NHS
Imperial College Healthcare
NHS Trust

Annual report

2020/21

Our annual report 2020/21 is dedicated to the ongoing commitment and expertise of all our people who continue to play a vital role in the UK's response to Covid-19.

We play special tribute to our colleagues who died during the pandemic of whatever cause and celebrate their lives and contribution to the NHS:

Daniela Gheorghe
Dax Daantos
Donald Suelto
Eliana Leitao
Elizabeth Lobeck
Flora Lassig Dimanno
Jennifer Emodi
Jennifer Huey
Jermaine Wright
Kumaran Manickam
Lenford Allen
Lesley Moran
Marlene Spellen
Melanie Tinte
Melujean Ballesteros
Mohammed Sami Shousha
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Alternative formats

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Welcome

Bob Alexander, interim chair

Welcome to the annual report for Imperial College Healthcare NHS Trust for 2020/21 – without doubt the most challenging year ever for our Trust and the wider NHS. It's been an extraordinary 12 months and, while the pandemic has caused much sadness and suffering, there have also been many achievements across our organisation. From the personal – individual acts of kindness and inspiring recoveries – to the strategic – with new and better ways of working and collaborating catalysed by our response to Covid-19.

I joined the Trust in October 2020 as a non-executive board member and was struck immediately by the expertise and commitment of our 14,500 staff. I also saw an organisation that recognises the need to openly engage and reflect so that we can learn and improve. That was evident in an initiative undertaken after the first wave of Covid-19 infections to draw on insights from staff, patients and a range of other stakeholders to help prepare for whatever came next. Notably, while the Trust experienced higher demand during the inevitable second wave, it was also able to help a greater proportion of patients to recover and maintain a higher level of planned care. Research trials flourished too, with more than 4,600 patients recruited to 31 different studies, contributing to breakthroughs in vaccines, testing, care and treatment.

It is especially impressive given the huge pressure on our staff throughout the year – the desire to provide the best care possible for patients with a disease that was virtually unknown, having to adapt to the rigours of personal protective equipment, being redeployed to new roles or having their unit double in size – all while dealing with the worry of becoming infected themselves or passing on the virus to their families. I am hugely grateful for the contribution of every one of our people and I especially want to recognise those who died in service during the pandemic. My heart goes out to their families and colleagues.

We're stepping up as an organisation, to provide greater support for our people for the longer term and to build on other strategic developments that will help us respond to challenges and opportunities presented by the pandemic as well as those that existed long before. We must deepen our collaboration with our health and care partners – particularly our acute Trust neighbours in north west London – as well as with our patients and local communities. Integrated care systems will become a reality in the coming year and we must ensure we make a full contribution to ours to help embed a real shift in patient-focused care and a 'levelling up' of quality and health outcomes. We must focus relentlessly on equality, diversity and inclusion – both within our organisation and our population. The poor condition of our estate is now at a critical point and so we must convert our inclusion in the government's new hospitals programme into the necessary approvals and investment to begin redevelopment in earnest. And, while we are at a particularly uncertain juncture in terms of the future for NHS funding, we must continue to move ourselves onto a genuinely sustainable financial footing, for the long term stability of this great organisation and the people we serve.

Drawing on the experience of a long career in the NHS, I feel certain that Imperial College Healthcare can – and should – emerge from the pandemic with a key role in shaping a new and better health service through a commitment to learning, collaboration and fairness. I feel privileged to be part of that journey.

Performance report

Overview

Professor Tim Orchard, Chief executive

For the second annual report in a row, it's hard to reflect comprehensively on our past year while we remain in the midst of the Covid-19 pandemic. Even now, as we move out of lockdown restrictions, we are having to plan for a potential third wave and assessing the full cost of the pandemic in terms of unmet and new needs.

We start this year's performance report with an overview of our Covid-19 activities which I really urge you to read. The scale of our operational response over the past year or so has been incredible – the numbers speak for themselves. I am immensely proud and grateful for what our staff and partners have achieved with and for our patients and local communities.

I want to try to focus here though on five key developments over the last year that have enabled us to respond to Covid-19 so effectively but are also likely to have a significant and long lasting impact on our future, beyond the pandemic.

Collaboration, integration and spreading improvement

The pandemic has necessitated much more joint planning and working across health and care partners. In particular, collaboration involving the four acute NHS trusts in north west London – managing a total of 12 hospitals between us - has enabled us to meet many different aspects of need, from surges in intensive care demand to securing enough personal protective equipment (PPE) to keep our staff safe.

Provider collaboration is now accelerating improvements in care quality and efficiency and will be a key means of reducing the huge backlog in planned care fairly and swiftly. We are continuing to harness our collective resources and expertise to share the practices and processes that we know deliver the best outcomes, to direct capacity where it is most needed and to reduce duplication and waste.

Closer working is also helping to break down barriers between acute, community and primary care. The need to avoid unnecessary visits to hospital and to help patients leave hospital as soon as they are well enough has been driving improvements in models of care. During 2021/22, this has included developing advice and guidance to make it easier for GPs to get input from specialist consultant colleagues before referring a patient to hospital, our clinicians supporting nursing home staff on Covid-19 testing and care and simplifying discharge arrangements with social care partners.

Inclusion, equality and responsiveness

One of the most striking aspects of Covid-19 has been the differential impact it has had on some communities – within our local population and our own workforce. We had already prioritised making improvements to staff equality and diversity before the pandemic – and had achieved some good progress in making our disciplinary processes fairer for our Black, Asian and minority ethnic (BAME) staff and raising awareness and understanding through, for example, reverse mentoring programmes for senior leaders and establishing and supporting a range of staff networks.

The past year has now really brought home the full extent of health inequalities. It has also shown the importance of listening, reflecting and responding to the needs

and views of our stakeholders – staff, patients, carers and local residents – in order to build trust, mutual understanding and solutions that work for everyone. We have engaged with community leaders, trade unions and staff networks to explore Covid-19 vaccine hesitancy, recognising and responding to genuine concerns; we were able to pick up, early on in the pandemic, worrying misinformation about end of life care for people from BAME communities and develop factual content with community leaders that they were able to share themselves; and we were able sensitively to incorporate ethnicity and disability considerations into Covid-19 individual risk assessments and actions.

We still have a long way to go, though; our most recent staff survey shows that many of our BAME staff in particular have yet to feel any direct improvement to their working lives. We have to redouble our efforts and continue to build a culture where all staff feel it's not only safe to speak up but also worthwhile.

The last year has also given us a glimpse of how we and our hospitals can act as anchors for our local communities, using our reach and resources to support health and wellbeing more generally. Bringing our expertise and experience together with that of our community leaders and running two community mass vaccination centres is making a real difference to vaccine uptake across north west London while the new 'compassionate communities' programme run in partnership with – and funded by – Imperial Health Charity will help to make a significant contribution to local resilience. Our growing links with our local authorities, the commitment we've made to sustainability through our new green plan and the opportunities presented by new ways of working will allow us to do much more.

Digitally-enabled transformation

Almost all of us will have had to get to grips with a greater reliance on digital technology during the pandemic across many aspects of our lives. It's been key to our ability to continue to provide safe care for thousands of patients through video or telephone outpatient consultations; to allow thousands of staff to work effectively off site for some or all of their time through the roll out of collaboration and virtual meetings software; and to support often time-critical communications and engagement with all of our audiences, also using virtual meetings as well as via our redeveloped intranet, website and growing social media channels.

> "We are continuing to harness our collective resources and expertise to share the practices and processes that we know deliver the best outcomes, to direct capacity where it is most needed and to reduce duplication and waste."

We're continuously learning how to use digital better and have put support and engagement in place to make the most of the opportunities to transform – not just transfer – the way we work. We recognise we need to improve the overall 'user experience' and create more joined up digital services. We're also finding out more about what doesn't work for patients – and for staff - so that we don't leave anyone behind and recognise when in-person care is essential as we build on the rapid change that Covid-19 has prompted.

We were also able to draw hugely on the benefits of having a shared electronic patient record system with neighbouring hospitals and the growing use of the Care information exchange, a secure online platform for all patients in north west London to access personal health information and appointments.

Workforce sustainability

It was ultimately the hard work, commitment and expertise of our 14,500 staff that enabled us to respond to Covid-19 and to save the lives and health of so many. The pandemic has challenged all aspects of how we build and sustain a high quality workforce. Up to 1,000 staff have been redeployed into temporary roles to meet urgent need, especially to allow our intensive care capacity to double within a few weeks. On 1 April 2020, we directly employed 1,000 porters, cleaners and catering staff who had previously been managed by an external company – a decision unrelated to the pandemic but which I believe helped us hugely as we responded continually to changing needs.

We have had to think much more deeply and holistically about ensuring the health and wellbeing of our staff, not just through the worst of the pandemic and to enable them to recover from the exhaustion of the past year but for the long term. Deep rooted inequalities have become more exposed and demand attention. Virtual meetings, training and education are now the norm and we need to explore the opportunities this creates.

NHS staff in general are aware that there is likely to be even more work and change ahead and worry about having enough time and resources to continue to provide high quality care. That's why we're putting workforce sustainability at the top of our priorities for the future. There is much to build on from the past year in terms of exploring more flexible roles and ways of working, the necessity of effective leadership at all levels of our organisation and the importance of meaningful involvement and recognition.

We have already begun to think differently about health and wellbeing. The public's generosity, especially during the first wave of infections, in offering our staff food, travel and other support was hugely appreciated but also shone a light on longstanding gaps in how we look after our staff ourselves. With funding from Imperial Health Charity, we last year launched a £1.7 million staff support programme which is enabling us to make significant and sustainable improvements to break rooms and other staff spaces, transform our retail food and shops offer and expand our counselling and mental health support in response to vastly increased need.

Focus, reflection and learning

We undertook a key piece of insights work between the first and second Covid-19 waves to find out what staff, patients and partners thought had worked well and what we could do better. Universally acknowledged as improvements to build on were having a clear and shared purpose, embedding reflection and evidence-based

learning into everything we do and widening out opportunities for everyone to get more involved in research and innovation.

We are beginning our NHS new year with a greater focus on our vision – 'better health for life' – and our three strategic goals. All were developed through engagement in 2017/18 and have been tested as part of our pandemic insights work. We will be rolling out a Trust-wide improvement and management approach this coming year to help all our staff to connect with our vision and goals and how they relate to a set of agreed priorities that we all have a responsibility to ensure are delivered.

Our staff have provided the best possible care for thousands of patients with Covid-19 as well as thousands more with other urgent or emergency conditions over the past year. We learnt a lot between waves one and two and we managed to safely maintain more planned care during the second wave, while also successfully treating more Covid-19 patients.

But many patients with non-urgent conditions have now been waiting for treatment or advice for a long time and this situation will get worse before it gets better as more people are likely to seek care as we move out of the pandemic. Adding to that are our underlying challenges of increasing and changing health and care needs, recruitment and retention, financial pressures, poor estate and, more generally, our commitment to become more 'user-focused' and inclusive.

Our Covid-19 legacy must build on all that has been achieved this past year, taking more time to involve and engage our staff, patients and communities so that we can resolve the aspects that aren't yet working well enough while also maintaining the momentum for further strategic improvement. In this context, and with the continuing decline of our very old estate, it's more important than ever that we are also finally able to progress the essential redevelopment of our hospitals. We owe it to our community, patients and ourselves to fully realise the potential of what we can achieve as a true health and care partnership.

Professor Tim Orchard
Chief executive

> "I am immensely proud and grateful for what our staff and partners have achieved with and for our patients and local communities."

About the Trust

At Imperial College Healthcare NHS Trust we provide acute and specialist healthcare for over one million people a year. Formed in 2007, we are one of the largest NHS trusts in the country, with more than 14,500 staff.

Our five hospitals in central and west London – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing care and treatment nationally and worldwide. We are developing a growing range of integrated and digital care services and offer private healthcare in dedicated facilities on all our sites.

With our partners, Imperial College London, The Institute of Cancer Research, London, The Royal Marsden NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust, we form Imperial College Academic Health Science Centre (AHSC). We are one of eight academic health science centres in England, working to improve health and care through the rapid translation of discoveries from early scientific research into benefits for patients.

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

Everything we do is underpinned by our 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 a hyper-acute stroke unit 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 a specialist heart attack centre. As well as being a major base for Imperial College London, the site also hosts Medical Research Council's London Institute of Medical Sciences.

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 complex 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 partnership with GPs and community, mental health and social care organisations.

We run eight renal satellite units.

Imperial Private Healthcare (IPH)

Imperial Private Healthcare (IPH) 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. The income from our private care is invested back into supporting all our services across the Trust.

For most of 2020/21, IPH was closed to all but urgent, time-critical care, diverting resources to support the NHS's Covid-19 pandemic response. When IPH was able to partially reopen to private patients, it treated over 10,000 private patients, 7,000 fewer than in the previous year.

Research, education and innovation

As well as being part of the Imperial College Academic Health Science Centre, the Trust, in partnership with Imperial College London, hosts one of 20 National Institute for Health Research (NIHR) Biomedical Research Centres (BRCs). This research infrastructure funding is awarded 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.

In 2020/21, the NIHR Imperial BRC supported 947 clinical research projects across 29 different disease areas.

The Trust is also part of the NIHR Health Informatics Collaborative (NIHR HIC), together with several other NHS Trusts around the country. This collaboration brings together clinical, scientific and informatics expertise to enable NHS clinical data to be catalogued, shared and analysed to gain 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 2020/21, some 1,997 Imperial College London medical undergraduates trained with us. We had 565 student nurses in training during 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 2020/21, the charity invested £6.4m in a wide range of initiatives for the benefit of patients and staff, including £3.1m to support our Covid-19 response. A full account will be available in the charity's annual report.

Throughout the Covid-19 pandemic, the charity has provided vital support to help our staff and patients, including a £1.7m grant to fund improvements to staff spaces and extra counselling services through our staff support Covid-19 legacy programme (see page 20) During the year, the charity also mobilised more than 500 crisis response volunteers to deliver free meals, run pop-up shops, welcome visitors and assist with the staff vaccination programme.

The charity also funds facility 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 manages an Arts Council England-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 2020/21, we also received generous support both from COSMIC (formed by the merger of Children of St Mary's Intensive Care and the Winnicott Foundation) which raised funds for our children's and neonatal intensive care units, and from each of the Friends of St Mary's, Charing Cross, and Hammersmith hospitals.

We had

565 student nurses

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Our lay partners

We are committed to increasing and deepening the involvement of patients and the public in every aspect of our work. One important element of our involvement approach is our community of lay partners – local people and/or patients who provide independent insight and oversight on a voluntary basis to help ensure we understand and respond to the needs of our patients and local communities.

The strategic lay forum was established in 2015 to ensure we put patients at the centre of everything we do and to oversee our patient and public involvement strategy. The forum meets every two months, when 12 lay partners and key staff from around the Trust come together to review and develop plans to make sure care is patient-centred, integrated and based on patients' wants, needs and preferences.

Lay partners on the forum and beyond are also involved in a wide range of strategic programmes, projects and discussions. As of the end of 2020/21, the Trust had 62 lay partner roles supporting 25 projects. Since November 2016, we have engaged with 138 lay partners on various projects.

Our commissioners

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

In response to the recommendation in the NHS Long Term Plan that the number of CCGs be significantly reduced to align with the emerging integrated care systems (ICSs), 2020/21 was a year of transition as work got under way towards a merger of the eight CCGs in north west London into a single North West London CCG. The formation of one organisation in April 2021 is a key step towards forming an ICS in our part of London. The role of the North West London CCG continues to be to commission health services for local people across the eight boroughs:

- Brent
- Ealing
- Hammersmith & Fulham
- Harrow
- Hillingdon
- Hounslow
- Kensington and Chelsea
- Westminster

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 for the population of north west London through one of London's five emerging integrated care systems (ICSs).

In February 2021, the Government published proposals to make ICSs statutory bodies across the country. This would mean that the NHS and local councils work together legally as part of ICSs, to plan health and care services around local population needs.

All NHS organisations and local authorities in north west London have been working informally as an ICS ahead of legislation which is expected during 2021, with ICSs becoming legally recognised bodies from April 2022.

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).

NHS England and NHS Improvement lead the NHS in England and came together as a single organisation in April 2019.

The CQC is the independent regulator of health and adult social care in England. The CQC monitors and inspects the Trust's sites using five quality domains: safe, effective, caring, responsive and well-led https://www.england.nhs.uk/well-led-framework/. Following inspections, the CQC awards performance ratings for each domain as well as the Trust overall.

The Trust is currently rated overall as 'requires improvement'; it is rated overall as 'good' for the caring and effective domains, and 'requires improvement' for the safe, responsive and well-led domains. Trust services were last inspected in February 2019 (report published in July 2019) – eight core services were inspected and the CQC increased its ratings for six of them, all of them were rated as 'good' or 'outstanding' and the overall rating for Queen Charlotte's and Chelsea Hospital was increased to 'outstanding'. A separate 'well-led' inspection in April 2019 increased our overall well-led rating to 'good'.

In response to the first wave of the Covid-19 pandemic, in March 2021, the CQC suspended all routine monitoring and inspections; this suspension remained in effect for the duration of 2020/21.

The CQC introduced a temporary regulatory framework, called the transitional regulatory approach (TRA), which included two virtual assessments for the Trust: one for infection prevention and control in July 2020 and the other for urgent and emergency services in November 2020. The CQC did not raise any concerns in relation to either assessment and the Trust was not asked to take any action.

Trust in numbers 2020/21

Our services

1,069,119

Patient contacts

(including inpatients, outpatients and days cases)

200,705

Emergency attendees

(including A&E and ambulatory emergency care)

9,168

Babies born

20,201

Operations

97 per cent*

Positive overall rating of care for inpatients

* FFT survey collection was suspended from end of March 2020 -September 2020 due to the Covid-19 pandemic and response numbers have been extremely low this annual year in general.

Our staff

2,023
Admin and clerical

772
Allied health professionals (qualified)

110
Allied health professionals (support)

1,073
Ancillary

38
Doctor (career grade)

1,216
Doctor (consultant)

1,790
Doctor (Trust and training grade)

4,053
Nursing and midwifery (qualified)

1,277
Nursing and midwifery (support)

154
Pharmacist

4
Physician associate

841
Scientific and technical (qualified)

375
Scientific and technical (support)

809
Senior managers

14,535
Trust total

Our students

1997

Medical students

565

Nurses in education, pre-registration

Our finances

£47k

Surplus

£1.425bn

Turnover

£85.9m

Capital investments including buildings, infrastructure and IT

The total number of staff was

14,535

in 2020/21.

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 also reviews a core set of indicators at our public meetings. Our scorecard report is aligned with the Trust's strategic goals and improvements.

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.

Clearly, 2020/21 has been a year like no other for the NHS, with our response to the Covid-19 pandemic dominating our focus. Performance against national standards and our own organisational objectives cannot be assessed in the usual way as we have had to reprioritise our efforts to caring for patients with Covid-19 and other urgent and emergency conditions. We have provided as much planned care as possible during and – to a larger degree – in between the two main waves of Covid-19 infections but waiting times for care that is not time-critical have, necessarily, grown significantly.

Reflecting the huge – and broadly unanticipated - challenges and changes of the past year, we begin this performance report with an overview of our response to the Covid-19 pandemic and follow with an assessment of what we have been able to achieve in addition, in terms of progress against our three strategic goals.

Our response to the Covid-19 pandemic

Our first patient with Covid-19 was admitted on 10 March 2020 and between then and 31 March 2021, we have cared for more than 5,593 patients with Covid-19, 4,708 of whom we have helped to recover while 885 have sadly died.

We experienced two main waves of demand, the first wave peaked on 7 April 2020 when 360 of our inpatients had Covid-19, and the second on 20 January 2021, with 492 Covid-19 patients. We expanded our intensive care units – and created additional ones by transforming our children's intensive care and surgical innovation unit as well as some recovery and general wards – going from 84 intensive care beds pre-pandemic up to 150 in early 2021.

