Conclusion

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

NHS Trust can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

I consider that any significant issues and risks identified in 2019/20 are detailed in the body of the annual governance statement above, namely:

- impact of COVID-19 on our ability to deliver business as usual
- ability to deliver financial recovery plan
- reliability of Trust estates critical equipment to support Trust operations.

Actions to address each of these areas is detailed in the relevant section of the corporate governance statement.

Professor Tim Orchard

Chief executive officer

Remuneration and staff report

Remuneration report

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

Remuneration consists mainly of salary, which is inclusive of high cost area supplement, and pension benefits in the form of contributions to the NHS pension fund. Annual salary increases are ordinarily in line with increases for the wider NHS workforce but may be higher where there is a significant change to an individual's responsibilities.
In order to attract high quality candidates to senior posts and to support retention we:

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

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based. Salary levels (which typically take effect from 1 April) for executive directors in 2019/20 are set out in the staff report.

The Trust has taken advantage of flexibilities offered in the agenda for change to offer pay spot salaries to 29 senior managers who are not executive directors. These salaries are set by the relevant executive director with approval from the director of people and organisation development.

Non-executive directors are normally appointed on fixed term contracts of between two and four years. Non-executive directors are not generally members of the pension scheme. Remuneration for non-executive directors is set by NHS Improvement based on a national framework.

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

Pay multiples (Subject to audit)

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

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the Trust and the median remuneration of all staff. The remuneration of the highest paid director in the financial year 2019/20 was £282,360 (£253,103 in 2018/19). This was 6.75 times (6.25 times in 2018/19) the median remuneration of the workforce, which was £41,814 (£40,481 in 2018/19). The change in the ratio from 6.25 (2018/19) to 6.75 this year is due to the impact of performance related payments to the highest paid director in 2019/20 which were not payable in 2018/19 because the relevant director took up their post during that year.

In both 2018/19 and 2019/20 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £9,590 to £282,360 (£7,922 to £253,103 in 2018/1

Remuneration tables

Salary and pension disclosure tables: information subject to audit

Remuneration report 2019/20

Salaries and Allowances	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
	Salary (bands of £5,000)	Expense Payments (taxable) (Total to nearest £00)	Performance Pay and Bonuses (bands of £5,000)	Long term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total Remuneration (bands of £5,000)
Name & title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Non-executive director						
Paula Vennells, chair[1]	55 - 60	0	0	0	0	55 - 60
Sir Gerald Acher, deputy chair	5 - 10	0	0	0	0	5 - 10
Prof. Andrew Bush, non-executive director	5 - 10	0	0	0	0	5 - 10
Peter Goldsbrough, non-executive director	5 - 10	0	0	0	0	5 - 10
Andreas Raffel , non-executive director	5 - 10	0	0	0	0	5 - 10
Victoria Russell, non-executive director [2]	0 - 5	0	0	0	0	0 - 5
Nick Ross, designate non-executive director	5 - 10	0	0	0	0	5 - 10
Kay Boycott, non-executive director [3]	5 - 10	0	0	0	0	5 - 10
Dr. Ben Maruthappu, associate non-executive director [4]	5 - 10	0	0	0	0	5 - 10
Executive director						
Prof. Tim Orchard, chief executive [6]	265 - 270	0	15 - 20	0	907.5 - 910	1,190 - 1,195
Prof. Julian Redhead, medical director [5]	245 - 250	0	0	0	385 – 387.5	630 - 635
Richard Alexander, chief financial officer [8]	215 - 220	0	0	0	0	215 - 220
Prof. Janice Sigsworth, director of nursing	175 - 180	0	0	0	47.5 - 50	225 - 230
Jazz Thind, interim chief financial officer [7]	35 - 40	0	0	0	0	35 - 40

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2019	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 31st March 2020	Employer's contribution to stakeholder pension
Name & title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-executive directors								
Paula Vennells, chair [1]	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Prof. Andrew Bush, non-executive director	0	0	0	0	0	0	0	0
Peter Goldsbrough, non-executive director	0	0	0	0	0	0	0	0
Andreas Raffel, non-executive director	0	0	0	0	0	0	0	0
Victoria Russell, non-executive director [2]	0	0	0	0	0	0	0	0
Nick Ross, designate non-executive director	0	0	0	0	0	0	0	0
Kay Boycott, non-executive director [3]	0	0	0	0	0	0	0	0
Dr.Ben Maruthappu, associate non-executive director [4]	0	0	0	0	0	0	0	0
Executive directors								
Prof. Tim Orchard, chief executive [6]	40 - 42.5	67.5 - 70	100 - 105	155 -160	861	677	1,558	0
Prof. Julian Redhead, medical director [5]	15 – 17.5	45 – 47.5	70 - 75	185 - 190	1,028	361	1,413	0
Richard Alexander, chief financial officer [8]	0	0	0	0	0	0	0	0
Prof. Janice Sigsworth, director of nursing	0 – 2.5	2.5 - 5	90 - 95	270 - 275	1,996	75	2,118	0
Jazz Thind, interim chief financial officer [7]	0	0	0	0	0	0	0	0

[1] Paula Vennells joined the board on 1 April 2019.

[2] Victoria Russell left the board on 30 June 2019.

[3] Kay Boycott joined the board on 1 September 2019.

[4] Dr. Ben Maruthappu joined the board on 1 September 2019.

[5] Prof. Julian Redhead - The amount of £55-60k of his salary relates to payment for clinical role. Prof. Redhead was not a member of the pension scheme in 2018/19 but re-joined in 2019/20. Elements of his remuneration became pensionable in 2019/20, giving rise to the disclosed pension benefits.

[6] Prof. Tim Orchard - £50–55k of his salary relates to payment for his clinical role. Elements of his remuneration became pensionable in 2019/20 giving rise to the disclosed pension benefits

[7] Jazz Thind joined the Trust on 6th January 2020 as Interim Chief Financial Officer on secondment from Oxleas NHS Foundation Trust. The salary disclosed covers the period from 6 January 2020 31 March 2020. She has not been a member of the pension scheme since joining the Trust. Details of her pension for 2019/20 are included in the Annual Report for Oxleas NHS Foundation Trust

[8] Richard Alexander led strategic finance projects for the Trust from January 2020 prior to leaving the Trust in April 2020. He was not a member of the pension scheme during 2019/20.

There were no non-contractual payments made to individuals where the payment was more than 12 months' annual salary (exit packages).
The movement in column (f) illustrates the real gain in value in the CETV in the year and excludes gains resulting from inflation, employee contributions or transfers of benefits.
NHS Pensions are assessing the impact of the McCloud case in relation to changes in benefits in 2015. The benefits and related CETVs disclosed
do not allow for any potential future adjustments that may arise from this judgement.

Remuneration Report 2018/19

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

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2017	Real increase in cash equivalent transfer value [8]	Cash Equivalent Transfer Value at 31st March 2018	Employer's contribution to stakeholder pension
Name & title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-executive directors								
Sir Richard Sykes, chairman[1]	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Prof. Andrew Bush, non-executive director	0	0	0	0	0	0	0	0
Peter Goldsbrough, non-executive director	0	0	0	0	0	0	0	0
Sarika Patel, non-executive director [4]	0	0	0	0	0	0	0	0
Andreas Raffel , non-executive director	0	0	0	0	0	0	0	0
Victoria Russell, non-executive director	0	0	0	0	0	0	0	0
Nick Ross, designate non-executive director [3]	0	0	0	0	0	0	0	0
Executive directors								
Prof. Tim Orchard, chief executive [6]	0 – 2.5	0 – 2.5	55 - 60	85 - 90	729	109	861	0
Prof. Julian Redhead, medical director [5]	0	0	0	0	0	0	0	0
Richard Alexander, chief financial officer [2]	0 – 2.5	0 – 2.5	25 - 30	85 - 90	581	14	655	0
Dr. William Oldfield, interim medical director [7]	0 – 2.5	0 – 2.5	50 - 55	75 - 80	752	15	858	0
Prof. Janice Sigsworth, director of nursing	0 – 2.5	0 – 2.5	85 - 90	260 - 265	1,760	182	1,996	0

[1] Sir Richard Sykes left the board on 31st December 2018

[2] Richard Alexander opted out of the Pension scheme on 30th June 2018.

[3] Nick Ross donated all his salary to the Imperial College Healthcare NHS Trust Charity.

[4] Sarika Patel left the board on 31st December 2018

[5] Prof. Julian Redhead was Interim Chief Executive till 6th June 2018. The amount of £135k – £140k of his salary relates to payment for clinical role.