We had to learn everything we could about a completely new disease, put in place unprecedented measures to protect our staff, patients and visitors from infection, redeploy up to 1,000 staff from planned care and corporate services to help with our Covid-19 response and ramp up practical and wellbeing support for our whole workforce.

Key to our response was our commitment to learn and understand all we could about Covid-19, from how it spreads, to finding the most effective treatments, including repurposing existing drugs, and searching for an effective vaccine.

More than 4,600 of our patients have signed-up to 31 different research studies so far during the pandemic. These trials, supported by the NIHR Imperial Biomedical Research Centre, have helped develop more effective drugs for treating patients with Covid-19 and contributed to international understanding of the virus.

A rigorous Covid-19 testing strategy – for patients and staff – has also been an important element of our pandemic response, with our North West London Pathology division increasing its capacity very significantly. They had processed more than half a million polymerase chain reaction (PCR) tests by the end of March 2021.

We instigated a rapid insight and learning initiative after the first wave, drawing on the feedback and ideas of staff, lay partners and other stakeholders to help us prepare for the second wave. While we saw more patients with Covid-19 during the second wave, we were also able to maintain more planned care and enable a greater proportion of patients with Covid-19 to recover – the mortality rate in our intensive care units during the second wave was around 13 per cent compared with some 30 per cent during the first wave.

Since December 2021, we have also been learning a huge amount about rolling out Covid-19 vaccinations to our own staff as well as those working for local health and care partners and to patients and the wider community. As of March 2021, we had administered 35,000 doses of approved Covid-19 vaccines through our own hospital vaccination hubs and were running two community mass-vaccination hubs, at Marble Arch and Hammersmith.

As we emerge from the second Covid-19 wave, we face a range of new challenges: very long waiting times for routine planned care, exacerbated health inequalities across our local population and staff who have been working relentlessly under extreme pressure. While we were able to maintain planned care for patients with clinically urgent needs and restart some routine services in between waves, many patients have had to have their care postponed – as of January 2021 over 1,600 patients are waiting over 52 weeks compared with two in January 2020 before the pandemic.

However, there is also much to build on in terms of new ways of working catalysed by the pandemic, including much greater collaboration with our health and care partners especially our neighbouring acute NHS trusts, a more strategic focus on staff health and wellbeing, stronger engagement with our local communities and other stakeholders, a big shift in the uptake of digital technology and systems and a greater awareness of research and innovation across the whole Trust.

Assessing our performance against our strategic goals

Our three strategic goals are:

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

While our primary focus in 2020/21 has been our immediate response to the Covid-19 pandemic, we have continued to consider our longer-term strategic goals, with significant synergy and learning generated by activities during the year. Here, we report on progress towards our strategic goals through developments this year, set out under the goal they most relate to.

Strategic goal 1: to help create a high-quality integrated care system with the population of north west London

Tackling health inequalities through 'Compassionate communities'

As a Trust, we understand that our responsibilities go beyond simply providing healthcare. We are also playing an active role outside traditional hospital settings, to address the many other factors that affect people's health. In line with our vision of 'better health for life' for our patients, staff and communities, we partnered with Imperial Health Charity in November 2020 to pioneer a new funding programme – Compassionate communities – to support the most vulnerable people affected by Covid-19 in north west London.

Imperial Health Charity has made a commitment of £450,000 to fund and evaluate the programme, through which we will deliver community-designed and led pilot projects to support people most affected by the direct and indirect effects of Covid-19. This includes tackling complex and long-term issues such as such as obesity, known to exacerbate the impact of Covid-19, and food poverty, a challenge faced by an increasing number of people, as the economic impact of the pandemic is realised. Other project areas available for funding include mental health and wellbeing, digital poverty and exclusion, and addressing language barriers and misinformation.

Between November and January 2021, we worked with partners across the patch to identify community leaders and organisations, forming a 'community panel' of over 80 local groups, who helped to co-design this grant-funding initiative, for maximum impact. Local groups were able to apply for a share of the funds – up to £30,000 from March 2021 – and the first set of grants were awarded to a series of projects from across all eight north west London boroughs in May 2021.

Improving how we engage with our local population

Throughout the year, including the peak of the Covid-19 pandemic, we continued to collaborate with our communities and respond to their feedback and concerns, a crucial part of addressing health inequalities. While more needs to be done, we are proud that during 2020/21 we made progress in addressing issues that are important to our local population.

One clear message from some of our patient groups, particularly those from Black, Asian and minority ethnic communities, and patients who had limited or no ability to speak English, was that patient communication for inpatients around 'end-of-life'

> "Throughout the year, including the peak of the Covid-19 pandemic, we continued to collaborate with our communities and respond to their feedback and concerns, a crucial part of addressing health inequalities."

care, 'do not resuscitate' or any ceilings of care, was incredibly difficult, traumatising and sometimes felt forced, or that informed consent was not being sought.

This issue was exacerbated by the fact that visitors couldn't be alongside their unwell loved ones to help support or translate; because staff were dealing with a crisis, these conversations were sometimes happening as soon as patients arrived with Covid-19.

This made clear the need to do more to address language barriers, through our interpreting service, and to better coordinate and explain this sensitive area of care. Communities were also concerned about how patients would be fed and cared for without visitors, how they'd regularly communicate with carers and that we couldn't follow patients' faith preferences.

In May, we created patient videos to specifically cover these concerns and reassure our communities that it was safe to come to hospital if they needed care. In the autumn, we reviewed our patient information on 'do not resuscitate' and formed a working group that identified the issues and challenges.

We also set up a regular virtual Q&A session between members of the BME Health Forum and our medical director, Prof Julian Redhead, alongside other senior clinicians. We listened to concerns on this and other issues important to community groups, such as vaccine safety and why Covid-19 affected people from BAME backgrounds disproportionally.

We now hold virtual Q&A sessions quarterly and are grateful that we have built a mutual sense of trust. This model has been adopted and expanded by the North West London CCG, which held a series of Q&As in early 2021 to address vaccine safety and hesitancy among Black, Asian and minority ethnic communities.

In recognition that much more needs to be done, we have identified and cited the two areas – patient interpreting and 'end of life' care – as projects in our organisational strategy.

Vaccinating our staff and the public against Covid-19

At the end of December 2020, we began vaccinating our staff, as well as some other north west London-based health and care workers, at our dedicated hospital vaccination hubs at Hammersmith, Charing Cross and St Mary's hospitals. We were able to provide frontline staff with their first dose of the Pfizer/BioNTech vaccine by the end of January 2021. We were also able to vaccinate our most vulnerable patients in line with Joint Committee on Vaccination and Immunisation (JCVI) guidelines.

By the end of March 2021, we had administered more than 35,000 doses of approved Covid-19 vaccines, including 11,600 second doses. 12,000 people that work at the Trust had been vaccinated, as well as over 7,000 local health and social care colleagues.

Since March 2021, we have helped run two dedicated community mass-vaccination hubs, at Marble Arch and Hammersmith, as part of the wider community vaccination programme. Using the Oxford/AstraZeneca vaccine, these community-based hubs are focusing on the wider population of north west London, as per the Joint Committee on Vaccination and Immunisation (JCVI) guidelines.

Read more about our vaccine programme in our quality section on page 63.

Working with vaccine hesitancy

Even though the national vaccination programme has progressed well, we acknowledge barriers that some communities face in accessing and consenting to the Covid-19 vaccine, especially people from Black, Asian and ethnic minority backgrounds.

To improve vaccine equity and to counter vaccine hesitancy in the community, we have led several internal and external initiatives. Internal work has focused on tailored communications, supporting access to clinical advice and the work of more than 120 vaccine advocates from within the Trust, who have been supporting their colleagues and networks to make an informed choice about the vaccine.

We have also been working collaboratively with community members, local authorities, the voluntary sector and healthcare colleagues across our integrated care system, to ensure everyone is equipped with access to accurate information about the Covid-19 vaccination. We have held a weekly online co-production and improvement huddle focused on vaccine equity since February 2021, to learn from a range of activities and engagement work happening across the sector, share challenges and hear a breadth of insights. The sessions have provided an opportunity to co-produce ideas and solutions, which individuals and teams can test in their own work.

These huddles have had a positive impact at many levels, with engagement from local councillors and learning from across the north west London sector being shared at a parliamentary committee on vaccine uptake. The sessions have resulted in new collaborations and initiatives focused on the Covid-19 vaccination and other health and wellbeing challenges in the sector.

Supporting care homes through the Covid-19 pandemic and beyond

Over the last few years we have focused on strengthening our relationships with care homes. In 2019, we introduced a care home liaison matron role to work directly with two large local care homes as a pilot. Building on this care home liaison matron role, and utilising resource from shielded and redeployed staff across the Trust, we rapidly expanded the service to care homes from April 2020 to enable us to work closely with

the 26 homes – including nursing, residential and extra care sheltered homes – across the tri-borough that routinely refer to the Trust.

The interventions introduced to care homes include:

- daily calls to all care homes to discuss any patient concerns and concerns about PPE, as well as providing support in understanding national guidance, and reassurance
- virtual and face-to-face PPE education and training in appropriate use
- support to identify patients requiring aerosol generating procedures (AGPs) and support on fit-testing and increased PPE requirements
- assistance with Covid-19 testing in homes and swabbing education to ensure sustainable good practice
- acute response to residents who were unwell, providing assessment and support to treat them in the most appropriate care setting
- remote monitoring of home residents using Current Health and the Care Information Exchange
- follow-ups for all discharged patients, ensuring excellent transfer of information
- advanced care planning and virtual multi-disciplinary team (MDT) support – we updated more than 200 Coordinate My Care records to support information sharing across the system
- the introduction of a clinical support line, daily between 0800 – midnight during the height of the pandemic
- close working relationships with care home managers and staff as part of the local health system and acting on unsatisfactory discharges – building a culture of continuous improvement and enabling continued response to emerging changes within homes as a healthcare system.

Piloting the virtual MDTs and remote monitoring highlighted an opportunity to expand this way of working in future to provide additional protection to homes by reducing visitors without compromising clinical care.

Our collaboration with community partners – including local authorities, Clinical Commissioning Groups (CCGs), community trusts, GPs and public health teams – provided a cohesive support structure to local care homes, which enabled us to introduce outbreak planning and management, shared decision-making and pooling of knowledge, resource and expertise. The care home liaison matrons will be continuing for 2021/22 and we are seeking funding to expand the service to a comprehensive sustainable model for the future.

West London Children's Healthcare Alliance: building an integrated children's healthcare network

We continue to work with our neighbouring acute NHS trust, Chelsea and Westminster Hospital NHS Foundation Trust, and our academic partner, Imperial College London, on our shared vision for how best to run, organise and develop care for children and young people in north west London. The West London Children's Healthcare Alliance (WLCHA) aims 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 are looking at how we improve child health across our population and move towards 'life course' pathways rather than one-off interventions.

During 2020/21, a major new Centre for Paediatrics and Child Health was launched at Imperial College London, working in close partnership with the WLCHA, bringing

together services offered by healthcare providers, charities and volunteers in north west London to create an integrated children's healthcare system. The centre unites researchers, clinicians and educators, fostering collaboration for the benefit of present and future generations of children.

Empowering young adults to be health-conscious adults

Every year we have more than 100,000 interactions with young people aged 13 to 25. Many of these do not fit easily into child or adult services and this can mean they don't have the best experience of care.

Over the past two years, the Trust has been looking at how we can improve the service we provide for young people. A key part of this has been weekly 'big room' meetings, led by consultant paediatrician Dr Katie Malbon and deputy director of transformation Paul Doyle, which generate ideas around education to staff, parents and patients about what is important to young people – how we can better engage with them and help them to be healthy and health-literate adults.

Our aim is to give young people a seamless transition from paediatric to adult services by starting that process when they are 13 and address that transition to adult care as they move through teenage years.

Improving access to urgent and emergency care

This year we have implemented changes to improve patient access to urgent and emergency care services – both in terms of how we offer care in A&E, to the physical location of our same-day emergency care services.

NHS 111 First: in November 2020, St Mary's and Charing Cross A&Es started to see patients with urgent but not life-threatening medical needs at allocated arrival times arranged through the NHS 111 First service, as part of a London-wide initiative.

NHS 111 can assess patients over the phone and make direct appointments online with a variety of health services. By triaging through NHS 111, only those who need care at A&E are referred and allocated a slot – meaning shorter waiting times and fewer people in A&E, helping with physical distancing and reducing the risk of Covid-19 infection.

Following the original implementation of the emergency department digital integration (EDDI) system in November 2020, we have increased our capacity and St Mary's and Charing Cross hospitals now offer four bookable NHS 111 slots per hour, 24 hours a day, seven days a week. Between 27 November 2020 and 31 March 2021, we saw approximately 2,800 patients who were referred via NHS 111.

Vocare: during winter 2020/21 we took part in a successful pilot with Vocare, which meant that urgent treatment centre patients were seen, and triaged quicker and overall pathways were faster by over 30 minutes. A further workshop with Vocare to review the model is planned for mid-2021 while we work with the north west London sector on the long-term service model post-pandemic.

Ambulatory Emergency Care services move: our ambulatory emergency care (AEC) services at St Mary's Hospital moved to the ground floor of the Paterson building, which has been converted into a new same-day emergency care triage and treatment service thanks to a £1.4m investment. This service has a significant impact on our ability to maintain a safe capacity in our emergency department while continuing to treat vulnerable patients safely through the winter, keeping them separate from the high-risk emergency patient pathway.

Since opening in December 2020 there has been an eight per cent increase in same day emergency care activity compared to the same time last year and a six per cent increase in AEC activity, despite seeing lower emergency department attendances overall because of the Covid-19 pandemic.

Outpatient transformation

Our outpatient transformation programme has been improving links and communication between primary and secondary care, by providing GPs and patients with better access to specialist advice. This ensures patients are seen at appropriate times by the right clinicians, equipped with the correct information.

The Covid-19 pandemic has accelerated the adoption of several changes. We ramped up the provision of advice and guidance (A&G) services across our specialities, to provide GPs with access to specialist opinion before making referrals. We aim to answer all GP requests for advice within 72 hours. Evidence from our pilots indicates that up to a third of patients referred to hospital can get the care and support they need in primary care, if specialist advice is available. We also worked with colleagues across our integrated care system to co-design and publish a set of clinical management and referral guidelines and have been running clinical webinars throughout the pandemic to share the latest evidence and information from across a range of clinical specialties.

The pandemic has also resulted in a significant number of patients waiting for an outpatient review, with some services estimating a waiting time of more than 18 weeks. We are working collaboratively with partners across our integrated care system in north west London to tackle this challenge, building on the existing measures to provide patients with the advice and support they need without coming into hospital. We have carried out clinical validation and prioritisation exercises to understand potential harm caused by longer waiting times, and we have now re-started all routine services that were paused during the recent surge in Covid activity.

- **Virtual appointments for patients**

Even before the pandemic, the Trust had proactively offered patients an alternative to face-to-face patient consultation using video and telephone where appropriate. Since the outbreak of Covid-19 there has been a rapid uptake of virtual clinics, with an average of 30 per cent of outpatient appointments taking place remotely in November 2020 and 40 per cent in January 2021. The expectation is for remote consultations to form 40 per cent of appointments going forward.

The rapid shift to virtual consultations during the pandemic has posed significant challenges for the systems sending out automated appointment invitation letters and texts. Many of these issues have now been resolved and we are continuing to work with our services to ensure that all our patients receive accurate, timely communication about their appointments.

Virtual clinics will be incorporated into new ways of working as we move out of the pandemic and provide flexibility for patients who do not need to attend the hospital for examination, procedures or investigations, as well as an on average saving of £16 per patient and up to two hours travel time.

Care Information Exchange

The Care Information Exchange (CIE) gives patients secure online access to their hospital health records, including appointments, test results and letters. There was a sharp rise in the use of CIE at the beginning of the pandemic. And, over the past year, the number of patients using the system increased from 43,123 to 110,391. This

demonstrates the importance that people place on access to information about their health and care. As well as information from hospitals, users can now see social care data from Hammersmith and Fulham, Kensington and Chelsea, and Westminster local authorities. This includes social worker contact details, care packages and case notes.

During the year, we added the ability to register for the Care Information Exchange using the NHS login. This means that our patients can register any time they want to, without having to wait to receive an invitation from us. Patients whose GP practice is in north west London can use the Care Information Exchange from within the NHS app. They can see their hospital records alongside their GP health records, from either their mobile device or desktop computer.

Patients Know Best was confirmed as the supplier for the Care Information Exchange in north west London for 2021-2024 and new features and methods of making registration easier are in the pipeline.

Strategic goal 2: to develop a sustainable portfolio of outstanding services

Progress on a comprehensive redevelopment of our hospital sites

While there's so much to be proud of in the way our staff have responded to the Covid-19 pandemic, the poor state of many of our facilities and buildings has not helped. We have the biggest backlog maintenance liability of all NHS Trusts – up to £1.3 billion. Redevelopment remains a priority, and we have continued to work on ambitious plans to transform our ageing estate. Across all our sites, we are committed to building better hospitals that will help us deliver better health for life, setting new standards for patient care and experience and where staff can thrive, learn, and develop.

In August 2020, we submitted a strategic outline case for the redevelopment of St Mary's Hospital as a first stage in the government approval process. In September 2020, the government's New Hospital Programme team confirmed support for our case for change and recognised the pressing need to rebuild St Mary's.

The vision for the new St Mary's is to be one of the most advanced, research-led, major trauma and acute hospitals in the world. It will deliver clinical excellence and new models of high-quality, safe care – with strengths in emergency, intensive and trauma care, neurosciences, and infectious diseases. The new hospital should meet the following criteria:

- It should be rooted in its local community to meet the acute and complex needs of a growing, diverse and deprived local population – an anchor institution that will help address the social and economic issues that widen health inequalities.
- London's largest trauma centre, responding to every major emergency of the last 30 years, it will serve central London and the wider north west London population.
- A centre of excellence for research, innovation and education, it will have national and global impact, and attract investment for UK PLC as the heart of a new Paddington life sciences cluster and business regeneration area.

Before proceeding to the next stage of approval (developing a more detailed, outline business case), we were asked to undertake further work to confirm the scope and size of the new hospital and to ensure we have considered all appropriate options. We are also setting out the 'critical path' we need to follow from now to deliver a new St Mary's in 2030. An updated strategic outline case will be submitted this spring. Following approval, we expect to start the next stage of the design process in the summer, reviewing and refining options for the outline business case. This will include a range of opportunities for our staff, patients, local communities and other stakeholders to get involved in co-design.

In the meantime, we are also progressing work on our plans for Charing Cross and Hammersmith/Queen Charlotte's & Chelsea (a mix of redevelopment and some new building) – also part of the Government's New Hospital Programme. In March, we started an infrastructure and feasibility assessment of both sites. This involved auditing the development opportunities and key constraints for each site, in consultation with Trust clinicians and estates staff. This is the first step in creating a strategic redevelopment plan for each site which will inform a strategic outline case for both hospitals. We aim to submit these cases for first-stage approval later this year.

Work is continuing to assess the options for incorporating the Western Eye Hospital in either St Mary's or Charing Cross. We intend to sell both the Western Eye and the adjacent former Samaritan Hospital (which has been closed since 1997), the proceeds from which will help to fund our redevelopment plans.

Bringing our hotel services staff in house

Our cleaning, portering and catering teams, known as hotel services, play a crucial role in the smooth running of our hospitals and in ensuring high-quality care for our patients. On 1 April 2020, these services were brought 'in-house' with hotel services staff becoming employees of the Trust, for a temporary 24-month period. This move came in response to concerns about staff terms and conditions and to recognise and value this staff group as a important part of our Trust. All hotel services staff were given NHS basic pay rates and sick leave and access to the NHS pension scheme.

We evaluated the new 'in-house' arrangements at the start of 2021 and saw several improvements in terms of staff satisfaction and engagement scores and quality scores for their services. Meanwhile, the costs of the services were comparable with those of other London NHS trusts. As a result, we made the decision on 31 March 2021 to continue managing hotel services in-house and we will now consult the 1,000 plus hotel services staff about moving to full NHS (Agenda for Change) terms and conditions.

Acute care recovery programme

The first surge of Covid-19 accelerated moves to work more as an integrated care system in north west London, across all acute, mental health and community trusts, as well as GPs, local authorities and voluntary sector organisations. It also sparked better team working internally, across services, sites and professions, as well as with our 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.

While we are proud of the care we have provided throughout the Covid-19 pandemic, and how much we have achieved, we emerged with additional challenges – long waiting times for planned elective care, exacerbated health inequalities and the wellbeing of staff who worked relentlessly under extreme pressure – on top of many previously existing challenges.

> "Across all our sites, we are committed to building better hospitals that will help us deliver better health for life, setting new standards for patient care and experience and where staff can thrive, learn, and develop."

In response to both surges of Covid-19, it was necessary to implement measures beyond our 'business as usual' arrangements in response to unprecedented increases in patients being admitted to hospital suffering with Covid-19. This involved instigating our pre-agreed surge plans and pausing all but time-critical care. However, as with the rest of the NHS, this meant we had to postpone planned operations, procedures and outpatient appointments for patients with less urgent needs, which generated a significant backlog for elective care.

We have worked on safely, quickly and fairly addressing the significant backlog of elective care that has been a major consequence of the pandemic and collaborated with our partners across the North West London Integrated Care System to support the reset and recovery of elective care and make longer-term improvements to models of care and care pathways. We are also ensuring that we are prepared, as a system, for a possible third Covid-19 surge or other future pandemics.

We introduced a methodology to prioritise patients through a clinical harm matrix. This allows clinicians to assess the level of potential or actual harm associated with waiting for a procedure alter the patient's surgical priority rating accordingly (read more on page 120).

This collaborative approach involves the acute care providers in north west London working together for the benefit of our local population through a joint programme to guide and coordinate developments within five main work streams: elective care (including cancer care); outpatients; intensive care; urgent and emergency care; and diagnostics and imaging.

Our shared aim is to ensure high-quality acute care across north west London by harnessing our collective resources, joining up our care and reducing unwarranted variations in access to services and health outcomes for patients.

Quality

In 2020/21, we identified six priority improvement areas in our Quality section on page 44 – based on engagement with staff at all levels and across different groups – aligned to the Trust-level focused improvements set out during the annual business planning cycle. These were:

1. To improve the Friends and Family Test (FFT) response rate
2. To improve the percentage of staff who feel they can 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.

Throughout 2020/21, we have had to respond to unprecedented demand and change because of Covid-19. Because of this, many of our work programmes and focused improvements were paused so that we could ensure that we could continue to provide high quality care to patients during the pandemic, keeping them and our staff safe. Our priority improvements were refocused to help us best respond to Covid-19 and involved making changes to how our services run to help prevent the spread of Covid-19, the establishment of a Clinical Reference Group to oversee all clinical decision-making, the implementation of a hand hygiene helpers programme to ensure the correct use of personal protective equipment in all clinical areas and the establishment of a Covid-19 vaccination programme for health and social care staff across the north west London integrated care system.

The 2021/22 improvement priorities are taken from the core priorities and programmes set out in the wider Trust strategy and reflect learning from the pandemic. They are:

1. To improve patient access to specialist advice, guidance, and treatment
2. To maintain a sustainable workforce
3. To deliver a comprehensive quality and safety improvement programme
4. To improve equality, diversity, and inclusion
5. To improve clinical prioritisation processes and harm reviews.

You can read more in the Quality section of this report on page 40.

Post-birth contraception service

In April 2020, North-West London CCG launched a post-birth contraception service to address the number of women unintentionally becoming pregnant within a year of giving birth. The initiative is led by the Trust and has been launched with a grant from Imperial Health Charity and funding agreed by the North West London CCGs. The project is led by Women's Health Clinic consultant Professor Lesley Regan, consultant Ed Mullins and midwife Claire Cousins, in collaboration with the Women's Health Research Centre.

According to Public Health England, one third of pregnancies in the UK are unplanned; one in three will end in abortion and 56 per cent of women undergoing abortion have already had a previous live birth.

Evidence suggests that interpregnancy intervals of less than 12 months are associated with premature birth, low birth weight and neonatal death.

As a Trust, we are dedicated to helping women avoid unplanned pregnancies and improving maternity safety; to do this, we've developed and delivered training for midwives and doctors across north west London to build confidence in counselling women about their post-birth contraceptive options.

This service offers education and a full range of contraceptive choices, including long-acting reversible contraception (LARC), prior to discharge from maternity services across north west London. Pregnant women are increasingly aware of their options, and how to actively plan which contraception they would like to use post-birth, through awareness-driven content for social media and user groups.

Approximately 700 women using our maternity services have benefitted from the post-birth contraception service. In February 2021 13 per cent of the women who birthed at our hospitals used the service.

PRISM – a new antenatal course

In May 2020 we launched a new online antenatal course, PRISM (preparation, recovery, inspiration and support for motherhood). The online antenatal course launched to resolve the challenge of women not having access to face-to-face antenatal courses throughout the Covid-19 lockdown.

The online course was developed by Ms Karen Joash, consultant obstetrician, and co-designed with service users and consumer representatives. Sessions are dedicated to reflecting on the different perspectives that parents, their families and caregivers may have, and brings these perspectives together to support each new parent's journey.

The course comprises of six sessions delivered over the course of six weeks. Over 5,000 women have registered for the online course, with over 100 classes being delivered since it launched last year.

PRISM is delivered by Karen Joash and consultant midwife, Susan Barry. The maternity team at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital co-deliver several core modules: including input from midwives, physiotherapists and doctors.

Since PRISM launched, our maternity team has supported many parents to feel prepared for the birth of their child. As a result of the course's overwhelming success, PRISM will continue its services post-Covid as a means of delivering effective antenatal care to our service users.

Integrating surgery and imaging with our hybrid theatre

In July 2020, a new 'hybrid theatre' integrating surgery and imaging opened at St Mary's.

The £2.8m Hybrid Endovascular Theatre Suite in the QEQM building allows us to undertake surgery and state of the art imaging at the same time in a single 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 the need for open surgery.

Patients with major trauma also benefit from the new theatre by allowing those with multiple injuries to undergo both endovascular and open surgery in the same place. A £1m grant from Imperial Health Charity helped fund the project, which had initially been planned to open in April 2020, but was delayed by the Covid-19 pandemic.

Capital imaging projects

In January 2021, we completed a nine-month project to rebuild our MRI scanner at Cambridge Wing of St Mary's hospital. The scanner was given new hardware components and systems, and enabling works entailed removal of non-mechanical plant and BMS panel with new plant compliant with new Covid-19 guidelines. There were also aesthetic works to existing MRI area.

February 2021 saw the completion of a project to update our brain-focused Ultrasound MRI at St Mary's. The project consisted of new scanner installations requiring new RF cage, power source from QEQM substation, and new external plant and deck to serve new MRI.

Also at St Mary's Hospital, we completed a project in December 2020 to replace existing MDR scanning equipment, which, due to the out-of-date service contract and reliability of equipment was a high risk. The area was also refurbished, which entailed a stand-alone new ventilation plant, new electrical works and an upgrade to finished.

Currently under way is a project to refurbish the current Nuclear Medicine area (PET CT) on the first floor of New North block of Charing Cross Hospital, with a total budget of £5.3 million.

Strategic goal 3: To build learning, improvement and innovation into everything we do

Staff wellbeing and support

Staff survey

The results of the latest annual NHS staff survey, received in March 2021, showed a third successive increase in the proportion of staff who would recommend the Trust as a place to work and as a place to be treated. Our special focus on ensuring the health and wellbeing of staff over the past year has coincided with an improved survey score in this area and we have maintained our overall staff engagement score of 7.2, which remains above the average for acute trusts.

However, our scores have decreased in three key areas: equality, diversity and inclusion, immediate managers and team working. The scores for morale and creating a safe environment (against bullying and harassment) remains unchanged from last year. We are looking in detail at the feedback from the staff survey. Our organisational priorities will be shaped by this feedback with our clinical divisions developing local plans to address any themes that specifically relate to data from their teams.

Staff support Covid-19 legacy programme

Even before Covid-19, we recognised that we weren't doing enough to support staff practically, and this was reflected in some of our annual staff survey findings. The poor state of rest areas and changing facilities was identified by staff as a key barrier to living our organisational values.

Our strategy refresh last year included an additional focus for us as an 'anchor institute', using our resources, partnerships and leverage to improve health and wellbeing in the broadest sense, including for our 14,500 staff who are often part of the local community we serve and our patients.

"Through the additional funding from the Charity we were able to almost double the number of counsellors available to support staff, both individuals and teams."

In September 2020, we announced a new £1.7m programme of practical and wellbeing support directly inspired by feedback from staff after the first wave. Supported by Imperial Health Charity, the programme has been developed in recognition of the enormous contribution made by our staff in response to the Covid-19 pandemic and is designed to take a more strategic approach to ensuring the health and wellbeing of our staff for the long term. It includes improvements to hundreds of staff facilities, transforming our on-site food and retail offer and expanding our mental health support service.

Improvements to staff spaces

We are spending an initial £1.2m on major improvements to up to 200 staff spaces (breakrooms, kitchens, changing rooms and showers), driven by staff views and ideas. Improvements began in December 2020 with showers and changing rooms that were in urgent need of refurbishment and have now progressed to design work for three pilot 'rest nests'. These are complete refurbishments of staff breakrooms/kitchens designed pro bono by Taylor Howes, a UK interior design agency. We are testing the first three 'rest nest' designs for stroke at Charing Cross Hospital, pharmacy at Hammersmith Hospital and intensive care at St Mary's Hospital and will then roll more rest nests out to up to 20 areas across our hospitals.

We also have plans to create 'flagship' staff lounges on each of our sites, where any member of staff can go to rest 24/7, get refreshments, meet with colleagues or check their emails. We are working with Taylor Howes and KLC, a local design college on designs for the first two lounges at Charing Cross and Hammersmith.

As part of this work stream, there are also many break room and kitchen schemes that are being taken forward and we are piloting the provision of regular supplies of 'break room' basics such as tea, coffee, snacks for all break rooms in our clinical areas. So far, we have provided three deliveries across our hospitals and are evaluating this work to determine what we do on an ongoing basis.

Transforming our on-site food and shops offer

A review of our retail food and shops offer was prompted by the need to make more considered decisions about the longer term future of a number of food and retail outlets that had to come under in-house management during the pandemic as well as opportunities relating to our hospitals' emerging role as anchor institutions for their local communities and economies. We are working with specialist agency Baxendale and a range of staff and lay partners to develop a strategic vision and outline service specification for our retail food and shops.

We are working through the best way of putting that specification in place with the right range of outlets and services, considering innovations like delivery, 'click and collect' and seasonal 'pop-ups'. While it is very likely we will still want to have a mix of providers running specific services, we are clear that the whole offer needs to be managed holistically so that it delivers our vision overall and ensures equity across our sites. We'll be evaluating different models – including managing it ourselves with specialist support or through a contract or partnership with an external organisation – and determining what support and governance needs to be in place to ensure successful implementation.

Expanding our mental health support service

Through the additional funding from the Charity we were able to almost double the number of counsellors available to support staff, both individuals and teams. The funding also allowed us to provide more training for managers and key staff in mental health

awareness, compassionate leadership and psychological first aid, plus bespoke support sessions for staff who have been shielding.

Staff engagement and improved digital working

The Covid-19 pandemic has seen all of us having to adapt to a 'new normal'; while this has been inconvenient and difficult in lots of ways, one upside is that it has accelerated our digital maturity and fostered better staff engagement.

In 2019/20 we decided to embed the NHS Digital Microsoft Teams service across our organisation, and its deployment during the pandemic – to enable virtual working – has been one of the most successful adoptions of the NHS digital service. We have been consistently in the top three of Microsoft Teams staff usage for 2020/21, with over 390,000 calls made, over 780,000 virtual meeting seats used and 3.8 million private chat messages sent. Our use of Microsoft Teams and other technologies also enabled us to carry out hospital appointments virtually to ensure delays to care were minimised as far as possible.

Using digital tools has supported our response to the pandemic such as utilising Microsoft Forms to:

- enable reporting of lateral flow Covid-19 testing among staff
- develop an online staff risk-assessment form to assess whether it is safe for individuals to be working on-site based on their health profile
- create a virtual engagement approach for staff required to shield

We embedded a virtual approach to our all-staff briefings in 2020/21, with a fortnightly virtual Q&A led by the chief executive. With an average of 700 people joining and 150 questions asked by staff at each session, this feedback has helped drive many aspects of our organisational response to Covid-19, such as staff feedback on their experiences working remotely during the first wave being incorporated into our agile and remote working policy.

Throughout the pandemic, our staff intranet has been a reliable source of real-time information. Supplemented by regular all-staff email bulletins driving staff to fuller intranet content, in 2020 over 40 million visits were made to the intranet via PC, mobile phone or tablet. Our insights work – learning from the first and second wave of the pandemic – has shown that our digital communications and engagement offer has been one of the successes to have emerged from our response to the pandemic.

Making our hospitals easier to navigate

In 2020/21, we started to roll out a new wayfinding system which includes new signage to help patients and visitors navigate our hospital sites.

We worked with a wayfinding agency to carry out extensive research and evaluation, involving staff and patient feedback during our pilot phases. This helped us to create a robust set of guidelines to support a consistent wayfinding approach across all our sites.

Our strategy to support patients and the public includes simplifying names and avoiding jargon and acronyms. This approach includes signage and ensuring other communications – website content, patient letters and leaflets – is consistent across the patient journey.

We have continued to look at the overall user journey across our patient pathways and have installed additional digital screens within key areas to display essential information for both patients, visitors and staff.

Equality, diversity and inclusion

In 2019/20 equality, diversity and inclusion (EDI) was a key organisational priority; at the same time, the disproportionate impact of Covid-19 on certain communities has highlighted systemic inequalities that society and the Trust must address. This focus manifested in investment to expand our central EDI team in late 2021 and to support the growth of our staff networks.

The increasing influence of our staff BAME nursing and midwifery and BAME Multi-disciplinary, LGBTQ+, I-CAN (disability) and women's networks, reflecting the direct feedback they are hearing from staff, has helped to drive our response to the pandemic.

Reflecting concerns raised by our two BAME networks about the availability and accessibility of Personal Protective Equipment (PPE), we founded a PPE steering group to strategically oversee stock levels, procurement and distribution of this essential equipment. The group, chaired jointly by the chief financial officer and director of nursing, and involving professional representatives from across the Trust, supported an idea by ward manager Noni Nyathi to help BAME colleagues wear PPE in Covid-secure areas, led to the Trust purchasing redesigned headwear to support staff, and a permanent change has been made to our dress code and uniform policy.

Acting on feedback from the I-CAN disability network, we have made improvements to our online all-staff briefings (hosted by our Chief Executive, Professor Tim Orchard) to make them more accessible. As well as exploring how we can make lip-reading easier during the sessions, we have created a section of our intranet where we now upload a written transcript and a YouTube version of the session that has improved captions. There is much more to be done to ensure virtual accessibility is improved, and we are exploring with Microsoft Teams what further changes can be made based on staff feedback that can benefit all NHS organisations.

Going forward, and in response to staff feedback in the national staff survey that shows more needs to be done to create an organisation that feels equal, inclusive and diverse, EDI will continue to be a key strategic priority for the Trust. The Trust is compliant with the public sector equality duty. The EDI committee, chaired by the

> "The Trust has been at the forefront of vaccine research, with work on three different vaccines continuing to help support the route out of the pandemic and futureproof populations against new variants and further surges in cases."

chief executive, is agreeing objectives that result in more improvements in this area. Further information on our Workforce EDI Progamme and performance metrics can be found in the EDI annual report.

Research during Covid-19 — urgent public health studies

When the Covid-19 pandemic hit the UK in 2020, the National Institute for Health Research (NIHR) asked NHS Trusts, universities and other research organisations to prioritise particular studies and trials that would help support the global response to Covid-19.

Since then, around 80 of these urgent public health clinical research studies have been initiated across the UK, with more than 30 under way at the Trust. We have recruited more than 4,600 patients to these studies, putting us among the top five in the country in terms of patients recruited.

These studies, which have been made possible through our research partnerships with Imperial College Academic Health Science Centre (AHSC) and NIHR Imperial Biomedical Research Centre (BRC), look at everything from potential new treatments, population testing, and further understanding and characterising of the virus, to finding a vaccine that could prevent it, as well as validating testing to help pave the way for life to return to normal. Through continued international partnerships, strong scientific focus and national support, results from these studies could have significant impact for patients very quickly.

Learning more about the virus that causes Covid-19

Early in 2020, little was known about the new coronavirus; once it had been sequenced in January, researchers very quickly began looking for new ways to treat and prevent it. Professor Peter Openshaw, an honorary physician at the Trust, continues to lead the largest European study to collect and analyse thousands of samples from Covid-19 patients. Known as the ISARIC4C study, which began in April 2020, the study aims to learn more about the natural history of the disease and understand how the virus causes it.

By July 2020, more than 66,000 Covid-19 patients had enrolled across the UK, including many patients at the Trust. Results from this trial have helped to characterise Covid-19 and better understand the risk factors so that clinicians can treat it more effectively and researchers can continue to look for new treatments. The study has also shown that children are less likely to develop severe disease and that being male or obese reduces the chance of survival from severe disease.

Vaccine research – contributing to the route out of the pandemic

The Trust has been at the forefront of vaccine research, with work on three different vaccines continuing to help support the route out of the pandemic and futureproof populations against new variants and further surges in cases. In early 2020, researchers led by Professor Robin Shattock at Imperial College London were awarded £22.5 million by the UK government to develop a self-amplifying RNA vaccine. Trials of this vaccine have been taking place in partnership with the Trust, and the team had been working on this technology for many years in relation to other diseases.

Unlike other vaccines that are developed by growing a virus or a protein, the Imperial vaccine is produced through a synthetic, self-amplifying RNA technology. It uses synthetic strands of genetic code (called RNA), based on the virus's genetic material. Once injected into muscle, the RNA generates copies of itself and instructs the body's own cells to make copies of a protein found on the outside of the virus. This trains the immune system so that the body can easily recognise the virus and defend itself

in future. The RNA technology can be used to produce millions of doses at a low cost and adapted to respond to future pandemics more quickly.

As other vaccines were licensed and rolled out, we focused our RNA vaccine technology on targeting new variants, vaccine boosters and finding a way to store the vaccine more easily. The team has also been looking at ways to develop the ability to respond rapidly if vaccine-resistant strains of Covid-19 emerge. The Trust continues to support these ongoing clinical trials.

Alongside studies of Imperial College London's vaccine, we have supported national studies of the Oxford/AstraZeneca vaccine, which received regulatory approval in December 2020, and the single-dose Janssen vaccine, which is undergoing Phase 3 clinical trials. All this work on vaccines has enabled researchers across the world to assess if people can be protected from Covid-19 by these vaccines and provided vital evidence on their safety and ability to produce an immune response.

Informing and responding through testing

With effective testing being a key part of the response to the pandemic, in May 2020, the government announced a new programme of home testing, which we supported, to track the progress and prevalence of the infection across England. The Real Time Assessment of Community Transmission (REACT) programme continues to supply vital data on infection rates and is used by the government to guide their response. A key arm of the study, known as REACT-2, investigated the accuracy and usability of at-home antibody testing to validate it for wider use.