[6] Prof. Tim Orchard was made Chief Executive from 7th June 2018. The amount of £60k – £65k of his salary relates to payment for clinical role

[7] Dr. William Oldfield left the Trust on 6th June 2018. The amount of £30k – £35k of his salary relates to payment for clinical role. Pension Benefit calculations are based on pro rata basis. NHS Pensions are assessing the impact of the McCloud case in relation to changes in benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

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

Staff report

The headcount data is at 31st March 2020 and is for clinical and corporate divisions and R&D (excluding hosted and contracted services).

Workforce composition by staff group

At the end of 2019/20 the Trust employed 12,919 staff. Approximately 68 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in table titled 'headcount by Trust staff group' below.

Headcount by Trust staff group	Headcount
Admin & Clerical	1,994
Allied Health Professional (Qualified)	727
Allied Health Professional (Unqualified)	108
Doctor (Career Grade)	35
Doctor (Consultant)	1,134
Doctor (Training Grade)	1,676
Nursing (Qualified)	4,035
Nursing (Unqualified)	1,108
Pharmacist	148
Physician Associate	6
Scientific & Technical (Qualified)	836
Scientific & Technical (Unqualified)	368
Senior Manager	744
Trust Total	**12,919**

Workforce composition by sex

71 per cent of our workforce is female and 29 per cent is male. The high proportion of female workers is typical of NHS organisations. The proportion of male employees increases in more senior roles. The gender tables below show that at the end of 2019/20 women accounted for 56 per cent of senior managers, 38 per cent of executive directors and 33 per cent of board directors. There are four directors who are defined both as executive team members and as board directors.

Gender - all	Headcount
Female	9,147
Male	3,772
Trust Total	**12,919**

Gender - Senior Managers	Headcount
Female	402
Male	316
Trust Total	**718**

Gender - Board of Directors	Headcount
Female	4
Male	8
Trust Total	**12**

Gender - Executive Team	Headcount
Female	7
Male	11
Trust Total	**18**

Workforce composition by age and ethnicity

Age Group	Headcount
16-19 years	15
20-29 years	2,729
30-39 years	3,936
40-49 years	3,048
50-59 years	2,299
60 years and over	892
Trust Total	**12,919**

Ethnic Origin	Headcount
White - British	3,257
White - Irish	377
White - Any other White background	1,599
Mixed - White & Black Caribbean	88
Mixed - White & Black African	84
Mixed - White & Asian	87
Mixed - Any other mixed background	190
Asian or Asian British - Indian	991
Asian or Asian British - Pakistani	272
Asian or Asian British - Bangladeshi	166
Asian or Asian British - Any other Asian background	1,183
Black or Black British - Caribbean	532
Black or Black British - African	1,284
Black or Black British - Any other Black background	460
Chinese	199
Any Other Ethnic Group	824
Undefined	966
Not Stated	360
Trust Total	**12,919**

Average staff numbers (subject to audit)

This table represents the average staff numbers through the year and so presents a different figure than the analysis tables above, which relate to the number of staff employed at 31st March 2020.

Average Staff Numbers	Total	Permanently Employed	Other	Total Prior Year	Prior Year Permanently Employed	Prior Year Other
Medical and dental	2,177	2,165	12	2,085	2,081	4
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,707	2,665	42	2,632	2,513	119
Healthcare assistants and other support staff	1,715	1,680	35	1,631	1,602	29
Nursing, midwifery and health visiting staff	4,242	4,111	132	4,176	3,986	190
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	1,110	985	124	974	880	94
Social care staff	632	632	0	651	651	0
Healthcare science staff	0	0	0	0	0	0
Other	6	6	0	1	1	0
TOTAL	**12,589**	**12,244**	**345**	**12,150**	**11,174**	**436**
Staff engaged on capital projects (included above)	32	32	0	27	27	0

The analysis of staff costs is shown below:

	2019-20			2018-19		
	Permanent	Other	Total	Permanent	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	526,896	71,189	598,085	479,072	84,040	536,112
Social security costs	58,502	3,469	61,971	54,261	3,143	57,404
Apprenticeship Levy	2,585	184	2,769	2,392	174	2,566
Employer Contributions to NHS BSA	88,383	1,361	89,744	56,675	1,015	57,690
Other pension costs	78	28	106	37	13	50
Termination benefits	0	0	0	38	0	38
Total employee benefits	676,444	76,231	752,676	592,475	88,385	680,860
Employee costs capitalised	2,646	213	2,859	1,786	230	2,016
Gross Employee Benefits ex. capitalised costs	673,798	76,018	749,816	595,034	83,810	678,844

Sickness absence

Due to the extraordinary events associated with the Covid-19 pandemic this year sickness data is not available across the sector in the usual way. When data is released it will be available via the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

Employment of staff with disabilities

The Trust is committed to attracting and developing staff with disabilities. The Trust's commitments are described in its equal opportunities policy and its policy on maintaining the employment of people with disabilities. The Trust is a 'two ticks' employer, guaranteeing an interview for any disabled person who meets the minimum criteria for a role. Information on the proportion of staff with declared disabilities is shown in the table below. Further information on the employment of people with disabilities is available in our annual equality workforce information report which is published on the Trust website.

Staff with Disabilities*	Headcount
No	8,685
Not declared	228
Prefer not to answer	28
Unspecified	3,761
Yes	217
Trust Total	12,919

Trade union facility time publication requirements report: 2019/20

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

Trade union facility time information required for publication

The below data refers to the relevant period which is 1 April 2019 - 31 March 2020. This data is not audited.

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

Number of employees who were relevant union officials during the relevant period	*FTE employee number*
46	44.35

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

Percentage of time	*Number of employees*
0%	18
1-50%	28
51%-99%	0
100%	0

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

First Column	*Figures*
Provide the total cost of facility time	*£47,713.18*
Provide the total pay bill	*£752,675 000 = total figure for 2019/2020 including apprenticeship levy (£2,769 000)* *£749,906 000 = total figure excluding apprenticeship levy*
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	*0.006%*

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

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	82%

Professor Tim Orchard

Chief executive officer

Appendix 1
Glossary of terms

Term	Definition
Relevant public sector employer	Section 7 of the regulations defines what is a relevant public sector employer. This specifies: • Government departments, which include executive agencies and non-ministerial departments (other than the Secret Intelligence Service, the Security Service and the Government Communications Headquarters) • the Scottish Ministers and • public authorities described or listed in Schedule 1 of the regulations
TU representative	A relevant union official. An official of an independent TU recognised by the employer.
Relevant period	A period of 12 months beginning with 1 April, the **first** relevant period starts on 1 April 2017.
Total pay bill	Is the total amount of (the total gross amount spent on wages) + (total pension contributions) + (total national insurance contributions) during the relevant period.
Full Time Equivalent (FTE) employee number	The (total number of full time employees) + (the total fractions of full time employee hours worked by all employees who are not full time).
TU Duties	Duties where there is a statutory right to reasonable paid time off during normal working hours to undertake recognised duties and to complete training relevant to their TU role. This arises under: (a) section 168, section 168A of the 1992 Act (TULR(C)A) (b) section 10(6) of the Employment Relations Act 1999; (c) regulations made under section 2(4) of the Health and Safety at Work etc. Act 1974.

TU Activities	Means time taken off under section 170 (1) (b) of the 1992 Act. TU activities could include: • meetings - where the purpose or principal purpose is to discuss internal union matters • TU conferences • internal administration of the union e.g. answering internal union correspondence, dealing with financial matters, responding to internal surveys. There is no statutory entitlement to paid time off to undertake activities. However TU representatives are entitled to be granted reasonable unpaid time off to participate in TU activities.
Paid TU Activities	Time taken off for TU activities under section 170 (1) (b) of the 1992 Act in respect of which a TU representative receives wages from the relevant public sector employer. There is no statutory entitlement to paid time off to undertake activities. It is accepted that there could be exceptional circumstances where paid time off for activities may be appropriate, however it is recommended the organisations ensure they have appropriate controls in place to monitor this.
Total paid facility time hours	Total number of hours spent on facility time by TU representatives during a relevant period. Does not include hours attributable to time taken off under section 170(1)(b) of the 1992 Act in respect of which a TU representative does not receive wages.
Hourly cost	For each employee: (the gross amount spent on wages) + (pension contributions) + (national insurance contributions) divided by the number of hours during the relevant period.
Total cost of facility time	For each employee who was a TU representative during the relevant period, facility time cost is calculated by: (Hourly cost for each employee x number of paid facility time hours) Total facility time cost is calculated by adding together the amounts produced by the calculation of facility time cost for each employee.

	In calculating this figure the wages of any employee who can be identified from the information being published must be expressed as a notional hourly cost to represent the employee's wages.