Around 300 staff from the Trust who had recovered from coronavirus volunteered to trial an antibody home-test, initially to help establish its accuracy. These were then rolled out to wider samples of volunteers to test whether members of the public can easily undertake the tests themselves at home. This information helped researchers understand how many people have become infected and recovered since the outbreak began and identify those who had antibodies. The wider use of these tests that followed has provided significant insight on the population's antibody levels and prevalence of Covid-19.

The Trust also helped to validate rapid lab-free coronavirus test kits known as DnaNudge, which can deliver results in 90 minutes. The simple test uses a swab sample, which is placed into a cartridge that extracts the genetic material from the virus if it is present. The cartridge is placed into a machine, which analyses it to provide a result to the clinician within 90 minutes. Early trials of the technology showed that the tests have a sensitivity of 94.4 per cent and a specificity of 100 per cent. These tests were implemented in our A&E, oncology and maternity departments to provide care to patients who were less able to plan their visit to hospital and unable to be tested in advance of their admission.

In March 2021, North West London Pathology (NWLP), which delivers pathology services for the partnership between our Trust, Hillingdon Hospitals NHS Foundation Trust, and Chelsea and Westminster NHS Foundation Trust, reached the significant milestone of processing more than half a million Covid-19 polymerase chain reaction (PCR) tests. We have offered PCR testing to all staff and their household contacts with symptoms since the earliest stages of the pandemic as a key part of our response and we use PCR to test patients regularly.

Understanding Covid-19 health disparities

An analysis of patients hospitalised early in the pandemic showed that black patients may be at increased risk of poorer health outcomes from Covid-19. By characterising

the main risk factors associated with deaths for patients admitted with Covid-19, researchers have been able to evaluate whether outcomes varied by ethnicity. The findings revealed that a large proportion of patients admitted during this time were from ethnic minority groups, when compared with last year's admissions. Black patients admitted to hospital with Covid-19 also tended to be younger, have fewer pre-existing health conditions, and have worse health outcomes compared to white patients.

Dr Shevanthi Nayagam, honorary consultant hepatologist, who led the work, has called for more to be done to better understand health disparities relating to Covid-19 and to target interventions at those who are most at risk of severe illness or death, ensuring vulnerable communities are protected.

We have since set up our compassionate communities programme to drive forward community-led projects designed to tackle major problems that affect people's health (see page 20).

Using technology to improve care and reduce risk during the pandemic

The Microsoft HoloLens, a mixed reality headset, was already in use by surgeons and interventional radiologists at the Trust before the pandemic to assist with procedures and operations. Clinical teams soon spotted how the headset could help with the pandemic response by reducing exposure when caring for patients.

Doctors started using the Hololens to carry out ward rounds for patients with Covid-19 and reduce the number of clinicians needed at a patient's bedside. A single doctor wearing the self-contained computer headset, can do a round of the ward, while the device sends a secure live video-feed to a computer screen in a room away from the ward, allowing other healthcare professionals to see everything the doctor can see on the ward. The headset enables the wearer to interact with 'holograms' made visible through the headset using just gestures and voice, which means the team outside the ward can also share medical notes, scans and x-rays for the doctor to see while with the patient.

Early research showed that HoloLens led to a fall in the time staff spent on coronavirus wards, as well as reducing the amount of personal protective equipment (PPE) being used, as only the doctor wearing the headset has to dress in PPE.

Identifying a new condition in children linked to Covid-19

Researchers in the UK and several European countries with high prevalence of Covid-19 in the first wave of the pandemic recognised a new inflammatory syndrome in children that was similar to Kawasaki disease, a rare syndrome known to affect young children. The condition is believed to be extremely rare, but there remains concerns about long-lasting damage to the heart.

A study of children with these severe symptoms, published in June by the Trust in partnership with Imperial College London, showed the condition is new and distinct from Kawasaki disease. Researchers identified the main symptoms and clinical markers of the new syndrome which could help clinicians diagnose and treat it, as well as providing information for researchers to understand it further and find new treatments.

Investigating new treatments for severely ill patients with Covid-19

The REMAP-CAP trial, led by Professor Anthony Gordon, consultant in intensive care medicine, is a key national study which evaluates the effect of treatments on survival rates and the length of time patients need support in an intensive care unit (ICU).

The study has already resulted in multiple new treatments for Covid-19 that have improved outcomes for the most critically unwell patients.

One of the first findings from the study showed that that treating critically ill Covid-19 patients with the steroid hydrocortisone for seven days could improve the chance of recovery. Patients in the UK were treated at 88 hospitals, including at our Trust. Hydrocortisone is now used widely to treat critically ill Covid-19 patients by helping to reduce inflammation.

In January 2021, landmark findings showed that treating critically ill patients with two drugs typically used for arthritis (tocilizumab and sarilumab) could significantly improve survival rates and reduce the length of time spent in ICU. Analysis showed the drugs reduced mortality by 8.5 per cent and improved recovery, meaning patients could be discharged from ICU about a week earlier. Tocilizumab and sarilumab, which regulate the response of the immune system, were subsequently included in national guidance for treating severe Covid-19 in February 2021.

Analysis from a different trial, the COVACTA study, has recently further supported the finding that tocilizumab could help reduce time spent in hospital and ICU, though it did not significantly improve outcomes for patients with severe Covid-19 pneumonia. The researchers will soon focus on a new trial with the aim of finding treatments that could help prevent inflammation much earlier in the disease.

Other research studies during the pandemic

Patients taking statins experience similar side effects from placebo

Statins are one of the most commonly prescribed drugs in the UK, with around seven or eight million adults in the UK taking them. They help lower cholesterol in the blood, which is potentially dangerous and can lead to cardiovascular disease. Statins can reduce the risk of heart attack, stroke and even death by about 25-35 per cent. Most people tolerate statins but it is estimated that around one fifth of patients stop taking or refuse the drug due to reported side effects such as muscle aches, fatigue, or joint pain.

A clinical trial at Hammersmith Hospital found that people taking placebo pills and statins experienced similar side effects, suggesting these side effects could be caused by the 'nocebo' effect – where people experience side effects from a therapy because they are subconsciously expecting them. The team suggest that doctors should manage patient expectations of taking them, to help encourage people to stay on or take the medication.

Severe morning sickness increases the risk of depression during and after pregnancy

Severe morning sickness, known as hyperemesis gravidarum (HG), is a debilitating condition that affects around 1-2 per cent of pregnant women in the UK. Far more serious than 'normal' morning sickness, it is one of the most common reasons for hospitalisation during pregnancy and can continue right up until birth. Women can be bedbound for weeks on end, suffer dehydration and weight loss and are often unable to work or care for other children they have.

A study by researchers from the Trust and Imperial College London, found that nearly half of women with HG suffered antenatal depression and nearly 30 per cent had postnatal depression. In women without the condition, just six per cent experienced antenatal depression and seven per cent suffered postnatal depression. The researchers hope that the findings can help improve understanding of HG and change clinical guidelines on how women with the condition are treated.

Innovative scan for prostate cancer could save lives by increasing early detection

Prostate cancer is the most commonly diagnosed cancer in the UK, with more than 49,000 cases a year. It affects one in eight men and there is thought to be an increased risk for black men – one in four are affected during their lifetime.

Researchers at the Trust and Imperial College London have developed a new scan, known as a 'Prostagram' that could help improve early detection of prostate cancer and potentially save thousands of lives a year. It is the first time that any scan has been shown to be accurate enough for use as a prostate cancer screening test. Researchers believe the 15-minute scan could have the potential to find thousands more cases of prostate cancer a year.

This non-invasive procedure uses innovative magnetic resonance imaging (MRI) techniques to provide detailed images of the prostate that can be analysed by doctors for evidence of prostate cancer. It is hoped the new scan may increase the chances of early detection among those who are reluctant to be tested for prostate cancer due to the intrusive nature of current examination techniques.

Looking forward

Drawing on insights from staff, patients and wider stakeholders about our response to Covid-19 as well as our pre-pandemic challenges and opportunities in relation to our strategic goals, we have developed an integrated business plan for 2021/22 with three core priorities, to:

- ensure all our patients who are waiting for acute and specialist care get the advice, guidance and/or treatments/operations they need as quickly as possible
- build a sustainable workforce – through improvments in health and wellbeing, recruitment, equality, diversity and inclusion, career pathways and retention
- advance our plans to redevelop our estate across each of our sites.

Across our work on each of these core priorities, we will ensure that we:

- proactively and collaboratively, play our full part in developing our integrated care system, specifically through the acute care programme
- continue to place quality (providing care that is safe, effective, caring, responsive, well-led, representing good use of resources, equitable) as the defining outcome of our work
- have a strong user focus, including through significant involvement and engagement with patients, staff and local communities

We will use the routines and rigour of a new management and improvement system, to be rolled out during the year, as our operational mechanism to deliver these core priorities.

Date: 25 June 2021

Professor Tim Orchard
Chief executive

Sustainability report

Stepping up sustainability through our new 'Green Plan'

This year, we have developed a new Green Plan to reduce our impact on the environment and deliver sustainable healthcare for future generations. The NHS is responsible for 5 per cent of the UK's carbon emissions and 3.5 per cent of all road travel. As the sixth largest NHS Trust, we can make a significant contribution to reducing those emissions.

We have identified 12 Green Plan goals, which together form a comprehensive framework for action, with continuous learning and innovation at its heart. Fundamental to putting the plan into action will be a collaborative approach towards sustainability – working with patients, staff, local communities and partners. The Green Plan is everyone's plan.

Reducing energy use and cleaning up toxic air pollution are among the core strategies of our Green Plan. We have secured a £26.9 million grant to reduce the carbon footprint of our hospital sites, through the government's Public Sector Decarbonisation Scheme (PSDS). The funds will be used to achieve more than 24 per cent emissions reductions at Charing Cross and Hammersmith hospitals. This will include an air source heat pump at Charing Cross Hospital, and a range of improved energy efficiency measures at both hospitals, including lighting, pumping, heating, ventilation and air conditioning, alongside better energy controls. The Trust will also benefit from a 1MW Battery Storage System that will not only help improve electrical infrastructure resilience but also offer opportunities to participate in demand side response initiatives and thereby improve.

Providing innovative care that is patient centred and close to home where possible, is another key pillar of our Green Plan. We have made good progress on transforming our renal services, by encouraging post-transplant clinic patients to receive the majority of their outpatient care virtually and by increasing the uptake of dialysis at home, rather than at our hospital sites. The number of dialysis patients receiving renal home therapies has more than doubled over this year, from 7 per cent before the pandemic hit to 15 per cent.

As a long-term strategic priority for the Trust, the Green Plan will address many other important areas, such as smarter travel and reducing plastics and waste, alongside sustainability in water, medicines, food and catering, and research and facilities.

Embarking on the plan now is in line with our ambitions to deliver a net zero new St Mary's hospital. This, alongside lowering the carbon footprint of our other hospitals, will help the Trust become a net-zero exemplar and could, we hope contribute to the NHS meeting its net zero carbon target earlier than 2040.

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. We are committed to reducing our carbon footprint. Since our baseline of 2007/08, when our baseline value was 46,424 tonnes, we have reduced our absolute carbon footprint by 13,953 tonnes CO2e1 (30 per cent).

The key environmental impacts of delivering services include:

- **Waste**: In 2020/21 a combined annual total of 5,078 tonnes of waste was generated, out of which 3,855 tonnes was recycled (co-mingled recycling, cardboard, WEEE (waste electrical and electronic), scrap metal, pallets, skip waste recycled, confidential waste). This underlines our commitment to environmental best practice and operational savings. In addition, via our contract management and procurement processes, transport hauliers of suppliers, manufacturers, contractors are requested to ensure delivery of carbon reduction in terms of fleet management by meeting criteria for low emission zones – ultra emissions zone, FORS (Fleet Operation Recognition Scheme) operating schemes and as legislation decrees.
- **Travel**: our business miles were 210,108 miles between 1 April 2020 and 30 April 2021. In addition, there were 66,600 miles travelled on the hopper bus which connects our sites and 281,188 patient journeys on our transport providers.
- **Gas and energy**: Despite increased consumption of gas from increased usage of combined heating and power (CHP) plant, we continue to reduce our emissions from energy use. In 2020/21 we used 32,471 tonnes – this is a 4.4 per cent reduction from 2019/20. This is mainly down to Hammersmith Hospital's electricity infrastructure benefiting from CHP connection. On the other hand, there has been a 14 per cent increase in electricity use at Charing Cross Hospital. This is due to more powerful scanners and x-ray equipment, and improved functioning of heater batteries in the tower block air conditioning system which has made the building warmer. Electricity use at St Mary's Hospital has increased 4.5 per cent, from a combination of factors, including more energy-hungry biomedical equipment.

Energy use and cost

Resource		2016/17	2017/18	2018/19	2019/20	2020/21
Gas	Use (kWh)	86,716	84,814	92,297	100,436	113,772
	tCO_2e	15,956	15,619	16,979	18,465	20,919
Coal	Use (kWh)	0	0	ERIC	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	54,757	57,534	56,988	57,858	49,546
	tCO_2e	28,898	22,118	17,507	15,520	11,551
Green Electricity	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Total Energy CO_2e		44,854	37,737	34,486	33,985	32,471
Total Energy Spend		£8,940,086	£9,242,247	£9,927,889	£10,028,345	£11,076,19

- **Water**: our annual consumption of water was 320,690 cubic metres with a total spend of £615,173. In 2019/20, the consumption was 404,650 cubic meters and spend was £831,510. Currently, Hammersmith Hospital is relying on Thames Water for water supply rather than the borehole, a source of free water, which is being replaced and upgraded and therefore will return to service this financial year.

Reducing our energy usage

We have successfully completed the flue gas heat recovery project at the St Mary's Hospital site and added an extension to the Hammersmith Hospital system. The project, entailing spend of £1.28 million is forecast to achieve savings of £288,000

per annum from FY 2021-22 onwards. In addition, the Trust will achieve 5.7 per cent reduction in carbon emissions amounting to 2,312 tonnes per annum. In 2021/22 we aim to complete the installation of all measures identified under energy performance contract (EPC). This will enable us to benefit from cutting edge technology and deliver guaranteed savings. An EPC will help us to have a holistic overview of all the remaining avenues for energy efficiency and innovations and profit from big-ticket items such as heat decarbonisation via heat pumps, de-steaming, boiler replacement and extending CHP ring main. 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.

Project Types	No. of Projects	Value	Annual Savings £	Lifetime Savings £	Annual CO^2 Savings (tonnes)
Boilers	1	£599,664	£154,660	£1,674,968	792
Building management systems	6	£2,949,302	£832,972	£7,159,133	5,234
Combined heat & power	1	£949,120	£250,440	£7,513,201	2,616
Heating	2	£1,238,356	£273,677	£2,650,005	2,077
Heating and hot water	4	£954,770	£267,770	£5,956,920	2,377
LED lighting	3	£886,250	£221,344	£2,877,470	1,075
Lighting upgrades	6	£673,260	£159,989	£3,199,776	1,090
MPS	1	£219,108	£117,878	£1,032,042	906
Street lighting	1	£190,950	£43,143	£862,854	294
Transformers	1	£177,415	£54,729	£1,641,883	373
Ventilation and cooling	2	£106,000	£22,499	£256,902	129
Voltage Management	1	£640,007	£150,492	£2,859,343	1,026
VSDs/Motor Controls	6	£816,280	£183,876	£1,886,571	1,147
Grand Total	**35**	**£10,400,482**	**£2,733,468**	**£39,571,069**	**19,135**

We have now delivered 36 energy efficiency projects. These were carried out at an investment of £11.6 million over the last ten years and they are contributing to a financial saving of £2.7 million and carbon reduction of 19,135 tonnes per annum.

We have secured a

£26.9 million grant to reduce the carbon footprint

of our hospital sites

Quality account

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.

Our improvement methodology

We have a dedicated improvement team whose aim is to build learning, improvement and innovation into everything we do across the Trust. The team continues to ensure the rigorous application of the Institute for Healthcare Improvement's methodology by coaching individuals and teams in their area of work, and through large-scale improvements to drive change. An extensive education programme, available to all staff, that aligns to our Imperial improvement competency framework, supports this work. The framework sets out how we embed improvement knowledge and skills across all levels of our organisation at scale and pace. This offer includes our Imperial Flow Coaching Academy (FCA), which uses big rooms to engage a variety of diverse stakeholders in improvement work across patient pathways, and the level 6 improvement apprenticeship, which supports colleagues in leading strategic improvement initiatives aligned with the organisation's strategy.

This year, our transformation team will continue to lead the implementation of the Imperial Management and Improvement System (IMIS). This method comprises annual objective setting, business planning and a management system designed to support improvement and delivery against our set objectives through a systematic approach to delivering our business. 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. Our plans to implement IMIS in full in 2020/21 were delayed because of the pandemic.

2021/22 improvement priorities

The priorities in this year's report focus on the quality and safety programme.

The priorities have been agreed following a review of incidents (including serious incidents), structured judgement reviews, medical examiner outcomes, national reviews and national audits. Within this programme, there are several areas of focus as follows:

Focus area	Rationale for selection	Progress metrics
Improve patient safety incident reporting rates across the Trust	High rates of incident reporting is a strong indicator that staff value safety, feel safe to raise safety concerns and can learn to continuously improve services. This is a key part of building our culture, being open, transparent when things go wrong and supporting patients, staff and families.	Patient safety incident reporting rate – consistently in top quartile (bed day) 10% improvement at WTE level

Focus area	Rationale for selection	Progress metrics
Improve hand hygiene practice, and the safe use of PPE in our clinical areas	We know that hand hygiene is the single most important factor in the control of infection. The pandemic has increased the risks associated with hand hygiene further, but has also increased the risk associated with the use of PPE. The correct use of PPE, alongside outstanding hand hygiene practice, is a key mechanism through which we can keep both our patients and staff safe, while reducing the risk of nosocomial infection, of Covid-19 and other pathogens. We have seen an increase in incidents causing patient harm during this last year, therefore this is an obvious priority while we continue through our pandemic response.	% compliance recorded by observational hand hygiene audits (6/12) % of appropriate hand hygiene practice observed during look, listen and learn audits (PPE helper visits) % of appropriate donning and doffing observed in look, listen and learn audits % of reported levels of staff anxiety in relation to hand hygiene practice and the correct use of PPE % of infection prevention and control incidents associated with nosocomial transmission
Improve how we agree and document appropriate treatment escalation plans, for our patients in an individualised, compassionate, and inclusive manner	During the pandemic, we saw an improvement in the number of patients where we have held individualised discussions regarding the action that we think should be taken if their heart stops (in patients with Covid-19). However, we continue to see incidents where this is not the case and we don't have a systematic way to measure this and support improvement. Intelligence from our medical examiners and from our structured judgement reviews are showing that this remains an issue. This feeds into end of life care planning, but also into the care of patients when they are deteriorating. We know that proactive consideration of the actions that we will take when a patient deteriorates improves not only patient experience, but also outcomes where escalation is appropriate and should take place in a timely and agreed manner. Importantly, it is also key to how we support those patients who are sadly at the end of their life. We want to build on the improvements we saw during the pandemic; specifically how we approach whether a patient should have cardiopulmonary resuscitation – ensuring decisions are individualised, take into account the patient's wishes and the extent to which the patient has the mental capacity to be involved in decision-making. Importantly we want an agreed treatment escalation plan to be in place for our patients, agreed by their consultant.	% of patients with a DNACPR recorded on our electronic patient record within 24-hours of admission % of DNACPR decisions reviewed by a consultant within 48-hours % of patients with a treatment escalation plan recorded on our electronic patient record % of patients with a DNACPR in place who have had their mental capacity assessed and documented % of documented conversations with next of kin where a patient, who lacks capacity, has a DNACPR in place

Focus area	Rationale for selection	Progress metrics
Improve how we document that our patients have provided informed consent prior to relevant procedures	We have a consent policy and process in place which we audit annually, with actions implemented where the audit identifies issues. However, there is work to do, with issues remaining around ensuring consent forms are uploaded onto the electronic patient record. In addition, our current consent process makes it difficult to determine if 'informed' consent has taken place. Both the Paterson Inquiry and The Cumberlege Report (see page 69) identified issues with the consent process, with patients being unable to make an informed decision and sufficiently weigh up the risks and benefits. The Cumberlege Report identified the confusion created by the volume of patient information leaflets and consent forms, while the Paterson Inquiry found that there was not enough time allowed during the consent process for patients to reflect on their treatment and options. A pilot of an electronic consent process has recently been trialled in breast surgery with positive feedback from both patients and staff. The process allows patients to review clear information on their treatment, ask questions directly of the clinical team, and electronically consent to the procedure. Implementing electronic consent, Trust-wide, could significantly improve how both patients and staff experience the consent process and improve our documentation of the process.	% of patients with informed consent recorded in the electronic patient record prior to a procedure taking place
Reduce avoidable harm and improve performance and outcomes associated with invasive procedures	Following a series of surgical 'never events' we planned to implement a rolling 18-month programme called 'HOTT' (Helping Our Teams Transform). HOTT provides simulation training, in situ coaching, 'conversation cafés', and human factors training for those areas conducting invasive procedures. The original aim of the HOTT programme was to improve performance, safety and staff experience during invasive procedures using a programme that addressed behaviours and human factors. We intend to relaunch our HOTT programme to improve compliance with our existing policies and procedures that are designed to reduce the risk of avoidable harm during invasive procedures.	% of audited compliance with the World Health organisation's five steps to safer surgery % of audited compliance with the Trust Count Policy % of avoidable harm incidents associated with invasive procedures Audit compliance with high risk (Local Safety Standards for Invasive Procedures) LocSSIPs

Focus area	Rationale for selection	Progress metrics
Reduce the number of patient falls and associated harm levels	The number of falls causing harm to patients has increased on a background of a reduction overall of falls. The recording of incidents is reliant on submissions in our incident reporting system, which means the overall numbers are not always aligned to the clinical records and the national audit data. Themes from incident reports shows an issue with consistent completion of risk assessments and implementation of the falls prevention policy. Falls reduction was a previous safety improvement stream which has not been transitioned to business as usual. We will use this next 12 months to ensure we implement the key interventions to prevent falls.	Overall number of patient falls recorded on our incident reporting system or our electronic patient record % of falls incidents causing harm % risk assessments completed on admission % compliance with falls prevention interventions

We are committed to focusing on these priorities, along with a wide range of other work focused on improving the quality of care provided to our patients, the experience they receive, and the environment and culture in which our staff work. We will continue to respond to the Covid-19 pandemic and will review our priorities as a trust should our response to Covid-19 require this.