Off-payroll arrangements

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

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

Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31st March 2020	7
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	-

New off-payroll engagements

For all new off - payroll engagements, or those that reached six months in duration, between 1st April 2019 and 31st March 2020, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2019 and 31st March 2020	1
Of which :	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off - payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off - payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	21

Exit packages (subject to audit)

In 2019/20 the Trust approved severance payments to 23 staff (2018/19: 5 staff).

Exit Packages

2019/20								
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of Departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	0	0	4	30,000	4	30,000	0	0
£10,000-£25,000	0	0	9	158,000	9	158,000	0	0
£25,001-£50,000	0	0	4	164,000	4	164,000	0	0
£50,001-£100,000	0	0	5	336,000	5	336,000	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	1	180,000	1	180,000	0	0
Total	**0**	**0**	**23**	**868,000**	**23**	**868,000**	**0**	**0**

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

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

Exit packages - other departures analysis

This table provides a breakdown of the Other Departures Agreed figures shown in the table above. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

	2019-20		**2018-19 (Restated)**	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000s**	**Number**	**£000s**
Voluntary redundancies including early retirement contractual costs	1	159	0	0
Mutually agreed resignations (MARS) contractual costs	10	476	0	0
Contractual payments in lieu of notice	5	79	0	0
Exit payments following Employment Tribunals or court orders	7	154	2	52
Total	**23**	**868**	**2**	**52**

Chief financial officer report

Introduction and overview

2019/20 has been a challenging year financially for both the Trust and the wider NHS. The Trust increased its focus on financial improvement including, but not limited to, a three per cent reduction in pay run rate, mainly through a decrease in the use of agency staff and the development and mobilisation of savings plans at pace. This was set against a backdrop of rising inflation and a growth in activity, driving an of 8.1 per cent increase in our cost versus a 6.5 per cent growth in our income; and saw us needing to balance delivering £57m of savings against the need to continue to provide high quality care and manage ever increasing demand.

The year ended with the outbreak of the COVID-19 (coronavirus) pandemic, which required us to significantly change our clinical and business operating models to meet the challenges it presented. For 2019/20, and for at least the first four months of 2020/21, all costs incurred to manage COVID-19 have been or will be underwritten by the Department of Health and Social Care (DHSC). This reflects the national commitment to ensure Trusts are not impacted either in terms of cash or their impaired ability to deliver the usual levels of services and savings expected each year. Guidance from our regulator, NHS England / Improvement (NHSE/I), has not yet confirmed the formal contracting arrangements for the balance of the 2020/21 financial year, however it does provide assurance that funding will continue to flow, and advises that providers prepare cash flow forecasts on this basis.

Financial review of 2019/20

Notwithstanding the challenges above, the Trust is pleased it was able deliver its financial targets for 2019/20 in respect of the control total and remaining within both the external financing and capital resource limits. It should be noted, however, that despite ongoing investment in the estate, there remains a material concern around potential estate failures and the Trust's ability to address these without additional support.

We ended the year with a reported surplus of £8.7m which includes £5.3m of central income to fund COVID-19 related costs or losses and £16.8m of Provider Sustainability Funding (PSF). In line with national guidance, the covid cost re-imbursement excludes the estimated additional £2.6m cost of annual leave that could not be taken as a result of managing the COVID-19 pandemic, resulting in a variance of £2.4m against the original control total, however, the Trust has received confirmation that this value has been discounted from the calculation of performance against control total for PSF purposes and thus the Trust was awarded 100 percent of core PSF.

The delivery of the surplus did require managing a deterioration in the underlying position compared to 2018/19 which was linked mainly to the increased expenditure of delivering activity above plan and the mobilisation costs associated with the in-housing of hotel services pre go-live on the 1 April 2020 (see page 41). These pressures were however mitigated through a combination of the delivery of recurrent efficiencies (although below plan) and other non-recurrent items.

The table below sets out the actual income and expenditure performance as at the 31 March 2020, including comparative information for 2018/19 and tracks this against the Trust control total:

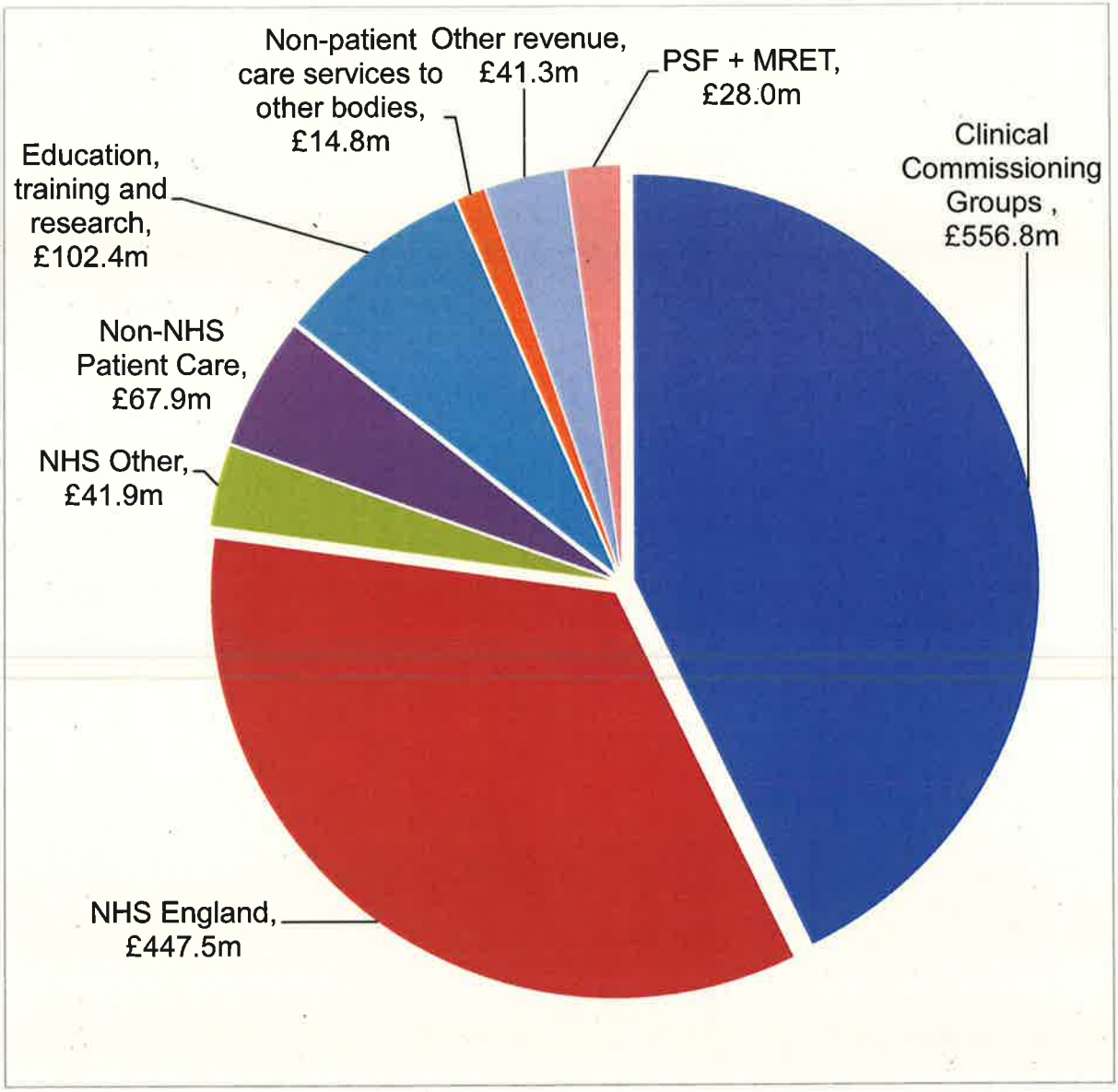
Statement of Comprehensive Income	2019/20 £'m	2018/19 £'m
Income	1,300.6	1,213.0
Expenditure	(1,264.4)	(1,169.9)
Net Financing Costs	(0.6)	(0.9)
Public dividend capital payable	(12.3)	(11.8)
Surplust before Revaluations and Impairments	**23.4**	**30.4**
Adjustments for Revaluations and Impairments	0.7	0.1
Surplus/(deficit) for the financial year	**24.1**	**30.5**

Performance Against Control Total	2019/20 £'m	2018/19 £'m
Surplus For the Year as per Annual Accounts	24.1	30.5
Remove 2018/19 post audit PSF reallocation (2019/20 only)	(1.0)	0.0
Surplus before allowed adjustments	**23.1**	**30.5**
Less PSF and MRET	(27.1)	(48.4)
Donated asset adjustment	(2.2)	(0.1)
Adjust for Revaluation and Impairment	(12.2)	(2.2)
Surplus before PSF, Donated assets and revaluation	**(18.4)**	**(20.2)**
Add Back		
MRET	10.2	0.0
Core PSF	16.8	34.2
Incentive PSF	0.0	1.3
Bonus PSF	0.0	3.8
General distribution PSF	0.0	9.1
Surplus for Control Total as per Annual Accounts	**8.7**	**28.2**
Add back Unfunded Covid annual leave accrual	2.6	0.0
Adjusted surplus for PSF calculation	**11.2**	**28.2**
Control Total	11.1	13.6
Performance Against Control Total for PSF calculation	**0.1**	**14.6**