Progress against our 2020/21 improvement priorities

Last year we identified six priority improvement areas – based on engagement with staff at all levels and across different groups – aligned to the Trust-level focused improvements set out during the annual business planning cycle.

Throughout 2020/21, the Trust has responded to unprecedented demand and change because of the Covid-19 pandemic. Because of this, many of our work programmes and focused improvements were suspended. We made changes to how our services run, and ensured that we focused our resources and expertise on the immediate pandemic response, while also continuing to treat patients that did not have Covid-19. The below table provides an update against our improvement priorities identified for 2020/21. We recognise that in many areas we have not delivered on our plans due to national or Trust-level suspension of activity. In the context of Covid-19, there are some cases where we fundamentally changed the focus of the priority.

Improvement priority	What did we achieve?
1. To improve the Friends and Family Test (FFT) response rate	In response to Covid-19, NHS England/Improvement (NHSE/I) suspended mandatory reporting of FFT data to allow resources to be diverted to focus on the pandemic response. This, in conjunction with reduced activity, resulted in a reduction in our FFT response rates. This year we made two changes to improve our FFT response rates and the usefulness of the data we collect. We amended the wording on the surveys to encourage people to leave detailed comments and moved to text message invitations for patients to complete the survey across all service areas and clinical pathways, learning from work completed in outpatients and emergency departments. Due to the suspension of the FFT reporting requirements and a reduction in responses during the first and second wave of the pandemic, we have not yet been able to assess the impact of these changes. In April 2020, at the height of the first wave, we received our lowest number of responses (1041) – with reductions evidenced during wave two also. In March 2021, we received 10,600 responses, which is approaching pre-Covid-19 response levels. We will continue to work on improving the richness and volume of comments we receive so that we can better plan interventions to improve patient experience. We typically measure patient experience by collating the results of a selection of questions from the national inpatient survey focusing on the responsiveness to personal needs. However, the national inpatient survey programme was suspended over the past year due to the Covid-19 pandemic. A new Trust patient experience scorecard has been developed to include the following: • positive overall rating of care (replaces likely to recommend score) • patient experience of care score – based on a composite score of four key questions that focus on what is important to patients • net sentiment score – which looks at all free text comments and identifies positive, neutral, and negative sentiments from which a score is derived. We will use our new scorecard to transition our FFT and patient experience priorities into our business as usual work via the IMIS programme (see introduction).

Improvement priority	What did we achieve?
2. To improve the percentage of staff who feel they can make improvements in their area	During the first and second wave of the pandemic, our formal quality improvement programme was suspended. Our staff have needed to adapt and improvise in how they deliver services, and, in many cases, step in to set up new services in redeployed roles. From this, we have seen that having an embedded improvement programme across the organisation has enabled them to do this with a rigorous approach. This includes the use of driver diagrams to plan and using data to drive insights via regular improvement huddles to iterate and improve. The NHS staff survey asks staff to consider if they can make improvements in their own area of work: 58 per cent of our staff that responded to the survey stated that they either strongly agreed, or agreed that they were able to do so. This is above the benchmark average of 55.4 per cent, but is a reduction from 61.3 per cent in 2019. In the past year there have been over 100 scoping requests made to the improvement team for support with project planning and implementation. Many others have set up improvements locally within their own teams, 12 of whom were selected to share their 'stories for improvement' at our virtual celebration events in September and December 2020. Heading into 2021/22, we are introducing a new online platform called 'Improve Well' to make it easier for staff to share their improvement ideas both locally with their team and across the organisation. We will also be focussing on restarting our quality improvement programme.
3. To improve incident reporting rates	Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. High rates of incident reporting enable us to identify with more accuracy actual or potential harm – analysing this data alongside other sources of intelligence, helps us to learn and continuously improve. We believe that high rates of incident reporting is an important measure of how we are embedding our values and behaviours framework, supporting staff to be open and to report and we chose this as a priority as it is something that every member of staff at every level can improve as part of their role. Pre-pandemic, the numbers of incidents we reported were variable and during the first surge in spring 2020 reporting dropped across all divisions, from 17.59 per 100 whole time equivalent (WTE) in March 2020 to 10.44 in April 2020. We have also seen a decrease in the number of incidents reported during the most recent surge, however the numbers overall have remained higher this time at 13.47 in February 2021. Bed buddies in critical care areas supported clinical teams to continue to report incidents during the second surge, which has helped to maintain incident reporting in these areas. We know that conducting protracted investigations is often a stressful experience for staff and may not always promote an effective learning culture when things go wrong. This may make staff less inclined to report incidents. Therefore, we continue to focus on rolling out 'after action reviews' (AAR) after a successful pilot – a well-recognised technique for conducting quick and effective patient safety investigations that engage staff in rapid local improvement. We are also engaging with colleagues in Imperial College London (Patient Safety Translational Research Centre) to use behavioural insights to increase incident reporting rates, particularly among specific professional groups who report less incidents than others do.

Improvement priority	What did we achieve?
4. To reduce temporary staffing spend	During the pandemic to date, we have carried out large-scale redeployment of our staff on two occasions to ensure that we could meet the unprecedented demand on our services. A newly established redeployment team who worked to support over 1,000 staff to redeploy in both waves led this. We redeployed clinical staff to intensive care (ICU), and we supported staff from across the Trust, including those not clinically trained, to learn new skills and redeploy to a range of roles. These roles included a central proning[1] team in critical care, ward support officers, mealtime assistants, vaccination hub staff, contact tracing, and additional administrative support for a range of teams under pressure. Monthly monitoring of our staffing provision, utilisation of temporary staffing, vacancy, turnover and absence rates, and capability is essential to the delivery of care through safe staffing, supporting excellent patient experience outcomes. Monitoring of these metrics ensures the care we provide is safe, responsive, and well-led. For the period April 2020 to February 2021, a total of £11.5m has been spent on agency staffing which accounts for 1.6 per cent of the Trust's total pay costs. This is £6.4m less than the same period of 2019/20, equating to a 36 per cent reduction. Year-to-date we have spent £4.5m less on bank staffing when compared to the same period in 2019/20. We have achieved cost avoidance of £647k through direct engagement for allied health professionals (AHP), healthcare scientists (HCS), and doctors, despite increased demand due to the Trust's response to Covid-19. Reduction in our temporary staffing spend will be a key component of how we build a sustainable workforce, which is a priority for the coming year. We plan to achieve this through domestic recruitment campaigns, increased international recruitment, targeted wellbeing and retention workplans, and a review of posts that were not actively recruited to during 2020/21 due to the pandemic.

1 proning is the process of turning a patient with precise, safe motions from their back onto their abdomen (stomach) so the individual is lying face down

Improvement priority	What did we achieve?
5. To reduce the number of patients with a length of stay of 21 days or more	Reducing the number of patients with a long length of stay (LLOS) has continued to be a key priority for the Trust throughout the pandemic. LLOS metrics have been included in revised divisional performance scorecards this year and plans are in place for embedding these in directorate scorecards in line with the rollout of IMIS. Pre-pandemic, there was an average of 210 patients with a stay in one of our acute beds that was 21 days or longer. This was above the target of 143 (set at 18/19 baseline). With the advent of the pandemic and significantly lower acute admissions, the number of LLOS patients dropped below the target for the majority of April-October 2020. During the second wave of the pandemic, it became evident that the number of Covid-19 patients the Trust was caring for, particularly those requiring intensive care, was driving LLOS performance. The number of LLOS patients rose between November 2019 to February 2020 and started to reduce through March 2020, as the first wave of Covid-19 subsided. **Medically optimised patients:** In early 2020, 40 per cent of LLOS patients were medically optimised and therefore no longer requiring a hospital bed. With the implementation of integrated discharge hubs as part of the pandemic response, working with our local system partners we have successfully reduced the number of medically optimised patients residing in hospital by approximately 50 per cent. Discharge hubs are operated by community providers and bring together hospital discharge, social work, community in-reach and commissioning brokerage teams to accelerate the implementation of the Discharge-to-Assess model with no permanent post-acute care decisions being made from hospital. **Future plans:** Despite significant improvements in processes, relationships, and reporting, we remain an outlier when compared with other London NHS Trusts in terms of percentage of beds occupied by patients with a length of stay over 14-days. Reducing the number of patients with a length of stay over 14 days will remain a key performance indicator for 2021/22. Priority actions to support continuous improvement in this area will include: • participation in the Alliance 16 programme delivered by NHSE/I during Q1-2, with a particular focus on demonstrating the effect on flow of embedding highly effective board rounds on wards at Hammersmith and Charing Cross hospitals. • completion of the first phase of the flow transformation programme focusing on liver and acute medical pathways at St Mary's Hospital, with a view to dissemination of learning and wider rollout. • embedding and recruiting to integrated discharge hubs with recurrent funding by Q2. • improving utilisation of discharge lounges including proposed estates work at Charing Cross Hospital.

Improvement priority	What did we achieve?
6. To reduce avoidable harm to our patients	We have continued to focus on reducing avoidable harm to our patients but revised our safety improvement programme in response to the pandemic. The percentage of all patient safety incidents (PSIs) causing moderate harm has increased slightly from 1.28 per cent (April 2019 - March 2020) to 1.47 per cent (April 2020 - March 2021), however the overall numbers have decreased (221 were reported in 2020/21 compared to 241 in 2019/20). The percentage of PSIs causing severe or major harm has increased from 0.03 per cent to 0.15 per cent over this period, with 36 being reported in 2020/21 compared to 26 in 2019/20. This is likely to be due to the increased acuity of patients admitted to our Trust during the pandemic. The percentage of extreme harm PSIs has reduced from 0.04 per cent to 0.02 per cent over the same period, with 18 reported in 2020/21 compared to 27 in 2019/20. We chose to focus on the elements of the programme that addressed our changed patient safety risk profile during the pandemic in order have a demonstrable impact on the safety of patients and staff during the first and subsequent waves. Focus areas included: • supporting staff with hand hygiene (HH) and personal protective equipment (PPE) through our award-winning HH/PPE 'helper' programme, which aims to improve compliance with infection control practices in a supportive manner. Ensuring staff always adhere to infection prevention and control practices helps to reduce the incidence of avoidable hospital acquired infections, including Covid-19, and has been key to keeping our staff and patients safe during the pandemic. We carried out over 2,200 visits to clinical areas to support our staff, the reported level of anxiety among our staff during theses about the correct use of PPE and infection control practices reduced since the programme has been running, and practice has improved. • staff and patient testing for Covid-19 (included in more detail in the next section). • reducing failure to rescue the deteriorating patient. We know that the acuity and dependency of many of our patients has increased during the pandemic, and our improvement work has focused on ensuring that we continue to provide appropriate care and treatment to our sickest patients. This includes developing real time reporting so we know where these patients are in the hospital and can respond to them quickly. We have also focused on ensuring that staff are appropriately supported to care for patients who are stepped down to general wards with more complex airway management issues because of Covid-19. • improvements in areas conducting invasive procedures continue, overseen through the invasive procedures group. We have completed our invasive procedure action plan, which was devised in response to a series of 'never events' in 2019/20. This has seen the introduction of local safety standards for invasive procedures among a series of actions. We have been supporting improvements in the safety culture in our operating theatres and other areas undertaking invasive procedures through our award winning Helping Our Teams Transform (HOTT) programme (described further in Part 3 of this report). Due to the suspension of large amounts of our elective surgical activity during 2020/21, the formal roll out of the programme was suspended. However, we continue to offer human factors and simulation training, as well as in-situ coaching where opportunities present themselves. We are focusing on listening to staff experience of teamwork during the pandemic to continue to evolve the programme in 2021/22.

Improvement priority	What did we achieve?
	• we have developed evidence-based treatment guidance for Covid-19 and continue with ongoing clinical audit to ensure compliance against best practice, as this emerges. We have also conducted audit against other aspects of the care and treatment of patients with Covid-19 including decision-making at end of life. This includes ceilings of treatment such as 'not for resuscitation' status. The clinical reference group, chaired by the medical director, continues to provide oversight of this and all other aspects of safety and effectiveness in response to the pandemic. • during summer 2020, we conducted a rapid review to identify learning and insights from the first surge of the pandemic. In September 2020, key insights and recommendations from a patient safety perspective were presented to the executive committee, which helped us to better prepare for the subsequent surge in winter 2020/21. In addition – and despite the operational pressures associated with our response to the pandemic – there is much locally-driven safety improvement work being undertaken in the Trust, which often arises from local audit activity. For instance, the division of surgery, cancer, and cardiovascular services work to reduce pre-operative fasting times, or 'nil by mouth' (NBM), prior to surgery. Work also continues to improve patient falls and staff wellbeing, which is linked to better patient safety and outcomes. We are now planning the next phase of our safety improvement programme: reducing avoidable harm to our patients, and indeed our staff, in the context of Covid-19, remains an improvement priority in to 2021/22.

Covid-19 quality improvement activities

Throughout much of the pandemic, and always while the NHS in England was at its highest level of emergency preparedness and the pandemic classified as a Level 4 Incident, the Trust has operated under a command and control structure, akin to a major incident.

Through our command and control structures, we reassessed our Trust-wide and site-specific improvement priorities, on a near daily basis, and as we exited the first wave of the pandemic.

We made unprecedented developments and changes, at pace, to promote and improve safety and quality as part of our Covid-19 pandemic response. This included making changes to our safety improvement programme that we have outlined above – we also refocused our priorities to reduce the risk of nosocomial infections while reducing harm associated with pressure ulcers.

We are currently reviewing the changes and additional services and processes that we put in place in response to the pandemic. We anticipate that many of these programmes will remain in the Trust for some time to come. This review will ensure that what we provide to our patients and staff remains of a high quality and relevant.

Clinical oversight and support

The Covid-19 pandemic has placed an overwhelming level of demand on the Trust and our clinicians. In response to this rapidly evolving landscape, we implemented several changes to support our staff and the governance of safety and effectiveness. These changes – described below – have helped us to provide a strengthened decision-making and clinical governance structure, deliver improved support for ethical decision-making and maximise the pace of assimilation of a rapidly evolving evidence base into practice in support of an effective organisational and clinical response to Covid-19.

Clinical Reference Group (CRG)

In March of 2020, we established the CRG to lead decision-making and clinical oversight of the Covid-19 response. The CRG, chaired by the Trust's medical director, meets daily and has representation from a wide array of clinical and corporate areas, including our clinical divisions, clinical ethics, infection control, compliance, and nursing.

The CRG has several responsibilities, including:

- to review and approve new clinical guidance in response to Covid-19, particularly where there may be a derogation of standards
- to provide senior clinical oversight and review of ethical decision-making in response to Covid-19
- to monitor incidents related to Covid-19 affecting patients, visitors, and staff members, including oversight to any clinical harm reviews conducted in response to Covid-19

This group has been instrumental in coordinating the Covid-19 response and disseminating essential information across the Trust. Meeting daily throughout the pandemic, the group has reviewed more than 1,000 items, making evidence-based decisions to ensure that our patients and staff remain safe and receive the most up to date care for Covid-19, while continually reflecting on how to improve and adapt our clinical response to the pandemic.

Clinical decision support (CDS)

Our clinical teams make difficult decisions regarding treatment plans for our patients daily. However, in the context of a pandemic, emerging and evolving clinical guidelines, restricted visiting, extreme pressures on our resources and patients less able to engage in decision-making due to respiratory support, we identified a need to provide additional support to our clinical teams, patients, and their families in considering the most difficult treatment decisions for those in our care. This included support relating to whether we should perform cardiopulmonary resuscitation, and whether we should escalate the patient's treatment to our intensive care units.

The CDS has operated uninterrupted since mid-March 2020, 24-hours a day, seven days a week. Its function is to provide clinicians with the opportunity to discuss patient care with colleagues, and to receive clinical ethics support where necessary. The CDS service can be triggered for any reason, but was predominantly set up for circumstances in which:

- the family and/or patient involved do not agree with the clinicians on management of the patient
- clinicians do not agree with each other on management of the patient
- all concerned parties agree on the best course of management, but resource constraints may prevent the implementation of this decision

Based on the concept of a 'three wise people' discussion, the CDS is a formal mechanism that has helped support those making decisions to try to resolve challenges and disagreements by calling on the support of those independent of the case.

The CDS was designed in line with the ethical framework developed by the Committee on Ethical Aspects of Pandemic Influenza first published in 2007, revised by the Department of Health and Social Care in 2017. The framework draws together several different ethical principles, including:

1. Respect
2. Minimising harm
3. Fairness
4. Working together
5. Reciprocity
6. Keeping things in proportion
7. Flexibility
8. Good decision-making, as defined by openness and transparency, inclusiveness, accountability, and reasonableness

Since the CDS was formed in March 2020, the panel has considered over 60 cases, all of which have been presented by a consultant to a panel of at least three doctors independent of the case. Chaired by an associate medical director, our consultants from intensive care, respiratory medicine, palliative medicine, clinical ethics, and many other areas have met to express viewpoints, consider key facts, and come to an independent conclusion with concrete actions – taking into account the view of the patient, their family, ethical decision-making and our legal and moral obligations.