Income

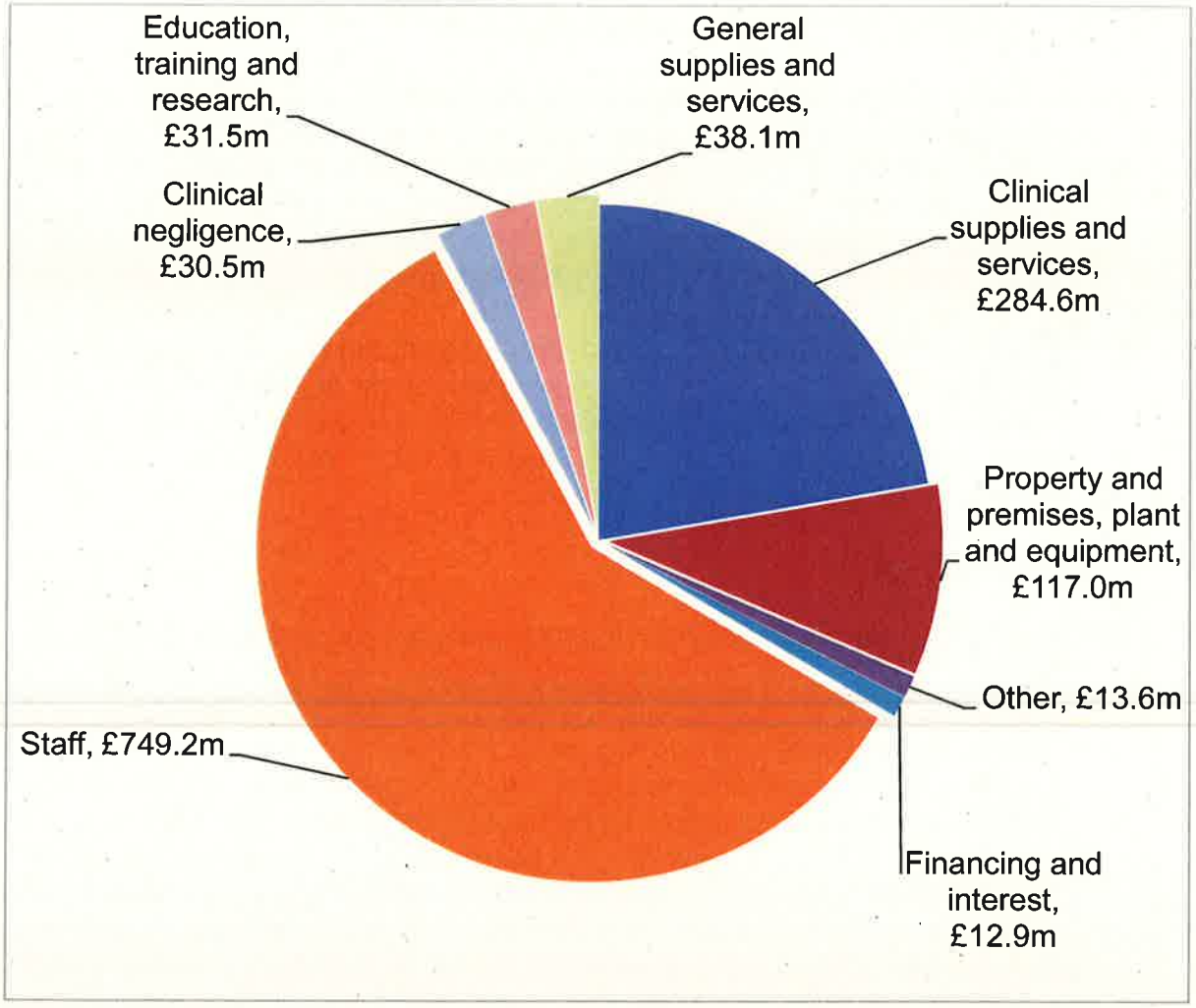
Health service income from the provision of goods and services in England exceeded income from the provision of other services, which form only a small part of our total income. Income from other services is used to support health services. Further detail is provided in notes 3 and 4 of the accounts.

Our total income amounted to £1,301m for 2019/20 (2018/19 £1,213m). The majority of this related to NHS patient care income for the provision of clinical services. There are a number of other income sources and these include: education and training income which supports the costs of training doctors, nurses and other healthcare professionals and in doing so supports the quality of care provided at the trust; non-contracted activity; and research and development.



Expenditure

Excluding financing and interest costs our total expenditure for 2019/20 was £1,264m (2018/19 £1,170m) with staff costs accounting for 59 per cent of this spend. To achieve our planned operational deficit of £18.4m (before PSF) we needed to deliver £57m of planned savings and efficiencies during the year. All divisions were allocated an element of the savings target and tasked with developing ambitious plans to close the gap. The plans covered a range of themes including reductions in expenditure:- decrease in corporate resources; savings through procurement of non-pay goods and services; staff skill mix reviews; decrease in temporary staff usage, medication usage; as well as income generation:- increased contribution via private income growth; NHS activity growth. Any residual unmitigated gap was managed through a number of agreed non-recurrent actions including enhanced scrutiny of business cases and weekly executive review of all recruitment requests, ending the year having delivered £43m of the £57m challenge.



Cash

The Trust continued to successfully manage its cash throughout 2019/20 thereby remaining within its external financing limit (EFL), with a cash balance at the 31 March 2020 of £43.9m. The Trust maintained its revolving working capital facility (initially provided by the DHSC in 2015/16) at £15.8m, but it should be noted that, whilst this is included in current liabilities in the annual accounts, it will be written off as part of the national announcement regarding the write-off of debt in 2020/21 and be converted into Public Dividend Capital thereby strengthening the cash position by an equal and opposite amount for the next financial year.

Capital

During the year the Trust invested £56m in capital expenditure, key themes included:

- Estates (£35m) including improvements to paediatric intensive are, Charing Cross A&E; inpatient parent accommodation, theatre enhancement and other improvements
- IT infrastructure and systems (£9.6m)
- Replacement of clinical equipment (£9m)

- Other (£2m) this includes redevelopment

Included in the total above is £4m of Imperial Health Charity money and £4m of new-in-year successful central bid funding. We are particularly grateful to the Charity for the ongoing support in this area and its incredible fundraising efforts. These additional funds make a huge contribution to enable the Trust to continue to improve both the quality of care it provides and support staff wellbeing. The capital expenditure excluding charitable funds was £52m, which was in line with the agreed capital resource limit target for the year.

The Trust bid for and was awarded £5m of 'seed funding' from the Health Infrastructure Plan (HIP2) in 2019/20 to enable the development of the outline business case for the re-development of the St Mary's Hospital. This is critical deliverable for the Trust and work has commenced at pace with an outline business case due to be submitted in 2020/21. £1m of this resource has been utilised to date.

Declarations

The Trust is committed to providing and maintaining an absolute standard of honesty and integrity in dealing with its assets. We are committed to the elimination of fraud and illegal acts within the trust, and ensure rigorous investigation and disciplinary or other actions are taken as appropriate. We strive to adopt best practice procedures to tackle fraud, as recommended by the NHS Counter Fraud Authority (NHSCFA) and contract with PriceWaterhouseCoopers to provide us with our specialist counter-fraud services.

Over the year, we have widely published our policies and procedures for staff to report any concern about potential fraud and this has been reinforced by a programme of awareness raising. Any concerns are investigated by our local counter fraud specialist or the NHSCFA as appropriate with all investigations reported to the Audit Risk and Governance Assurance Committee.

At the time of writing the report, so far as all directors are aware, there is no relevant audit information of which the Trust's auditor is unaware, and they have taken all the steps that are necessary as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury, has met the income disclosures as required by section 43(2A) of the NHS Act 2006 and did not make any political donations during 2019/20.

Within the provisions of the Better Payment Practice Code (BPPC) the Trust is required to pay 95 per cent of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. During 2019/20 86.3 per cent of invoices by value and 93.7 per cent by volume of total payables were paid within the required standard, this represents an improvement against 2018/19. It should be noted that whilst in aggregate the target was missed, for non-NHS payables, the volume target of 95 per cent was achieved.

Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in

accounting terms, the organisation is a 'going concern'. The Board has reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services. If current arrangements continue, the Trust would breakeven for the year, however if arrangements revert to previous planning assumptions, the Trust would be expected to report a £5.6m deficit for 2020/21 as indicated by the NHSE/I planning trajectory.

It should be noted that whilst the financial position has been on an improving trajectory, and cash balances are increasing year-on-year, the estate continues to pose a significant risk in terms of backlog of improvements required and potentially unaffordable failures, and while the Trust is part of the HIP2 and has received £5m of seed funding to progress the site redevelopment business case for the St Mary's site, there is no formal commitment to cover any unexpected estates failures at the point of writing this report.

2020/21 looking ahead

- 2020/21 planning: due to the outbreak of COVID-19, 2020/21 planning was suspended in March 2020 and all NHS Providers will be subject to a new finance regime, the details of which at present only cover the first four months to 31 July 2020. For the initial four month period NHS trusts and foundation trusts will move to block contract payments with top up facilities to ensure financial balance and providers have been advised to prepare cashflow forecasts on this basis until the publication of further guidance from the regulator on what arrangements will be put in place from 1st August 2020.

- Operational focus: we will continue to pay due attention to our operational and clinical performance and ensure the safe running of the hospital is maintained and applicable national targets are met wherever possible. However given the impact of COVID-19 it is recognised that there is likely to be limited capacity to focus on the business transformation aimed at delivering the improvement in the underlying deficit.

- Hotel services: in December 2019 the Trust Board approved the business case to in-house soft facilities management services (catering, cleaning, and portering) with effective from 1 April 2020. This decision was taken to significantly improve the standards and quality of services for our patients and enhance the pay conditions of the staff involved. The effectiveness of these changes will be monitored on an on-going basis during 2020/21.

- Redevelopment: despite the current COVID-19 pandemic, the production of the business case for the redevelopment of the St Mary's Hospital site remains a key priority. Delivering a sustainable, cost effective building is critical to the future stability of the Trust and the care it provides, £5m of HIP funding has been received to support this project.

- Integrated care systems: the Trust is part of the North West London sustainability and transformation partnership (STP) and is actively engaging in the local sector level post COVID-19 'recovery and reset' thinking.

None of the above removes the requirement for the Trust to maintain financial control to ensure its resources are utilised in the most effective and efficient manner. Therefore, the Trust is continuing to develop its 2020/21 plan in accordance with the COVID-19 guidelines, with any further guidance to be incorporated as it becomes available.

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

Report on the audit of the financial statements

Opinion
In our opinion the financial statements of Imperial College Healthcare NHS Trust (the 'trust'):
- give a true and fair view of the financial position of the trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements of the trust which comprise:
- the statement of comprehensive income;
- the statement of financial position;
- the statements of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 31.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:
- the table of salaries and allowances of senior managers on page 138
- the table of pension benefits of senior managers and related narrative notes on page 139; and
- the disclosure of pay multiples and related narrative notes on page 137.

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

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

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

Emphasis of matter – material uncertainty related to property valuation
We draw attention to note 1.2.1.1, which describes the effects of the uncertainties created by the coronavirus (COVID-19) pandemic on the valuation of the trust's estate. As noted by the trust's external valuer, the pandemic has caused extensive disruptions to businesses and economic activities and the uncertainties created have increased the estimation uncertainty over the valuation of properties at the balance sheet date. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern
We are required by ISAs (UK) to report in respect of the following matters where:
- the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the 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.

Other information
The directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's

report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in respect of these matters.

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

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

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

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

Report on other legal and regulatory requirements

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

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

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

Qualified Conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, with the exception of the matters reported in the basis for qualified conclusion section below, we are satisfied that, in all significant respects, Imperial College Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion
As disclosed in Note 1.1.2 to the Financial Statements, the Annual Governance statement and the Chief Financial Officer's statement, whilst the Trust's financial performance and position have been on an improvement trajectory, there continue to be significant risks to the organisation's financial sustainability predominantly linked to the estate. The Annual Governance statement discloses the key risk to financial sustainability as the condition of the Trust's estate.

During the 2019/20 period, there continued to be evidence of weaknesses in arrangements over financial sustainability linked to the estate. Whilst financial targets have been delivered, the Trust is not in a position to generate sufficient surplus in order to maintain the condition of its estate such that it can deliver its strategic priorities without external funding. The Trust continues to have a significant backlog maintenance requirement. The ongoing deterioration creates a material risk of an estate failure that would negatively impact the ability of the Trust to deliver its strategic priorities.

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

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

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

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

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

The Comptroller & Auditor General determined this overall evaluation criterion as that necessary for us to consider under its Code of Audit Practice in satisfying ourselves whether the trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

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

Matters on which we are required to report by exception

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

We have nothing to report in respect of these matters.

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

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

We have nothing to report in respect of these matters.

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

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

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

24 June 2020

Imperial College Healthcare NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	1,114,061	1,030,874
Other operating income	4	186,555	182,085
Operating expenses	6, 8	(1,264,351)	(1,169,891)
Operating surplus/(deficit) from continuing operations		**36,265**	**43,068**
Finance income	11	514	309
Finance expenses	12	(1,131)	(1,167)
PDC dividends payable		(12,254)	(11,764)
Net finance costs		**(12,871)**	**(12,622)**
Surplus/(deficit) for the year		**23,394**	**30,446**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	63
Revaluations		721	-
Total comprehensive income/(expense) for the period		**24,115**	**30,509**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		23,394	30,446
Remove net impairments not scoring to the departmental expenditure limit		(11,515)	(2,138)
Remove I&E impact of capital grants and donations		(2,237)	(143)
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(968)	
Adjusted financial performance surplus/(deficit)		**8,674**	**28,165**

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

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	4,260	3,158
Property, plant and equipment	13	538,191	511,326
Total non-current assets		**542,451**	**514,484**
Current assets			
Inventories	14	15,270	13,934
Receivables	16	125,489	148,964
Cash and cash equivalents	15	43,944	26,692
Total current assets		**184,703**	**189,590**
Current liabilities			
Trade and other payables	17	(158,253)	(157,137)
Borrowings	19	(17,981)	(1,807)
Provisions	20	(33,455)	(33,715)
Other liabilities	18	(19,879)	(26,012)
Total current liabilities		**(229,568)**	**(218,671)**
Total assets less current liabilities		**497,586**	**485,403**
Non-current liabilities			
Borrowings	19	(16,042)	(32,341)
Other liabilities	18	(2,058)	(2,058)
Total non-current liabilities		**(18,100)**	**(34,399)**
Total assets employed		**479,486**	**451,004**
Financed by			
Public dividend capital		720,787	716,420
Revaluation reserve		2,498	1,777
Income and expenditure reserve		(243,799)	(267,193)
Total taxpayers' equity		**479,486**	**451,004**

The notes on pages 167 to 187 form part of these accounts.

Name: Professor Tim Orchard
Position: Chief executive officer
Date: 22nd June 2020

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**716,420**	**1,777**	**(267,193)**	**451,004**
Surplus/(deficit) for the year	-	-	23,394	**23,394**
Impairments	-	-	-	-
Revaluations	-	721	-	**721**
Public dividend capital received	4,367	-	-	**4,367**
Taxpayers' and others' equity at 31 March 2020	**720,787**	**2,498**	**(243,799)**	**479,486**

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

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

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus/(deficit)		36,265	43,068
Non-cash income and expense:			
Depreciation and amortisation	6	38,144	35,326
Net impairments	7	(9,902)	2,693
Income recognised in respect of capital donations	4	(3,783)	(1,680)
(Increase)/decrease in receivables and other assets		23,510	15,766
(Increase)/decrease in inventories		(1,336)	(863)
Increase/(decrease) in payables and other liabilities		(670)	(14,954)
Increase/(decrease) in provisions		(260)	(11,256)
Net cash flows from/(used in) operating activities		**81,968**	**68,100**
Cash flows from investing activities			
Interest received		479	309
Purchase of PPE and investment property		(57,395)	(64,432)
Receipt of cash donations to purchase assets		3,783	1,680
Net cash flows from/(used in) investing activities		**(53,133)**	**(62,443)**
Cash flows from financing activities			
Public dividend capital received		4,367	10,037
Movement on loans from DHSC		(1,226)	(1,226)
Movement on other loans		(129)	163
Capital element of finance lease rental payments		(90)	-
Interest on loans		(1,124)	(1,170)
Other interest		-	(1)
Interest paid on finance lease liabilities		(9)	-
PDC dividend (paid)/refunded		(12,140)	(11,232)
Cash flows from (used in) other financing activities		(1,232)	-
Net cash flows from/(used in) financing activities		**(11,583)**	**(3,429)**
Increase/(decrease) in cash and cash equivalents		**17,252**	**2,228**
Cash and cash equivalents at 1 April - brought forward		**26,692**	**24,464**
Cash and cash equivalents at 31 March	15	**43,944**	**26,692**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The DHSC has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
Under International Accounting Standard 1, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a 'going concern'. The board has reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services, even though we will not be returning to financial balance in 2020/21. Since the Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate for the foreseeable future.