Medical examiner service

Sadly, the Covid-19 pandemic led to an increase in the number of deaths across the Trust during pandemic peaks. Our medical examiner service was newly formed between January and March 2020, in line with national guidelines not associated

with Covid-19. There was no requirement to maintain this service during the pandemic, but we recognised the importance of ensuring we maintained this service. The medical examiners independently review every death that occurs within the Trust to ensure the cause of death is accurate, is explained to the bereaved and that they are provided with the opportunity to raise any concerns about the quality of care or treatment that the patient received.

In 2020/21, 2,111 deaths occurred at the Trust, all deaths were subject to review by our medical examiner service, 802 patients died within 28-days of a positive Covid-19 test result and/or had Covid-19 recorded as causing or contributing to their death on their medical certificate of cause of death. The majority of the 802 patients died in condensed periods of time correlating with the first and second wave of the pandemic – placing significant pressure on the medical examiner service (346 in quarter one, seven in quarter two, 92 in quarter three and 357 in quarter four). In both waves of the pandemic, we redeployed staff to increase our resources in the medical examiner service, and despite increased mortality, independent scrutiny of every death has taken place. Working together with our bereavement team, the medical examiner service has been an intrinsic part of our offer to the bereaved with positive feedback.

Infection prevention and control

Our approach to enhanced infection prevention, and control (IPC) has been an integral part of how we have kept patients and staff safe during the pandemic. Our dedicated team supported by our CRG and clinical teams have responded to emerging clinical guidelines and the ever-changing nature of the pandemic. We have sought to ensure our staff are always clear on the current advice and guidelines – supporting the development of new clinical pathways to ensure that we keep our patients and staff safe.

Hospital-associated Covid-19 infection and transmission

The Trust has used the NHS England categorisation for hospital-onset Covid-19 infections (HOCI) since the start of the pandemic. This system uses four categories to define the onset of a Covid-19 infection:

- community onset: positive test result <= 2 days prior to admission
- hospital-onset indeterminate healthcare associated (HOIHA, positive test result 3-7 days post admission)
- hospital-onset probable healthcare-associated (HOPHA, positive test result 8-14 days post admission)
- hospital-onset definite healthcare-associated (HODHA, positive test result >= 15 days post admission)

The Trust has recorded 478 hospital onset Covid-19 infections in the 2020/21 reporting period, which are broken down as follows:

Hospital-onset indeterminate healthcare associated (HOIHA, positive test result 3-7 days post admission)	222
Hospital-onset probable healthcare-associated (HOPHA, positive test result 8-14 days post admission)	118
Hospital-onset definite healthcare-associated (HODHA, positive test result >= 15 days post admission)	138

Sadly, of these 478 cases, 136 patients died following either an indeterminate, probable or definite hospital onset Covid-19 infection. We have an established surveillance system for hospital-onset Covid-19 infections (HOCI) and the rate of HOCIs in the Trust for the period December 2020 – March 2021 is in line with the mean average rate of other London NHS trusts; we rank 13/30 against other NHS trusts in London.

The Trust's clinical incident management systems are used to investigate and learn from Covid-19 outbreaks and related incidents. An individual review is undertaken for each case of hospital-onset Covid-19 infection in a patient >7 days after their day of admission where the patient is not included as part of our outbreak management policy.

We have undertaken several actions to prevent, identify, and manage hospital-associated Covid-19 infection and transmission among staff and patients. These include:

- creating an IPC board assurance framework, which is updated monthly with an associated action plan that is reviewed weekly at our CRG
- establishing a surveillance system for hospital-onset Covid-19 infections (HOCI) within the Trust
- in partnership with occupational health, developing and establishing systems to identify and manage possible outbreaks of Covid-19 among staff
- using the Trust's clinical incident management systems to investigate and learn from Covid-19 outbreaks and related incidents
- undertaking reviews for each individual case of hospital-onset Covid-19 infection in a patient occurring more than seven days after their day of admission where the onset of infection is not part of an outbreak

In response to updated Public Health England (PHE) national guidelines for the prevention and management of Covid-19, and in response to learning from our experience during the first wave of the pandemic, we have also implemented the following changes:

- All contacts of patients diagnosed with Covid-19 are tested daily for 14-days following exposure
- All patients who test negative for Covid-19 at the point of admission to hospital are tested daily for the first seven days of their admission, and weekly thereafter should they remain in hospital
- We have updated guidance on managing elective and emergency admissions, including how best to care for patients that have recovered from a previous Covid-19 diagnosis, while identifying possible reinfection
- We have changed pre-procedure isolation protocols for elective procedures – balancing how we can support our patients to be safely admitted against the challenge of patients and their household isolating prior to admission.
- We have initiated a process for phasing out valved FFP3 respirators in clinical areas where sterile procedures are undertaken

Personal Protective Equipment (PPE) helper programme

The 'PPE helper programme' was launched during the first wave of Covid-19 to provide ward-level support for staff to use the correct PPE, and to use it safely. Our PPE helpers visit clinical areas daily to observe PPE use and support best practice. In addition to providing advice, PPE helpers record observed compliance with donning

(putting on PPE), doffing (taking off PPE), and levels of staff anxiety. This allows us to track progress over time. Our PPE helpers have delivered over 300 instances of 1:1 training – either by request from departments or due to an outbreak – to clinical and non-clinical staff. We carried out over 2,200 visits to clinical areas to support our staff. The reported level of anxiety among our staff about the correct use of PPE and infection control practices reduced since the programme has been running, and practice has improved.

Health and wellbeing helpline

At the start of the pandemic, we opened a dedicated helpline for our staff. The helpline provided staff with a reference point for all queries relating to the rapidly evolving national and local Covid-19 guidance. Focusing on symptomology, we were able to provide quick advice to our staff regarding self-isolation and testing and shielding once introduced. In the first week alone, we assisted 700 members of our staff via this helpline. Since then, the helpline has provided, and continues to provide, a valuable resource – giving support and guidance, as well as a listening ear, to colleagues across the organisation.

In the first week alone

we assisted 700 members

of our staff via our health and wellbeing helpline

Pressure ulcers

Pressure ulcers are an injury affecting areas of the skin and underlying tissue – 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 investigate each pressure ulcer and put in place a robust action plan for each serious incident. In 2020/21 we reported 42 category 3 and unstageable Trust-acquired pressure ulcers – of these 22 were acquired on patients with a diagnosis of Covid-19 in our critical care areas during the pandemic.

Many of our patients with Covid-19 that acquired pressure ulcers were proned. Proning, where a patient is moved to lie on their front, is a recommended treatment for patients with severe hypoxemia and has been shown to significantly improve the condition and reduce mortality in patients with moderate to severe acute respiratory distress syndrome (ARDS). In many cases, patients were proned for at least 16 hours, and in some cases longer if other positions were not clinically indicated. Prior to the pandemic, proning was a procedure that was infrequently used in a very small proportion of patients admitted to the critical care in the Trust.

To respond to the risk of pressure ulcer damage during proning we implemented a specialist trained proning team to assist with undertaking proning and de-proning as well as patient re-positioning. Proning is a complex procedure and has many potential complications associated with it – including pressure ulcer damage. Our plastic surgery team, working with our tissue viability team, worked throughout the pandemic to review our guidance to provide standardised advice to our clinical teams along with case management to manage pressure relief in relevant cases – this included the need to consider, as a standard, pressure areas for proned patients as part of care planning.

Testing

The Trust's Covid-19 testing programme has formed an integral part of our response to the pandemic. Designed to keep our patients, staff, and their household members safe, the programme has been designed to reduce the risk of nosocomial infection, and to ensure that our staff and their household members could access symptomatic testing quickly when needed.

In partnership with North West London Pathology, the Trust has a comprehensive testing programme for patients and staff as well as their household members. This is led by a central testing team and programme based within the office of the medical director, with inpatient care provided by our clinical teams, alongside contact tracing expertise for staff in our occupational health team and for patients in our infection, prevention and control team.

220,725 polymerase chain reaction (PCR) tests have been carried out for patients, staff, and their household members since 1 March 2020. In addition to this over, 10,000 staff have enrolled in a twice-weekly rapid home testing using lateral flow testing devices – including 80 percent of our staff designated as patient-facing staff.

Patients

The testing team are responsible for the pre-admission screening of patients due to undergo procedures or admission to the Trust in line with PHE guidance. Pre-elective screening is required between three and five days prior to admission and is provided in dedicated testing facilities across all three sites – designed to ensure that we understand a patient's Covid-19 infection status prior to admission so that we can take appropriate steps to keep the patient, other patients, and staff safe. For those

patients that are not able to easily travel to one of our testing facilities we have also designed a home courier testing service in partnership with our patient transport provider.

From 1 April 2020 to 31 March 2021, the Trust performed 174,786 patient tests, prior to admission, at the point of admission, and during inpatient stays, with a total of 7,339 positive results. We have audited our compliance with testing our patients and the findings from this are at pages 68 and 69.

Staff and their household contacts

In the earlier part of the year, all patient-facing staff in areas where there was a higher risk to patients should they contract Covid-19 were tested on a twice-weekly basis with polymerase chain reaction (PCR) tests. In September 2020, this was scaled back in response to pandemic conditions and now is only undertaken in three distinct specialties that continue to require ongoing asymptomatic PCR testing (paediatric haematology, oncology and adult haematology). These staff continue to undergo bi-weekly asymptomatic testing.

Since November 2020, all staff have had access to twice-weekly rapid lateral flow testing; over 1,000 of our staff have taken part in this testing programme. We have reported more than 150,000 test results to PHE and have identified nearly 700 staff infected with Covid-19 via the lateral flow-testing programme. We continue to use lateral flow testing in line with national guidance and it remains an integral element of how we keep our patients and staff safe.

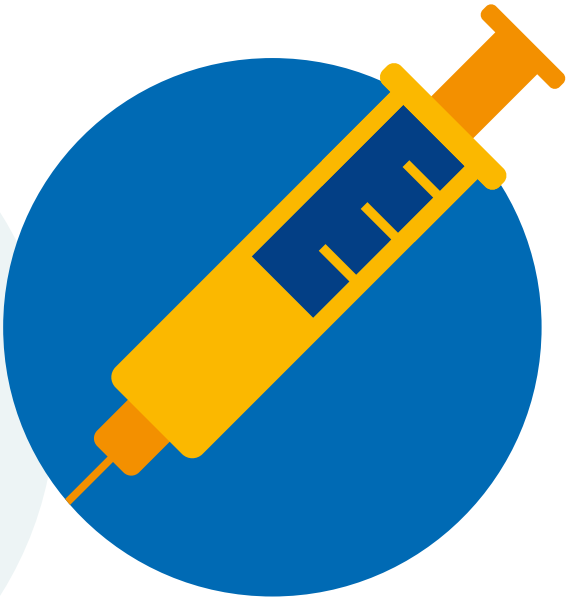
The Trust also provides access to testing for any staff with symptoms suggestive of Covid-19. Staff can self-refer for a test, conducted either in our on-site testing hub, or, if necessary, completed via home courier testing service. We also offer this option to household members of staff. This has been an incredibly helpful service in terms of offering rapid access to testing for our staff as well as reducing isolation periods for staff and household contacts where the test has been negative.

From 1 April 2020 to 31 March 2021, we performed 45,939 tests for staff and their household members, with a total of 1,468 positive results.

By the end of March 2021, we had administered

35,000 doses

of approved Covid-19 vaccines, including 11,600 second doses



Vaccination programme

The Trust's vaccination programme began at the end of December 2020 and remains an essential component of our response to the pandemic. We operate three vaccination hubs across our main hospital sites, with capacity to provide over 3,500 vaccinations per week. We currently provide vaccination to our staff, health and social care colleagues across London, and our most vulnerable patients that meet the Joint Committee on Vaccination and Immunisation (JCVI) eligibility criteria.

The delivery of the Covid-19 vaccination programme is a whole hospital effort, led by the office of the medical director; the success of the programme has been contingent on hundreds of colleagues from a range of professional backgrounds who have given their time, enthusiasm, and expertise to the programme.

By the end of March 2021, we had:

- administered 35,000 doses of approved Covid-19 vaccines, including 11,600 second doses
- vaccinated over 12,000 people that work at the Trust, as well as over 7,000 colleagues from the wider health and social care family, and over 2,000 patients
- vaccinated hundreds of students, contractors and volunteers that work in patient-facing roles.

Our vaccination programme has been designed to ensure that we provide the maximum protection possible to those working in health and social care, and to our patients.

We are incredibly proud of our efforts to date and our role in the biggest vaccination programme in the history of the NHS. However, we recognise that there is room for improvement, particularly in vaccination uptake among our staff. As of 31 March, we had vaccinated over 85 per cent of our frontline staff – this is a number that increases daily.

We are completely committed to increasing uptake, and have deployed numerous interventions including face-to-face engagement sessions, digital engagement and pilot activity based on advice from behavioural insight experts from Imperial College London. Some examples that have driven improvements include:

- ongoing communication campaign, with leaflets available in different languages
- outreach work in clinical areas, with the vaccination team speaking to vaccine hesitant colleagues and supporting immediate vaccination and focused staff sessions where needed
- ability for staff to book an appointment to speak to a clinician about their concerns launched, across several areas including fertility and general health
- personalised letters and emails sent to all staff who had not responded
- calls to all staff registered but not vaccinated
- creation of a vaccine advocate programme, training staff to serve as advocates to encourage vaccine uptake.

We are constantly reviewing the programme and feedback from colleagues to increase uptake and improve the experiences of those accessing the vaccine at the Trust.

Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2020/21. 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 2020/21, Imperial College Healthcare NHS Trust provided services to combat the pandemic and endeavoured to provide its standard commissioned services.

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

The income generated by the NHS services reviewed in 2020/21 represents 96.7 per cent of the total income generated from the provision of Trust services in 2020/21.

The income generated by patient care services associated with the services above in 2020/21 represents 86.6 per cent of the total income generated from the provision of services by the Trust for 2020/21.

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 allocate resources to areas requiring improvement and as part of our commitment to ensure the best treatment and care for our patients.

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

During 2020/21, 46 national clinical audits and two national confidential enquiries covered NHS services that we provide. During this period, we participated in 98 per cent of national clinical audits and 100 per cent of national confidential enquiries in which we were eligible to participate. The one national clinical audit the Trust did not participate in was the Society for Acute Medicine's Benchmarking Audit; we have not participated in this non-mandatory audit since 2016. The division of medicine and integrated care review other metrics to provide assurance through divisional governance processes and as part of the oversight of operational performance of emergency pathways.

The national clinical audits and national confidential enquiries that we were eligible to participate in are included in a table at Annex 3 (page 98), with the number of cases submitted presented as a percentage where available. Please note that percentages will be accurate up to February 2021 where hosts were contacted with most of the data collection still ongoing.

National clinical audit

We reviewed the reports of 46 national clinical audits and confidential enquires in 2020/21. These clinical audits, linked with our focused improvement work, have identified several areas of excellent practice as well as opportunities for development and improvement. Some examples of these national audit reports are given below to indicate the range of work and performance across the Trust.

National diabetes inpatient audit (NaDIA) 2019 report

NaDIA measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital. Over the last 18 months, the Trust has had a strong focus on improving inpatient diabetes care and has demonstrated measurable improvements in patient outcomes and in key clinical metrics. The audit demonstrates an increase in the acuity of our patient population, of our inpatients with diabetes, 85 per cent were admitted as emergencies, indicating an uptrend from 2016 (70.6 per

cent) and 2017 (77.5 per cent). Improved attention to the chronic and preventative health needs of these patients are reflected by the fact that of the inpatients admitted with clinical episodes related to diabetes, 5.6 per cent were admitted due to diabetic foot disease, compared to 10.4 per cent in 2017. Within 24-hours of admission, 30.9 per cent of diabetes inpatients had received a diabetic foot risk assessment. We have improved significantly in terms of severe hypoglycaemia, with 4.2 per cent of inpatients with diabetes having experienced one episode compared to 10.4 per cent in 2017. Increased awareness of best practice related to diabetes management for inpatients means that more patients are referred to the diabetes nurses early on for review. Remote reviews have also resulted in more medicine adjustments according to blood glucose levels. Our ongoing focus for improvement is to create systems that allow for all high-risk inpatients with diabetes to be reviewed by the diabetes team and have management plans adjusted appropriately. There is work in progress in collaboration with Chelsea and Westminster Hospital NHS Foundation Trust and the North West London Diabetes Clinical Reference Group to further involve patients and their carers in planning and understanding their care more frequently.

Sentinel stroke national audit programme (SSNAP) report (seventh annual report)

SSNAP measures both the processes of care provided to stroke patients, as well as the structure of stroke services against evidence-based standards. Our stroke performance remains consistently strong and of the highest quality. We recently won the chair award for research and innovation for 'using data to improve patient care', relating to our excellent SSNAP performance. We are one of the best performing hyper-acute stroke units in London and the UK. The national Getting It Right First Time (GIRFT) Team, in the UK Stroke Forum, has used our good clinical practice as an exemplar. In terms of outcomes, we have the second lowest standardised hospital mortality rate for stroke in the UK, and our length of stay has been improving quarter by quarter for the past three years.

National joint registry (NJR) 17th annual report 2020

The NJR collects information on hip, knee, elbow, and shoulder joint replacement surgery and monitors the performance of joint replacement implants. The number of joint replacement operations fell significantly in 2020, as all elective orthopaedic surgery ceased in March 2020 and did not resume until September 2020 due to the Covid-19 pandemic. The reported revision rate for knees was 6.11 per cent versus 4.19 per cent nationally at 10-years, and at one year, it is 0.94 per cent versus 0.47 per cent nationally. The clinical director and clinical team have revised our revision rate and it is felt to represent the number of unicompartmental knee replacements being performed at the Trust. The Trust already holds a surgical multidisciplinary team meeting for all patients referred for revision surgery (some complex referrals come from other trusts in the sector). The Trust's revision rate for hips is lower than the national average at 3.6 per cent versus five per cent nationally at ten years. At one year, we have a slightly higher chance of revision 1.53 per cent versus 0.78 per cent nationally.

National neonatal audit programme (NNAP) 2020 annual report on 2019 data

The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales consistently receive high quality care and identifies areas for quality improvement in relation to the delivery and outcomes of care. We continue to perform well against many of the audit measures, frequently exceeding the national

average. Both units at the Trust have a strong breastfeeding ethos with support from lactation consultants. We have an integrated family-delivered care model that encourages parental education and involvement in their baby's care that also supports confidence and breastfeeding. This has resulted in higher than national average rates for babies receiving mother's milk at the time of discharge. We have a nearly 100 per cent success rate in antenatal steroids and magnesium sulphate on both units. In parameters such as consultation with parents, keeping mothers and babies together (term and late preterm) and screening for retinopathy of prematurity, we have performed much above the national average on both units. There has been an ongoing problem with documenting parental presence on the consultant ward round. Although we have made progress from last year, it remains below the national average. We have commenced a focus project aimed at improving this.

National maternity and perinatal audit (NMPA) – NHS maternity care for women with multiple births and their babies

Multiple pregnancies are associated with an increased risk of adverse maternal and neonatal outcomes. NMPA focuses on the maternity care of women with multiple births. The maternity service at the Trust is compliant with all recommendations from the report, including requesting and recording data on the number of fetuses in the first trimester of pregnancy, in addition to number at birth, for women with multiple pregnancies. Compliance for all the recommendations in the report were rated at low risk or satisfactory.

National oesophago-gastric cancer audit (NOGCA) 2020

The NOGCA report focuses on the care received by patients diagnosed with oesophago-gastric cancer in England and Wales, and the outcomes of treatment. The report also evaluates the care pathway followed by patients diagnosed with oesophageal high-grade dysplasia in England. We meet all the recommendations for this audit. All cases are confirmed by two expert pathologists and discussed at a multi-professional meeting. We have the appropriate expertise to offer endoscopic options. A higher than average number of patients on a curative pathway have a CT or PET scan, which are offered in all appropriate cases. We met most national targets, even during the peak of the pandemic. We continue to work with partners who refer to our services to improve any delays to referrals. Survival and local recurrence rates are better than the national average. Our resection margin positivity rate is among the lowest in the country. All specimens are completely blocked and cut to make sure margin assessment is accurate. All patients are considered for palliative treatment.