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

The Trust submitted a draft 2020/21 plan in March 2020 which indicated that at that point, the trajectory total deficit of £5.8m could not be accepted due to the planning assumptions that had been applied at that time. However, work was ongoing to close the unmitigated £9.7m gap by the second submission in April 2020 through revisiting the assumptions, before the planning round was paused due to covid19. The Trust had indicated that despite the planning gap and resulting deficit, management has the reasonable expectation that the Trust will continue to have access to adequate cash resources to service its operational activities in cash terms for the next 12 months and into the first half of 2021/22. The resilience of the cash position has been further strengthened by the writing off of the working capital loan of £15.8m (which was due for repayment in February 2021) through a public dividend capital (PDC) award as announced by the regulator on 2 April 2020.

Block contract values have been issued to providers to provide minimum guaranteed cash payments for the period 1 April 2020 to 31 July 2020 based on average monthly expenditure, including inflation uplift, and excluding efficiencies. Access to further top up payments will be available should the block values not cover the cost base during this time. It is expected that these measures will ensure a level of cash resilience for the Trust. There has been no announcement as yet as to the expected regime after this period.

The Trust is one of many organisations in the North West London sustainability and transformation partnership (STP) and is therefore mindful that it needs to engage with and take account of, the sector level planning work and how this may/may not impact on its organisational level operational and financial plan. STPs require organisations to take collective responsibility for the delivery of financial sustainability of the system and this may lead to the Trust being required to contribute a greater level of efficiencies but it will also receive a share of any benefits generated through joint working. Dialogue with the STP around achievability of cost improvement programmes and quality, innovation, productivity and prevention (QIPP) targets is ongoing. The Trust board is clear that it will only accept a greater efficiency target where the system has developed plans that are robust, clinically assessed and approved, lead to a real reduction in costs and ensure any double counts has been removed.

As disclosed in the annual report the Trust's estate is in a poor condition due to its age and this gives two specific causes for concern. Firstly, should the Trust miss its financial plan there is little flexibility in the capital programme to release additional cash to mitigate the shortfall. Secondly, should the level of expenditure required to maintain a safe and acceptable estate exceed that planned for, then this would require further, possibly material, central funding. The Trust has initiated an estate redevelopment programme for which it has already received £5m of HIP2 seed funding in order to develop a full business case to be presented to the DHSC in order to secure the funding required to redevelop the St. Mary's site.

Additionally, should provisions disclosed in Note 20 crystallise during the year, this would result in a potentially significant outflow of cash resources, meaning that the Trust would not be able to meet its liabilities as they fell due without additional departmental funding. The risk of this is considered relatively low for 2020/21.

These factors have been considered in assessing the Trust's ability to continue as a going concern and The Trust board is in regular contact with its regulator, and as such, should any of these circumstances arise, has a reasonable expectation that funding would be provided, although this funding is not yet committed. Therefore, no adjustments have been made to the financial statements as a result of this potential uncertainty.

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

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies
The following are the critical judgements, apart from those involving estimations (see 1.2.2) that management have made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.1.1 Land and buildings valuation
The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.7 for further details.

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

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

The valuation carried out as at 31st March 2020 is based on assumptions made by a suitably qualified professional in accordance with HM Treasury Guidance. The valuer provided the Trust with a valuation of land and building assets. This process leads to revaluation adjustments as set out in Note 13 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

The valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a material valuation uncertainty in the valuation report. This is on the basis of uncertainties in markets caused by the covid19 outbreak which was declared by the World Health Organisation as a global pandemic on 11 March 2020. This has impacted market activity across many sectors and is not specific to the Trust. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. As at the valuation date, the valuer considered they could attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Due to the unprecedented set of circumstances on which this judgement is based, the impact could not be quantified. In line with the recommendation of our valuer, management will keep the valuation of assets impacted under frequent review.

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

Note 1.2.2 Key sources of estimation uncertainty

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

Note 1.2.2.1 Provisions

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

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

Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.
The carrying amounts of the Trust's provisions are detailed in Note 20 to these accounts.

Note 1.2.2.2 Allowance for credit losses

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

The carrying amounts of the Trust's provisions are detailed in Note 16.1 to these accounts.

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

The Trust made preparations through 2019/20 for the potential impact of the UK's exit from the European Union (EU), including planning for the case of a 'no deal' EU exit, including following recommendations in the DHSC's EU Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

The Director of Operational Performance is the Trust's EU exit Senior Responsible Officer, reporting to the Board and Executive Management Committee on a regular basis with other committees considering issues as relevant through the year. The Trust has completed a risk assessment of the impact of a 'no deal' exit from the EU and associated risks in respect of the UK's exit from the EU (including the potential impact in areas such as workforce), Board Assurance Framework and has implemented appropriate mitigations. These are included in the Trust's Risk Register and have been monitored through the year by the Board.

Note 1.3 Interests in other entities

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

Note 1.4 Income

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 was 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 receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.
Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they are brought into use.

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

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

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.
Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses
Revaluations of property, plant and equipment are performed with sufficient frequency (annually) to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use basis
- Specialised buildings – depreciated replacement cost basis

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

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

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

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

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and where the cost is more than £5,000.

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

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

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

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

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

Note 1.9 Other relevant asset disclosures

Note 1.9.1 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Assets which are to be scrapped or demolished do not qualify for recognition as 'held for sale' and instead are retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.9.2 Donated and grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other assets in that class.

Note 1.10 Inventories

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

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Cash and bank balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

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

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

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

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

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

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

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

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.
Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and other receivables.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.
Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.
Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.
Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

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

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

Note 1.13 Leases

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

Note 1.13.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net irivestment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trusts' net investment outstanding in respect of the leases.

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

Note 1.14 Provisions

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at Note 20.1 but is not recognised in the Trust's accounts.

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

Note 1.15 Contingencies

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

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

Note 1.16 Public dividend capital

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

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Third party assets

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

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.20 Gifts

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2019/20. These standards are either being implemented in 2020/21 or are still subject to implementation.

IFRS 16 Leases:
Application required for accounting periods beginning on or after 1 January 2019, but owing to the coronavirus pandemic implementation has been deferred.
HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.23 Restatement

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

Note 2 Operating Segments

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

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

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

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	183,807	181,756
Non elective income	282,490	250,645
First outpatient income	57,240	57,199
Follow up outpatient income	80,731	73,460
A&E income	40,407	34,805
High cost drugs income from commissioners (excluding pass-through costs)	118,322	117,012
Other NHS clinical income	212,555	201,137
Community services		
Community services income from CCGs and NHS England	9,189	9,112
Income from other sources (e.g. local authorities)	993	539
All services		
Private patient income	53,839	52,221
Agenda for Change pay award central funding*		7,661
Additional pension contribution central funding**	27,264	
Other clinical income	47,224	45,327
Total income from activities	**1,114,061**	**1,030,874**

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

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

Note 3.2 Income from patient care activities (by source)	2019/20 £000	2018/19 £000
Income from patient care activities received from:		
NHS England	447,456	351,184
Clinical commissioning groups	556,847	539,202
Department of Health and Social Care	368	7,666
Other NHS providers	41,466	57,738
NHS other	24	8,552
Local authorities	467	667
Non-NHS: private patients	53,839	52,221
Non-NHS: overseas patients (chargeable to patient)	5,519	6,739
Injury cost recovery scheme	2,514	2,651
Non NHS: other	5,561	4,254
Total income from activities	**1,114,061**	**1,030,874**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	2019/20 £000	2018/19 £000
Income recognised this year	5,519	6,739
Cash payments received in-year	3,184	2,390
Amounts added to provision for impairment of receivables	1,154	3,505
Amounts written off in-year	1,245	1,927

Note 4 Other operating income	2019/20 £000	2018/19 £000
Research and development	50,852	46,418
Education and training	51,551	52,001
Non-patient care services to other bodies	14,765	15,191
Provider sustainability fund (PSF)	17,809	48,401
Marginal rate emergency tariff funding (MRET)	10,232	
Income in respect of employee benefits accounted on a gross basis	7,861	7,165
Receipt of capital grants and donations	3,783	1,680
Charitable and other contributions to expenditure	2,708	2,380
Rental revenue from operating leases	1,940	2,320
Other income	25,054	6,529
Total other operating income	**186,555**	**182,085**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	9,638	3,066
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	4,108	4,952

Note 5.1 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	15,098	16,692
Purchase of healthcare from non-NHS and non-DHSC bodies	12,784	16,114
Staff and executive directors costs	749,049	678,778
Remuneration of non-executive directors	119	54
Supplies and services - clinical (excluding drugs costs)	131,801	134,430
Supplies and services - general	38,088	37,529
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	124,895	124,595
Inventories written down	450	496
Consultancy costs	2,330	2,093
Establishment	9,260	7,630
Premises	51,470	50,122
Transport (including patient travel)	18,119	15,049
Depreciation on property, plant and equipment	36,055	33,639
Amortisation on intangible assets	2,089	1,687
Net impairments	(9,902)	2,693
Movement in credit loss allowance: contract receivables/contract assets	1,286	(13,502)
External audit services	182	150
Internal audit costs	267	275
Clinical negligence	30,452	30,510
Legal fees	1,090	711
Insurance	489	620
Research and development	29,301	24,835
Education and training	2,165	1,790
Rentals under operating leases	3,953	1,640
Redundancy	767	66
Hospitality	346	159
Other	12,348	1,036
Total	**1,264,351**	**1,169,891**

Note 6.1 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Annual statutory audit fee	150	128
Audit-related assurance services	-	22
All assurance services not falling within items 1 to 5	32	-
Total	**182**	**150**
Of which		
Value added tax	30	25

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus/deficit resulting from:		
Abandonment of assets in course of construction	1,613	4,831
Changes in market price	(11,515)	(2,138)
Impairments charged to the revaluation reserve	-	(63)
Total net impairments	**(9,902)**	**2,630**

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	579,443	533,344
Social security costs	61,971	57,404
Apprenticeship levy	2,769	2,566
Employer's contributions to NHS pensions	89,744	57,690
Pension cost - other	106	50
Temporary staff (including agency)	18,642	29,806
Total staff costs	**752,675**	**680,860**
Of which		
Costs capitalised as part of assets	2,859	2,016

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £81k (£60k in 2018/19).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Note 10 Operating leases

Note 10.1 Imperial College Healthcare NHS Trust as a lessor

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

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	1,940	2,320
Total	**1,940**	**2,320**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	174	1,735
- later than one year and not later than five years;	1,529	5,454
- later than five years.	10,340	5,142
Total	**12,043**	**12,331**

Note 10.2 Imperial College Healthcare NHS Trust as a lessee

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

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	3,953	1,640
Total	**3,953**	**1,640**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	3,517	1,598
- later than one year and not later than five years;	8,746	4,790
- later than five years.	2,049	2,119
Total	**14,312**	**8,507**

Note 11 Finance income

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

	2019/20 £000	2018/19 £000
Interest on bank accounts	514	309
Total finance income	**514**	**309**

Note 12 Finance expenditure

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

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,122	1,167
Finance leases	9	-
Total finance costs	**1,131**	**1,167**

Note 13 Non-current assets

Note 13.1 Non-current assets - 2019/20

	Intangible assets		Property, plant and equipment							
	Information technology	Total	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total	Total assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**11,902**	**11,902**	**79,161**	**304,992**	**82,433**	**163,484**	**56,011**	**1,234**	**687,315**	**699,217**
Additions	-	-	-	-	55,488	-	-	-	**55,488**	**55,488**
Impairments	-	-	-	(14,890)	(1,613)	-	-	-	**(16,503)**	**(16,503)**
Reversals of impairments	-	-	5,004	-	-	-	-	-	**5,004**	**5,004**
Revaluations	-	-	3	(5,266)	-	-	-	-	**(5,263)**	**(5,263)**
Reclassifications	3,191	3,191	-	54,495	(81,194)	15,250	7,881	377	**(3,191)**	-
Valuation/gross cost at 31 March 2020	**15,093**	**15,093**	**84,168**	**339,331**	**55,114**	**178,734**	**63,892**	**1,611**	**722,850**	**737,943**
Accumulated amortisation/depreciation at 1 April 2019 - brought forward	**8,744**	**8,744**	**-**	**4,234**	**-**	**129,318**	**41,641**	**796**	**175,989**	**184,733**
Provided during the year	2,089	**2,089**	-	23,151	-	7,852	4,868	184	**36,055**	**38,144**
Impairments	-	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	(21,401)	-	-	-	-	**(21,401)**	**(21,401)**
Revaluations	-	-	-	(5,984)	-	-	-	-	**(5,984)**	**(5,984)**
Accumulated amortisation/depreciation at 31 March 2020	**10,833**	**10,833**	**-**	**-**	**-**	**137,170**	**46,509**	**980**	**184,659**	**195,492**
Net book value at 31 March 2020	**4,260**	**4,260**	**84,168**	**339,331**	**55,114**	**41,564**	**17,383**	**631**	**538,191**	**542,451**
Net book value at 1 April 2019	**3,158**	**3,158**	**79,161**	**300,758**	**82,433**	**34,166**	**14,370**	**438**	**511,326**	**514,484**
Owned - purchased			84,168	316,497	47,758	38,999	16,124	631	**504,177**	**504,177**
Owned - finance leased			-	-	-	-	1,259	-	**1,259**	**1,259**
Owned - government granted			-	1,214	-	282	-	-	**1,496**	**1,496**
Owned - donated			-	21,620	7,356	2,283	-	-	**31,259**	**31,259**
NBV total at 31 March 2020			**84,168**	**339,331**	**55,114**	**41,564**	**17,383**	**631**	**538,191**	**538,191**

Note 13.2 Non-current assets - 2018/19

	Information technology	Total	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	**10,304**	**10,304**	**71,216**	**315,252**	**66,498**	**156,894**	**48,497**	**1,082**	**659,439**	**669,743**
Additions	-	-	-	-	53,378	1,680	-	-	**55,058**	**55,058**
Impairments	-	-	-	(15,623)	(4,831)	-	-	-	**(20,454)**	**(20,454)**
Reversals of impairments	-	-	7,945	(13,075)	-	-	-	-	**(5,130)**	**(5,130)**
Revaluations	-	-	-	-	-	-	-	-	-	-
Reclassifications	1,598	1,598	-	18,438	(32,612)	4,910	7,514	152	**(1,598)**	-
Valuation/gross cost at 31 March 2019	**11,902**	**11,902**	**79,161**	**304,992**	**82,433**	**163,484**	**56,011**	**1,234**	**687,315**	**699,217**
Accumulated amortisation/depreciation at 1 April 2018 - as previously stated	**7,057**	**7,057**	**-**	**6,174**	**-**	**121,316**	**37,153**	**661**	**165,304**	**172,361**
Provided during the year	1,687	**1,687**	-	21,014	-	8,002	4,488	135	**33,639**	**35,326**
Impairments	-	-	-	3	-	-	-	-	**3**	**3**
Reversals of impairments	-	-	-	(22,957)	-	-	-	-	**(22,957)**	**(22,957)**
Revaluations	-	-	-	-	-	-	-	-	-	-
Accumulated amortisation/depreciation at 31 March 2019	**8,744**	**8,744**	**-**	**4,234**	**-**	**129,318**	**41,641**	**796**	**175,989**	**184,733**
Net book value at 31 March 2019	**3,158**	**3,158**	**79,161**	**300,758**	**82,433**	**34,166**	**14,370**	**438**	**511,326**	**514,484**
Net book value at 1 April 2018	**3,247**	**3,247**	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**	**497,382**
Net book value at 31 March 2019										
Owned - purchased			79,161	278,728	75,559	31,055	14,370	438	**479,311**	**479,311**
Owned - finance leased			-	-	-	-	-	-	-	-
Owned - government granted			-	1,113	-	336	-	-	**1,450**	**1,450**
Owned - donated			-	20,916	6,874	2,775	-	-	**30,565**	**30,565**
NBV total at 31 March 2019			**79,161**	**300,758**	**82,433**	**34,166**	**14,370**	**438**	**511,326**	**511,326**

Note 13.3 Useful economic lives

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

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

Note 14 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	8,045	7,029
Consumables	7,008	6,656
Energy	217	249
Total inventories	**15,270**	**13,934**

Inventories recognised in expenses for the year were £179,535k (2018/19: £166,193k). Write-down of inventories recognised as expenses for the year were £450k (2018/19: £496k).