National ophthalmology dataset (NOD) report 2018-2019

The NOD audit report is based on cataract surgery performed in England, Wales, and Guernsey between September 2018 and 2019. The Trust treats some of the most complex cases in the country but still perform consistently well in terms of surgery outcomes and results. Approximately 3,500 cataract operations were performed at the Trust this year, with the highest complexity score of 2.46 per cent (range 0.4-2.46 per cent).

National patient and parent reported experience measures (PREMs)

The PREMs national audit report is from the National Paediatric Diabetes Audit but focuses on the experience of patients and or carers attending paediatric diabetes units. We received 41 responses to the audit (approximately 37 per cent of cases) – 24.4 per cent were from young people and 75.6 per cent were from their parents and or carers. The overall score of the Trust is significantly higher than the local

and national unit scores – with the Trust performing in the top five per cent of all national units. We received very high scores in the following areas: diabetes team has a positive relationship with children and carers; communicating effectively; respecting religion and cultural beliefs; and overall satisfaction. The Trust scored higher than the average of local and national units in the following areas: understanding the individual needs – 90 per cent (young people) and 96.8 per cent carers; and involving the patients/parents – 90 per cent young people and 96.7 per cent carers. However, there were areas that we needed to review and plan improvements including dietitian and the psychologist staffing levels. We have recruited a new dietitian, clinical psychologist, and new consultant diabetologist.

Local clinical audit

During the pandemic to date, the Trust has identified several areas where targeted audit would support ongoing assurance and learning – linked to the Trust's strategic aim in reducing avoidable harm. The Trust's audit programme was formally suspended during the pandemic and audits associated with Covid-19 were coordinated centrally and reported to the Trust audit group and to the clinical reference group for oversight and monitoring of actions and to provide assurance. Many of these audits form part of our safety improvement programme, with the results used to inform specific quality improvement work. In addition, specialties within directorates conduct local audit activity. Over 2020/21 there were 469 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 relevant audits associated with Covid-19 that took place to improve the quality of healthcare provided to patients with Covid-19 at the Trust include:

Audit title	Audit findings
Covid-19 consent audit	This audit highlighted a high risk that patients were not being fully counselled for contracting Covid-19 prior to surgery at the Trust and not all consent forms were being uploaded to our electronic patient record to confirm that consent had been received. During the past year, the Trust has changed the way consent is obtained, and we now use specific consent forms that relate to the pandemic.
Covid-19 Dexamethasone audit	This audit identified that not all patients admitted with Covid-19 who required oxygen and or ventilation were being considered for dexamethasone treatment in line with Trust guidance, and the decision to prescribe dexamethasone was not always considered alongside the patient's pre-existing conditions. Monthly data is now obtained as ongoing assurance to determine whether dexamethasone is considered for all eligible patients in accordance with the Trust guideline.
Assurance for patient isolation for elective surgery	This audit demonstrated that there was satisfactory assurance that patients were being tested for Covid-19 72-hours prior to the date of their admission for surgery. This is a key mechanism to prevent the transmission of Covid-19 within our hospitals. The audit, however, demonstrated that there was insufficient evidence that patients were being asked to self-isolate prior to their admission and actions to improve this were put in place.
Compliance with documentation of Covid-19 infection risk at the time of admission	Patients attending our emergency departments were reviewed as part of this audit to determine whether they were being managed on the appropriate patient pathways in accordance with their Covid-19 infection status. The audit demonstrated that there was satisfactory assurance that Trust procedure was being followed for all patient admissions via our emergency departments, and that appropriate documentation was in place to reflect this.

Audit title	Audit findings
Audit of patient transfer at the Trust documentation during the Covid-19 pandemic	This audit reviewed whether there was appropriate documentation in place to communicate the Covid-19 status for patients as they are moved around the Trust. This is important to prevent the spread of Covid-19 when patients are transferred from ward to ward and site to site at the Trust. The audit demonstrated that there was satisfactory assurance that the Covid-19 infection status of the patient was documented and communicated to the receiving ward or site.
Audit of patient discharge to care homes from the Trust	This audit reviewed whether there was documented evidence to confirm that patients being discharged from the Trust to care homes were declared as being clinically fit prior to discharge, and that patients had a Covid-19 test 72-hours prior to discharge with the result documented in the medical record and communicated to the onward care home. The audit demonstrated that there was reasonable assurance that this was happening overall.
Audit to assess process and documentation of DNACPR decision-making for patients with a learning disability during the Covid-19 pandemic	This audit demonstrated good clinical practice and satisfactory assurance against the Trust policy. However, it highlighted that conversations and other modes of communication with families and next of kin were not always recorded and this could be improved. Conversations with patients were noted to happen in a timely manner with evidence that community DNACPR decisions were reviewed and maintained following hospital admission. There was no evidence of any blanket decision-making.
Audit to assess process and documentation of DNACPR decision-making for patients with dementia during the Covid-19 pandemic	This audit demonstrated satisfactory assurance that that the DNACPR decisions were being made in accordance with Trust policy. DNACPR decision-making was timely and recorded within 14 hours of admission in 80.5 per cent of cases, and a consultant confirmed the DNACPR decision within 24 hours in 98 per cent of cases. There was no evidence of any blanket decision-making.
Vitamin D Covid-19 Audit	The aim of this audit was to assess the proportion of patients receiving corticosteroids for acute Covid-19 infection who had Vitamin D and bone profile reviewed on admission, and to assess the proportion of patients who received appropriate bone therapy. The audit demonstrated that Vitamin D was not checked in a significant proportion of patients receiving corticosteroids for Covid-19 and that a significant proportion of patients did not receive appropriate bone protection in the form of Vitamin D. Because of the findings of this audit, we held a teaching session for junior doctors managing Covid-19 patients and we have added the prescribing of Vitamin D to the Covid-19 care set in our electronic patient record.
Audit of documentation of appropriateness for patient transfer	This audit aimed to determine whether there was documentation with a justified medical reason for patient transfers at the Trust. In addition, it aimed to determine the percentage of patient transfers that took place out-of-hours without a clinically justified reason in a snapshot of time. Overall, the audit demonstrated that there was reasonable assurance that there was documentation of justified medical reasons for patient transfers in and out-of-hours.

The Paterson, Cumberlege and Ockenden, inquiries and reports

This year we have also considered the findings of three national inquires/reports:

- **The Paterson investigation and inquiry (report of the Independent Inquiry into the issues raised by Paterson) published in February 2020:** The Paterson investigation and inquiry was commissioned by the government in December 2017, to investigate the malpractice of breast surgeon Mr Paterson and to make recommendations to improve patient safety.

- **The report of the Independent Medicines and Medical Devices Safety Review (The Cumberlege Review) published in July 2020**: The Cumberlege Review was commissioned by the Secretary of State for Health and Social Care in February 2018. Its purpose was to examine how the healthcare system in England responds to reports about harmful side effects from medicines and medical devices and to consider how to respond to them more quickly and effectively in the future.
- **The Ockenden Report (emerging findings and recommendations from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust) published in December 2020**: In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm while receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

1.1. Each of these inquiries/reports highlight significant learning for the NHS. We have reviewed the findings and recommendations and have reported our review of assurance against these to our Trust Executive and Board as follows:

Cumberlege Review:

The Cumberlege review considered specifically hormone pregnancy tests (HPTs), sodium valproate and pelvic mesh implants. A local review was done by the division at the time the issues were identified and assurance was provided that we no longer use these, which has been re-confirmed.

Paterson Review:

The Paterson review raised specific issues about governance of private practice, and links with the NHS. Imperial Private Healthcare (IPH) facilities are governed under the Trust governance systems. As a private practice unit (PPU) Imperial Private Healthcare has access to full range of Trust emergency services including intensive care. Complaints and incidents in IPH are managed through the same processes and seen as part of a whole at trust level, meaning issues in either would be picked up.

Both the Cumberlege and Paterson reviews describe significant failures in the ability of the healthcare system to detect and protect patients from harm. Although the reports focus on system-wide errors and the recommendations are primarily at national level rather than for individual trusts, we have reviewed them to identify any themes and learning that we can use to improve patient and staff safety. We believe we have reasonable assurance that our existing governance and risk management processes would help prevent similar events which led to the commissioning of the Paterson and Cumberlege reports from happening at the Trust. This will be strengthened further as and when the national recommendations made by the reports are implemented. In the meantime, there are existing programmes of work which we are currently progressing which will provide further assurance, these include:

- Incident reporting focused improvement
- Organisational culture improvement programme
- Development of director-led user-insights function
- Procurement of new software for appraisal and revalidation
- Improvements to the learning from deaths and medical examiner process
- Implementation of an electronic consent process

Ockenden report:

We have conducted a self-assessment against the 'Immediate and Essential Actions'. This has been peer reviewed and most elements rated as compliant and some as partially compliant, in line with peers. A comprehensive action plan is in place to meet the recommendations outlined in this report.

Our participation in clinical research

In collaboration with Imperial College London and our other regional partners – plus industry, the charity sector and government – the Imperial Academic Health Science Centre (AHSC) partnership drives our biomedical and clinical research strategy and allows us to coordinate our efforts and align priorities across north west London. 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.

Covid-19 has had a major impact on the portfolio of research being undertaken within the Trust and AHSC in 2020/21, as well as on the way this research is delivered. Research is providing the route out of the pandemic and our response has been of national and international relevance.

Collectively, we have led the UK arm of the REMAP-CAP Urgent Public Health study of patients in critical care with Covid-19, which has rapidly identified several therapeutic options – hydrocortisone, tocilizumab and sarilumab. These all have a significant impact on patient survival, reducing mortality and improving recovery so that, on average, patients were able to be discharged earlier from critical care. The study also demonstrated the limited impact of convalescent plasma on patient outcomes for those with Covid-19.

We have conducted important studies focused on the cardiovascular and respiratory damage caused by Covid-19, the characteristics and longer-term effects of the disease, diagnostic technologies, community prevalence, and vaccine studies. Through our NIHR Clinical Research Facility, from over 16,000 applications received, we recruited 822 volunteers to the Oxford/AstraZeneca, Janssen and Imperial's own mRNA vaccine studies.

The pandemic has accelerated our aim to link and analyse large, health-related datasets securely, providing a high-performance solution to allow fast processing of data to provide real-time insight into operational and research needs. The i-Care research platform enables de-identified data to be accessed securely and safely for researchers to analyse data related to the disease, helping us to understand and improve the healthcare response to the pandemic in both north west London and nationally through the work carried out in the NIHR Health Informatics Collaborative (HIC).

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 complements this. This year, we have also progressed a new strategy to support the academic career development of nurses, midwives, and other allied health professionals.

The total number of patients receiving NHS services provided or sub-contracted by the Trust in 2020/21 that were recruited to participate in research approved by a research

ethics committee was 13,186. 10,671 patients were recruited into 202 NIHR portfolio studies in 2020/21 – this includes 4,496 patients recruited into 34 Covid-19 Urgent Public Health (UPH) studies. 623 patients were recruited into 44 studies sponsored by commercial clinical research and development organisations (four of which were UPH studies).

In addition to this, colleagues from our infection prevention and control team have been at the forefront of a range of expert advisory groups and have undertaken applied research to improve decision-making regarding IPC and Covid-19 for the future. We are currently collaborating with the Covid-19 Genomics UK Consortium (COG-UK) to investigate the role of whole genome sequencing in understanding the transmission of Covid-19. We are also collaborating with the World Health Organisation (WHO) and the National Institute for Health Research (NIHR) on projects related to Covid-19.

Our CQUIN performance

Commissioning for Quality and Innovation (CQUIN) is a quality framework that allows commissioners to agree annual payments to hospitals based on the number of schemes implemented, and a proportion of our income is conditional on achieving goals through the framework. Although we agreed to implement 10 CQUIN schemes for 2020/21, these were suspended because of Covid-19.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) for all of its sites; the Trust was compliant with the requirements of its CQC registration during 2020/21 and our current registration status is 'registered without conditions'. The Trust was not subject to any enforcement action this year.

The Trust's overall CQC rating remains 'requires improvement'.

In March 2020, as a response to the first wave of the Covid-19 pandemic, the CQC suspended all routine activity and routine inspections remained suspended for the duration of 2020/21. The CQC introduced a temporary regulatory framework, called the Transitional Regulatory Approach (TRA) which included two virtual assessments for the Trust: one for infection prevention and control in July 2020, and one for urgent and emergency services in November 2020. The CQC neither raised any concerns in relation to these assessments nor required the Trust to take any action. Some routine CQC activity was undertaken with the Trust between July 2020 and March 2021, including engagement meetings and requests for incident reports (as part of the CQC's mandate for learning from deaths).

The Trust has not participated in any special reviews or investigations by the CQC during the year. The CQC reviews all trusts via patient surveys. The outcomes from the 2019 Adult Inpatient Survey were published in July 2020 and one area where we performed worse than expected, "*staff discussing additional equipment or home adaption needs*" was not substantiated by the Trust's own surveys, responded to by significantly more patients (141 in the CQC survey compared to more than 30,000 to the Trust's own). The other area where we performed worse than expected was "*feeling well looked after by non-clinical staff*" – this was attributed primarily to general dissatisfaction among Sodexo staff at the time, which was a known issue. We expect this to have been improved by the bringing in-house of hospitality services in April 2020, patient surveys were undertaken on a delayed schedule during 2020/21 and therefore outcomes from them will not be published until 2021/22 where we expect to see an improvement in this area.

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 us and essential to our mission.

NHS number and general medical practice code validity

The Trust submitted records during 2020/21 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 (current to January 2021), which included the patient's valid NHS number, was:

1. 98.4 per cent for admitted patient care
2. 99.0 per cent for outpatient care; and
3. 95.5 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:

1. 100 per cent for admitted patient care
2. 100 per cent for outpatient care; and
3. 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 any clinical coding audits by NHS commissioners in 2020/21.

Data quality

In 2019/20 the Trust had a robust waiting list data quality improvement programme in place. On an annual basis several quality indicators were highlighted for review and improvement; this process had been in place since 2016. In March 2020, due to the Covid-19 pandemic, immediate changes were implemented for the provision of services across the Trust. To reduce the number of face-to-face contacts taking place in the outpatient departments, where clinically appropriate, services were transferred to telephone or video consultations. For inpatient procedures, all non-urgent elective treatments were stood down and clinical reviews completed by services. Through these review processes, many appointments deemed non-urgent, were cancelled or

postponed. This has had an impact on Trust waiting lists, associated performance, and data quality metrics.

In April 2020, a paper was presented to our Trust executive outlining a Covid-19 elective care waiting list data quality and reporting framework. Several metrics were proposed to create a supporting dashboard, including data quality metrics, and it was agreed the performance support team would carry out a monthly in-depth analysis with a bi-monthly report to the Trust executive and specialty teams advised of any urgent issues as they arise. The Covid-19 waiting list and data quality framework was set to provide oversight and ensure the Trust had full visibility of all patients that were waiting for review and treatment. One of the main functions of the framework is to ensure that patients are on the correct waiting list with the correct waiting time to assist with equitable booking when the Trust was able to restart routine work. There are five steps to the framework, which are outlined in the below table:

#	Process Step	Rationale / Action	Detail
1	Real-time recording of outcomes	For all clinician – patient touchpoints, e.g. cancellations, virtual clinic and clinical review	Supported by operationally owned standard operating procedures for each of the touchpoints (in development)
2	Measurement of activity	Count of above activity (step 1)	Available through current business Intelligence reporting
3	Mitigation reporting	Providing assurance patients are not lost to follow-up and returned to the correct waiting list	Partly supported by the current data quality improvement programme, however, to provide full mitigation several new reports will be required
4	Assurance sample audits	Auditing above (step 3)	Small sample audit on cohorts yet to be defined from step 3
5	Trend analysis of outcomes (RTT)	% breakdown of outcomes (step 1)	Highlight outlying areas for further review to provide assurance Trust-wide approach has been applied

In November 2020, a task and finish group, with wide-ranging professional and technical expertise, reporting to the Trust executive, was commissioned to address several specific technical data quality issues across the Trust affecting elective care and reporting of waiting lists. The group initially reviewed 14 issues and prioritised a subset of six for improvement based on volume of errors, risk to patient waiting times and impact on performance.

Considering the second wave of Covid-19, and that the Trust has been working in this manner for several months, a review of the Covid-19 waiting list and data quality dashboard took place in January 2021 to ensure any in-year process changes and newly identified risks were accommodated.

Data quality continues to be reported to the Trust executive on a bi-monthly basis. There is also a weekly waiting list decision support panel to support rapid review of operational process changes alongside impact and mitigations for data quality and reporting.

Learning from deaths

We comply with all elements of the national learning from deaths process, with a policy that sets out standards and measures, compliance with which is regularly reported to the Trust's board. In line with national guidance our medical examiner (ME) service was fully operational prior to the 1 April 2020 deadline. With the ME service review of clinical notes and most importantly a discussion with the bereaved for all deaths occurring in our hospitals, we have ensured that a) the proposed cause

of death is accurate, b) there is appropriate and consistent referral to the coroner, c) the bereaved understand the cause of death and have an opportunity to raise any concerns and d) cases are appropriately referred for Structured Judgement Review (SJR) when the criteria are met.

SJR is a validated methodology in which trained clinicians critically review medical records and comment on and score phases of care through the patient journey and determine if there were any problems with the care delivered. These undergo further review and are dependent on any issues identified may be subject to more in-depth investigation via our serious incident framework to identify the areas for learning and implementation of appropriate actions to address these.

Patient deaths: April 2020 – March 2021

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	618	343	457	693	2111
Number of deaths subjected to SJR – based on date of death	64	90	46	75	275

Deaths which occurred in 2020/21

Of the 2,111 deaths that occurred during 2020/21, all deaths were subject to ME review, 275 were referred for structured Judgement review (SJR). Of the 275 deaths which underwent SJR, there were seven for which some issues were identified in the overall care delivered. In five of these cases, the issues were not found to have contributed to the outcome and the deaths were deemed to be unavoidable. The themes for these were: situations outside of the familiarity of the responsible specialty team may not have been immediately identified and treated. The potential learning from these have been fed into our safety streams: 'responding to the deteriorating patient'. Another theme was 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. Where concerns were raised following the SJR these cases have been managed via our serious incident framework.

Previously, neonatal deaths were either reviewed through SJR or the national perinatal mortality review (PMRT) tool. From August 2020, all neonatal deaths have been referred for PMRT. There has been a total of 40 cases – of the reviews completed, there has been one case where care delivery issues were identified which may have changed the outcome.

The outcomes of SJRs and PMRTs are shared with the relevant clinical teams and across the Trust through divisional quality and safety committees. Individual action plans are developed in response to each case. Cases are also shared with the safety stream leads to ensure the improvement work covers the findings of the reviews.

The Trust is aiming to reduce the time taken for completion of SJRs from 30 working days to seven working days over the course of the next year. In order to achieve this, six consultants across specialties have been appointed as new SJR reviewers who will take over from the existing reviewers and will have dedicated time to undertake SJRs. This dedicated resource will also facilitate increased consistency and opportunity for consolidation of learning from both good practice and areas for improvement to be cascaded through the Trust.

Seven-day hospital services

From 2018, all NHS trusts have been required to report their activity and progress towards delivering high quality and consistent levels of service and care seven days a week. There are 10 defined standards for seven-day services, of which NHS England/ Improvement (NHSE/I) classify four as key standards. As a result of the pandemic NHSE/I suspended reporting against these standards, in addition to this the Trust's priority audit programme to focus on essential Covid-19 and patient safety audit work only has continued.