Note 15 Cash and cash equivalents movements

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

	2019/20 £000	2018/19 £000
At 1 April	**26,692**	**24,464**
Net change in year	17,252	2,228
At 31 March	**43,944**	**26,692**
Broken down into:		
Cash at commercial banks and in hand	45	139
Cash with the Government Banking Service	43,899	26,553
Total cash and cash equivalents as in SoCF	**43,944**	**26,692**

Note 15.1 Third party assets held by the trust

Imperial College Healthcare NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000	31 March 2019 £000
Monies on deposit	59	73
Total third party assets	**59**	**73**

Note 16 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	112,369	136,796
Allowance for impaired contract receivables/assets	(8,238)	(8,324)
Prepayments	12,516	12,439
Interest receivable	35	-
VAT receivable	6,375	5,069
Other receivables	2,432	2,984
Total current receivables	**125,489**	**148,964**
Of which receivable from NHS and DHSC group bodies:		
Current	73,804	118,540

Note 16.1 Allowances for credit losses

	2019/20 Contract receivables and contract assets £000	2018/19 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**8,324**	**21,826**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018		(15,873)
New allowances arising	1,286	6,432
Reversals of allowances	-	(911)
Utilisation of allowances (write offs)	(1,372)	(3,150)
Allowances as at 31 Mar	**8,238**	**8,324**

Note 16.2 Exposure to credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31st March 2020 is in receivables from customers, as disclosed in the trade and other receivables note. At the 31st March 2020 the main customer (excluding NHS entities) debts totaled £39.0m for which the Trust feels it has made adequate provision.

Note 17 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	48,705	45,977
Capital payables	10,320	13,548
Accruals	63,000	67,432
Social security costs	9,161	8,708
Other taxes payable	7,912	7,393
PDC dividend payable	351	237
Other payables	18,804	13,842
Total current trade and other payables	**158,253**	**157,137**
Of which payables from NHS and DHSC group bodies:		
Current	18,035	13,072

Note 18 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	19,879	26,012
Total other current liabilities	**19,879**	**26,012**
Non-current		
Lease incentives	2,058	2,058
Total other non-current liabilities	**2,058**	**2,058**

Note 19 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	17,054	1,251
Other loans	652	556
Obligations under finance leases	275	-
Total current borrowings	**17,981**	**1,807**
Non-current		
Loans from DHSC	12,240	29,271
Other loans	2,845	3,070
Obligations under finance leases	957	-
Total non-current borrowings	**16,042**	**32,341**

The Trust is party to five loans as follows:

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

Loan 2 - working capital facility of £15.8m. Commencing 7 April 2016 and continuing until settled on 28 February 2021. Fixed interest rate of 3.5%

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

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

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

Note 19.1 Reconciliation of liabilities arising from financing activities - 2019/20

	DHSC Loans £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2019	**30,522**	**3,626**	**-**	**34,148**
Financing cash flows - payments and receipts of principal	(1,226)	(129)	(90)	**(1,445)**
Financing cash flows - payments of interest	(1,124)	-	(9)	**(1,133)**
Additions	-	-	1,322	**1,322**
Application of effective interest rate	1,122	-	9	**1,131**
Other changes	-	-	-	-
Carrying value at 31 March 2020	**29,294**	**3,497**	**1,232**	**34,023**

Note 19.2 Reconciliation of liabilities arising from financing activities - 2018/19

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

Note 20 Provisions for liabilities and charges analysis

	Redundancy	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**79**	**442**	**33,194**	**33,715**
Arising during the year	644	40	607	**1,291**
Utilised during the year	(330)	(17)	(128)	**(475)**
Reversed unused	-	(340)	(736)	**(1,076)**
At 31 March 2020	**393**	**125**	**32,937**	**33,455**
Expected timing of cash flows:				
- not later than one year	393	125	32,937	**33,455**
Total	**393**	**125**	**32,937**	**33,455**

Provisions classified as 'other' includes potential commercial liabilities and, as has been disclosed in Note 1.1.2, there is significant uncertainty as to the timing of these outflows.

Note 20.1 Clinical negligence liabilities

At 31 March 2020, £440,043k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2019: £450,858k).

Note 21 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(67)	(65)
Net value of contingent liabilities	**(67)**	**(65)**

Note 22 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	12,381	5,104
Total	**12,381**	**5,104**

Note 23 Financial instruments

Note 23.1 Financial risk management

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

Currency risk

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

Interest rate risk

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

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

Credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31st March 2020 is in receivables from non-NHS customers, as disclosed in the trade and other receivables note. At the 31st March 2020 the main customer debts totaled £39.0m for which the Trust feels it has made adequate provision.

Liquidity risk

Liquidity risk reflects the risk that the Trust will have insufficient resources to meet its financial liabilities as they fall due. Management have noted areas affecting liquidity in the going concern disclosure in note 1.1.2. Mitigating this, the Trust's operating costs are incurred in relation to contracts with CCGs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure from internally generated resources. The Trust's strategy is to manage liquidity risk by ensuring that it has sufficient funds to meet all of its potential liabilities as they fall due. Liquidity forecasts are produced regularly to ensure the utilisation of current facilities is optimised and liquidity is maintained. The Trust also continually assesses its loan funding.

Carrying values of financial assets as at 31 March	2019/20	2018/19
	£000	£000
Trade and other receivables excluding non financial assets	106,563	131,456
Cash and cash equivalents	43,944	26,692
Total at 31 March	**150,507**	**158,148**

Note 23.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March	2019/20	2018/19
	£000	£000
Loans from the Department of Health and Social Care	29,294	30,522
Obligations under finance leases	1,232	-
Other borrowings	3,497	3,626
Trade and other payables excluding non financial liabilities	140,829	140,799
Total at 31 March	**174,852**	**174,947**

Note 23.3 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	158,830	142,607
In more than one year but not more than two years	4,350	1,878
In more than two years but not more than five years	5,562	20,240
In more than five years	6,110	10,222
Total	**174,852**	**174,947**

Note 24 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	38	54	50	87
Bad debts and claims abandoned	266	1,318	423	2,185
Stores losses and damage to property	12	454	12	505
Total losses	**316**	**1,826**	**485**	**2,777**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	1
Ex-gratia payments	82	36	69	35
Total special payments	**82**	**36**	**70**	**36**
Total losses and special payments	**398**	**1,862**	**555**	**2,813**

There are no individual cases over £300k.

Note 25 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Imperial College Healthcare NHS Trust. During the year 2019/20 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below for the year ending 31 March 2020. This list is indicative and not exhaustive.

Department of Health
NHS England
NHS Foundation Trusts including:
- Chelsea and Westminster NHS Foundation Trust
- Hillingdon Hospitals NHS Foundation Trust

CCGs including:
- Brent CCG
- Camden CCG
- Central London (Westminster) CCG
- Ealing CCG
- Hammersmith and Fulham CCG
- Harrow CCG
- Hillingdon CCG
- Hounslow CCG
- Richmond CCG
- West London (Kensington & Chelsea) CCG

NHS Trusts including
- London North West University Healthcare NHS Trust

Other NHS Bodies including:
- Health Education England
- NHS Litigation Authority
- NHS Pension Scheme
- NHS Blood & Transplant

Other non-NHS entities
- Imperial College London
- Imperial College Healthcare Charity
- HM Revenue and Customs

Note 26 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £15.8m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 27 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	163,773	638,300	172,068	554,545
Total non-NHS trade invoices paid within target	155,402	563,786	144,673	418,873
Percentage of non-NHS trade invoices paid within target	94.9%	88.3%	84.1%	75.5%
NHS Payables				
Total NHS trade invoices paid in the year	7,212	71,792	7,312	78,183
Total NHS trade invoices paid within target	4,826	49,310	3,658	49,249
Percentage of NHS trade invoices paid within target	66.9%	68.7%	50.0%	63.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 28 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2019/20 £000	2018/19 £000
Net cash (generated from)/used in operations	(81,968)	(68,100)
Net cash (generated from)/used in investing activities	53,133	62,443
Relevant cash adjustments from financing activities	13,273	12,403
External financing requirement	**(15,562)**	**6,746**
External financing limit (EFL)	8,195	14,794
Under/(over) spend against EFL	**23,757**	**8,048**

Note 29 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	55,488	55,058
Less: Donated and granted capital additions	(3,783)	(1,680)
Charge against Capital Resource Limit	**51,705**	**53,378**
Capital Resource Limit	51,846	54,175
Under/(over) spend against CRL	**141**	**797**

Note 30 Breakeven duty financial performance

	2019/20 £000	2018/19 £000
Adjusted financial performance surplus/(deficit) (control total basis)	8,674	28,165
Remove impairments scoring to Departmental Expenditure Limit	1,613	4,831
Add back income for impact of 2018/19 post-accounts PSF reallocation	968	-
Breakeven duty financial performance surplus/(deficit)	**11,255**	**32,996**

Note 31 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)	(15,330)	3,023	32,996	11,255
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283	6,953	9,976	42,972	54,227
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905	1,096,575	1,160,803	1,212,959	1,300,616
Cumulative breakeven position as a percentage of operating income		3.8%	4.2%	3.2%	4.1%	5.6%	7.0%	2.2%	0.6%	0.9%	3.5%	4.2%