Through our Covid-19 audit programme and patient safety audit work we continue to be able to report substantial levels of assurance against the four priority standards, and full or partial compliance with all other standards; however this is not through the same audits previously completed.

Standard 2 – Time to first consultant review: we audited admission to general adult wards in 2019 and reported substantial assurance against this standard. This exact audit has not been repeated in 2020; however we have undertaken specific Covid-19 related audits to examine the care and decision-making for patient groups admitted to Imperial College Healthcare NHS Trust during the pandemic. In all patient groups we met the standard for consultant review within 14-hours.

Standard 5 – Diagnostics: we have previously reported substantial assurance against this standard. An area for improvement in our previous submission related to access to consultant completed reporting out of hours within the one-hour time frame for urgent patients. We have now implemented regular consultant weekend reporting sessions so that all urgent trainee reports are checked within 12 hours for ED and urgent inpatient activity. This is overseen by the clinical director and reviewed via directorate governance processes.

Standard 6 – Intervention/key services: the Trust previously reported substantial assurance against this standard – 24-hours access is maintained by rostered consultant led teams and rotas.

Standard 8 – Ongoing review: the variety of multi-specialty teams supporting the critical care units during the pandemic has increased the access to early consultant review from specialty teams (vascular surgery access/lines teams, plastic surgery/tissue viability, MDT working with respiratory medicine/infection prevention and control)

Additional standards and next steps: we have assessed ourselves as having reasonable assurance against the six additional non-priority standards, although we have improvements to make in some areas, including how we record patient and family involvement with decision-making, and how we manage patients with mental health needs in our emergency departments. We also need to audit the impact and effectiveness of some of the improvements already made, including to discharge planning and handover of care. We will continue to focus on these standards as we recover from the Covid-19 pandemic and plan the future of our services.

Rota gaps

We have 806 doctors in training working at the Trust, with 45 gaps on the rota, 22 of these gaps have been filled by locally employed doctors. We have 23 unfilled posts, 15 of which are being recruited to. The remaining eight 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.

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, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare ourselves with our peers. Both 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 2020/21*			Trust performance				
	Mean	Lowest	Highest	2020/21*	2019/20	2018/19	2017/18	2016/17
SHMI	100	69.51	118.69	74.07	70.24	73.21	74.13	75.54
Banding**	2	3	1	3	3	3	3	3
% deaths with palliative care coding	36.8%	8.0%	59.0%	58.0%	58.1%	57.70%	56.70%	54.90%

*National and Trust position currently only available for December 2019 to November 2020.
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital

HSMR

	Trust performance			
	2017/18	2018/19	2019/20	2020/21*
HSMR	67.37	64	67.6	76.3
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	3rd lowest HSMR of all acute non-specialist providers

*2021 data is for 12 months up to January 2021.
Source: Dr. Foster

We consider the SHMI and HSMR data to be as described for the following reasons:

- it is drawn from nationally reported data
- we have reported a lower-than-expected SHMI ratio for the last three years
- we have the second lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (1 Dec 2019 - 31 Nov 2020)
- we have the third lowest HSMR of all acute non-specialist providers across the last available year of data (February 2020 - January 2021)

We intend to take the following actions to improve our mortality rates, 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

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 that 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	2019/20*	2018/19	2017/18	2016/17
Hip replacement surgery (EQ-5D)	0.460	0.617	0.371	0.468	0.480	0.464	0.443
Knee replacement surgery (EQ-5D)	0.341	0.509	0.284	0.425	0.310	0.298	0.276

Source: NHS Digital
*2019/20 data is latest full year of data available. Currently provisional.

We consider that this data is as described for the following reasons:

- We have a process in place to collect, collate and calculate this information monthly, which is then sent to NHS Digital.
- Data is compared to peers, highest and lowest performers, and our own previous performance.
- We are performing above the mean for both hip and knee replacement surgery. 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*	2020/21**	2019/20	2018/19	2017/18	2016/17
28-day readmission rate (Patients aged 0-15)	9.10%	4.60%	4.78%	4.88%	4.92%	5.15%
28-day readmission rate (Patients aged 16+)	10.18%	6.93%	7.45%	6.75%	6.92%	6.64%

*National Mean: 12 months up to September 2020.
**2020/21 Figures: 12 months up to October 2020.
*National Mean: April 2020 – October 2020.
**2020/21 Figures: April 2020 – October 2020.

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.

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. In the 2020 National Staff Survey results our results improved for the fourth consecutive year. Our performance, compared to our peers and our previous performance, is listed in the table below.

	National performance			Trust performance		
	Mean	Best	Worst	2020	2019	2018
Percentage of staff who would recommend the Trust to friends and family needing care	74%	91%	49%	79%	75.8%	71.7%

	National performance			Trust performance		
	Mean	Best	Worst	2020	2019	2018
Percentage of staff who would recommend the Trust as a place to work	67%	84%	47%	71%	67%	61%

We consider that this data is as described for the following reasons:

- We utilise nationally reported and validated data from the national staff survey.
- Our results have been above average for acute trusts for the last three years.

During 2020 our staff engagement focus was on supporting staff wellbeing in response to the pandemic. The Trust delivered a significant programme of work on staff wellbeing including:

- supporting our staff working surge rotas and supporting our pandemic response by offering onsite and local hotel accommodation
- investing in CONTACT, our comprehensive staff support service, to offer psychological wellbeing support including counselling, emotional wellbeing groups, psychological first aid training and bespoke support programmes for critical care
- monthly shielding staff network meetings to connect and support our shielding staff including a Christmas Day social
- providing daily hot food deliveries during surge periods for high-risk pathway areas and breakroom supply boxes for more than 5,000 staff working in critical care and wards where patients were being treated for or recovering from Covid-19
- creating a range of wellbeing resources including "before you go home" checklists, a toolkit of activities to support teams and individuals with their wellbeing, regular wellbeing briefings for staff to keep them updated on the latest wellbeing offers
- a network of Filipino staff support champions who offered pastoral support to Filipino support who were living alone of shielding and raising the profile of Filipino staff in the organisation
- dispatched monitors to support staff who are isolating at home following a positive test result for Covid-19 so that they could monitor their oxygen levels and seek appropriate additional healthcare provision in a timely manner if needed
- established more than 50 wobble rooms and open spaces for staff during the initial surge of the pandemic to provide a space to rest and take a break during surge periods
- letters for staff to give their children on behalf of the chief executive to thank them for their understanding of why their parents were working during the pandemic

In the 2020 National Staff Survey results

our results improved

for the fourth year in a row.

- launch of a bike user group and refurbishment of cycle sheds
- free parking across all our sites
- provision of staff shops with free grocery and other supplies in the first wave across the three main sites
- the commencement of a 'staff spaces' programme to facilitate long term refurbishment of staff rest rooms, shower rooms, and communal spaces funded by our Imperial Health Charity
- the development of a longer-term programme to re-evaluate and improve the provision of retail and catering across all our sites.

In the 2020 staff survey we achieved our highest ever score for the health and wellbeing theme (5.9) which was a statistically significant improvement on the 2019 result.

We are currently reviewing the 2020 staff survey results in detail and have identified the following areas of focus for 2021/22:

- Continue and enhance our existing programmes of work equality, diversity and inclusion and health and wellbeing including the development of a longer-term wellbeing strategy for the Trust.
- Implement a significant Trust-wide programme in response to the immediate manager theme of the staff survey including how we recruit, develop, and support our managers.
- Continued roll out of our values and behaviours programme, and work on conflict resolution and teamworking.

Patient recommendation to friends and family

The Friends and Family Test (FFT) was initially rolled out to NHS services between 2013 and 2015. The FFT question asked patients, their families and or carers whether they would recommend our services to friends and family if they required similar treatment. This is a key indicator of patient satisfaction.

Revisions were made to the FFT following an extensive review during 2018/19. NHS England sought input from a wide range of stakeholders, including patients, patient experience leads, clinical staff and commissioners.

The Trust had made all preparations to adopt the changes; however mandatory reporting of FFT was suspended by NHS England due to the Covid-19 pandemic.

A&E Friends and Family test

The previous data was based on an average response rate of 17 percent (over 3,000 respondents per month). In 2020/21 this was significantly lower with an average 850 respondents per month.

This lower response rate was expected. Due to the impact of Covid-19 on our services and the additional infection control measures we had in place, we had stopped using hand-held devices and paper surveys in this area.

We believe our performance reflects that:

- We have maintained high standards of care in the ED, as evidenced by the overall rating of care, whilst changing our patient pathways to ensure patients are nursed in appropriate environments based on their Covid-19 status and risk.

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

- embedding the new FFT survey into practice
- reviewing our promotional materials in the departments, to ensure staff and patients are aware of the results and associated improvements in practice
- continuing to work towards reinstating the services following the pandemic
- closely monitoring and responding to changes in national guidance in the event of an anticipated third wave of Covid-19

Inpatient Friends and Family test

We believe our performance reflects that:

- we have maintained high standards of care for our patients throughout the Covid-19 pandemic, as evidenced by the overall rating of care
- our staff deliver consistently good care, even when they have been redeployed to areas, they do not normally work in. This is a positive reflection of strong local leadership and support throughout this exceptional year

For patients reporting a positive experience, interaction with staff continues to be the most significant factor. This year this has been especially important as national restrictions were placed on all visitors to hospitals.

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

- embedding the new FFT survey into practice
- reinstating the work we had planned before the impact of Covid-19 on our services, this includes:
    - the deaf awareness pilot in cardiac services. We will need to train staff again and work with the pathway to introduce the use of blue bands to promote deaf awareness.
    - the 'eat, drink, move and sleep' project will need to be reviewed considering the significant changes to the services with catering, cleaning and portering services now being provided 'in-house'.

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	2020/21**	2019/20*	2018/19	2017/18	2016/17
Percentage of patients' risk assessed for VTE	95.47%	100%	71.83%	96.7%	96.27%	95.39%	93.87%	95.33%

Source: NHS Improvement
*2019/20 includes only Q1-Q3; Q4 unavailable. 2020/21 also unavailable due to Covid-19 reporting delays.
** Provisional figure based on Trust data.

We believe our performance reflects that:

- we have monitored VTE risk assessments monthly throughout the year.

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

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 with previous years.

	National performance*			Trust performance				
	Mean	Best	Worst	2020/21*	2019/20	2018/19	2017/18	2016/17
Rate of *Clostridium difficile* per 100,000 bed days	42 cases	0 cases	174 cases	16.47 (59 cases**)	19.6 (72 cases)	14.3 (51 cases)	17.6 (63 cases)	18.03 (63 cases)

*National and Trust performance are based on Apr-20 to Jan-21 figures. Full 20/21 FY data will be available from PHE in May 2021.
** Based on 48 Hospital-Onset, Healthcare Associated (HOHA) and 11 Community-Onset Healthcare Associated (COHA) cases.

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 2020/21, we reported 59 cases of *C. difficile* attributed to the Trust; 48 of these cases were hospital onset (HOHA), and 11 were community onset (COHA). This is below our target of no more than 77 cases. Two of these cases were related to lapses in care, compared to one last year

We intend to take the following actions to improve in this area:

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

Patient safety incidents

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

	National performance**			Trust performance				
	Mean	Best	Worst	2020/21	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 20: 53.0* Oct 20 – Mar 21: 54.7*	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

*20/21 data is provisional and is calculated from our Trust figures.
**National performance data is as of 2019/20. NHSE has moved to publishing the national patient safety incident reports once per year, with the next publication due September 2021.

We believe our performance reflects that:

- we utilise the nationally reported and verified data from the National Reporting and Learning System (NRLS)
- our individual incident reporting data is made available by the NRLS every six months.

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

- improving how we report, manage, and learn from incidents, included as part of our quality and safety improvement programme.

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 (SIs) 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	2020/21*	2019/20	2018/19	2017/18	2016/17
Percentage of severe/ major harm incidents ***(# of incidents)***	Apr-Sep 19: 0.23% *(15)*	Apr-Sep 19: 0.00% *(0)*	Apr-Sep 19: 1.22% *(17)*	Apr-Sep 20: 0.18% (12) Oct 20 – Mar 21: 0.12% (10)	Apr-Sep 19: 0.03% *(2)* Oct 19 – Mar 20: 0.04% *(3)*	Apr-Sep 18: 0.05% *(4)* Oct 18 – Mar 19: 0.04% *(3)*	Apr – Sep 17: 0.06% *(5)* Oct 17 – Mar 18: 0.12% *(9)*	Apr – Sep 16: 0.08% *(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 20: 0.02% (1) Oct 20 – Feb 21: 0.02% (2)	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)*

*20/21 data is provisional and is calculated from our Trust figures.
**National performance data is as of 2019/20. NHSE has shifted to publishing the national patient safety incident reports once per year, with the next publication due September 2021.

We believe our performance reflects that:

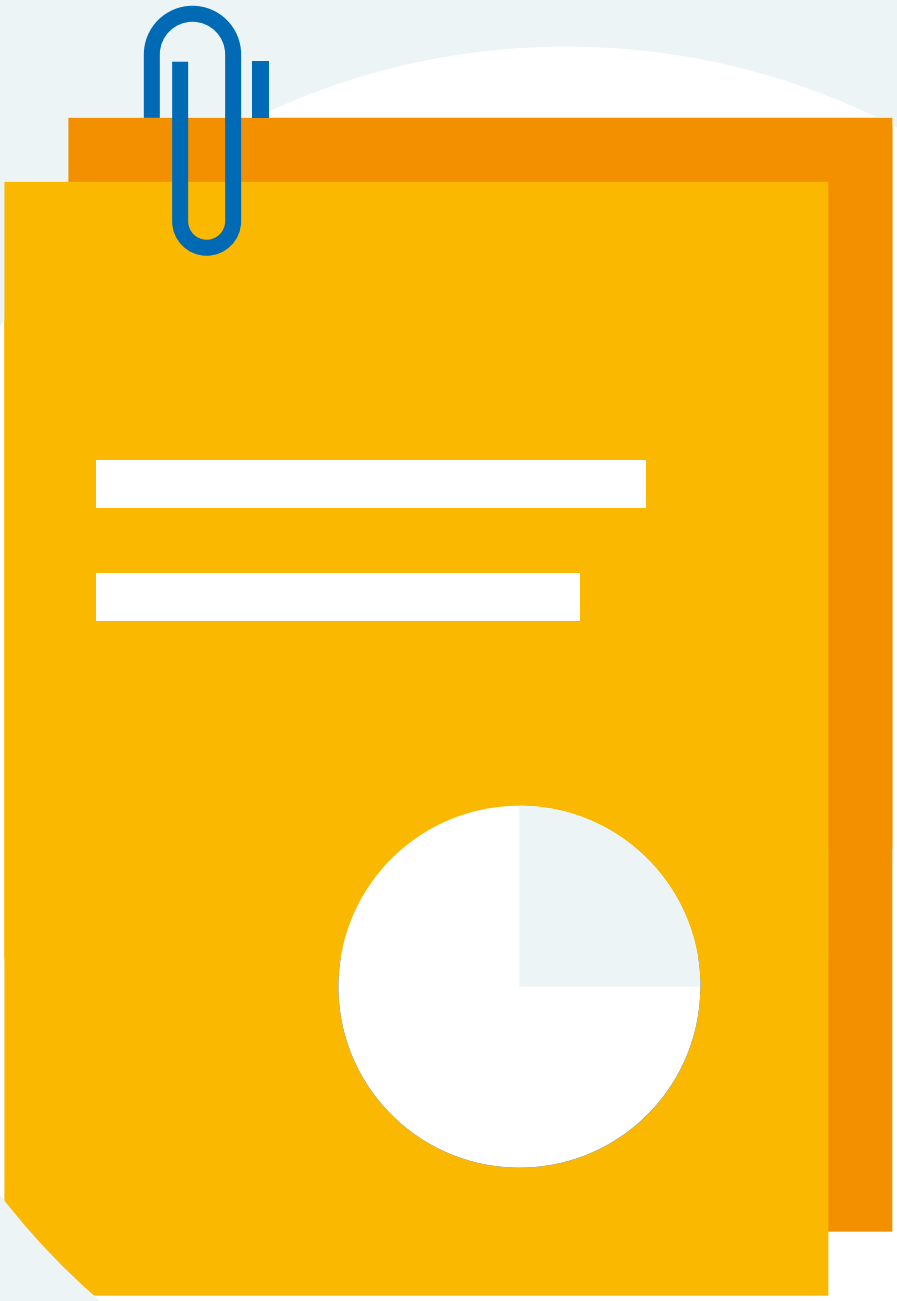
- we utilise nationally reported and verified data from the NRLS
- between April and September 2019 (most recent national data available), we reported 0.03 per cent severe/major harm incidents (two incidents) compared to a national average of 0.23 per cent and 0.06 per cent extreme/death incidents (five 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 2021/22 improvement priorities' section for more detail.

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 have selected.



Our performance with NHS Improvement Single Oversight Framework indicators

NHS Improvement uses several 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 performance scorecards.

Key performance indicators

As anticipated, performance against the operational standards has been impacted because 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%	67.3%	67.3%	61.0%	76.1%	TBC
Diagnostics	Maximum six week wait for diagnostic procedures	1%	49.2%	66.4%	49.7%	30.0%	TBC
Cancer access initial treatments	Two-week wait	93%		94.3%	85.1%	93.0%	94.8%
Cancer access initial treatments	Breast symptom two week wait	93%		91.9%	89.9%	88.2%	96.8%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%		76.9%	73.6%	73.9%	76.5%
Cancer access initial treatments	% patients treated within 62 days from screening referral	90%		63.2%	52.9%	92.5%	45.8%
Cancer access initial treatments	% patients treated within 62 days (upgrade standard)	85%		73.7%	90.7%	89.6%	88.3%
Cancer access initial treatments	% patients treated within 31 days of decision to treat	96%		96.3%	95.3%	97.5%	97.5%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%		96.1%	95.4%	97.0%	94.9%
Cancer access subsequent treatments	Chemotherapy treatments within 31 days	98%		99.3%	99.8%	100%	100%
Cancer access subsequent treatments	Radiotherapy treatments within 31 days	94%		98.4%	95.0%	98.4%	97.9%
Infection control	C. difficile acquisitions	77	59	17	14	9	19

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

Annex 1: Statements in response to the quality account from commissioners, local Healthwatch organisations and overview and scrutiny committees

Healthwatch Hammersmith & Fulham Statement

Healthwatch Hammersmith & Fulham is pleased to be able to respond to the Imperial College Healthcare NHS Trust's Quality Account for 2020/21. We welcome the continued pageworking relationship we have with the Trust and give our full support to its efforts to involve Healthwatch and wider patients in its work.

We note the progress and limitations on achievements for 2020/21 and further congratulate the Trust and staff for their hard work and dedication during an extremely challenging and demanding year dealing with the Covid-19 pandemic.

Placing particular importance on patient feedback and the patient voice, Healthwatch Hammersmith & Fulham is exceptionally pleased to note the following achievements of the Trust against their 2020/21 improvement priorities and other focus areas:

- Changes to the Friends and Family test (FFT) wording to encourage detailed feedback
- Introduction of text message notifications for patients to complete the FFT
- Development of a new Trust patient experience scorecard
- 36 per cent reduction in temporary staffing spend compared to the previous year – Healthwatch is keenly aware of the variable patient experience feedback that can be attributed to temporary staff
- Improving inpatient diabetes care and measurable improvements in patient outcomes and in key clinical metrics for diabetes care
- Performance in the top five percent of national units for paediatric diabetes and receiving very high scores in the following areas: diabetes team has a positive relationship with children and carers; communicating effectively; respecting religion and cultural beliefs; and overall satisfaction
- The unprecedented developments and changes that took place, at pace, to promote and improve safety and quality as part of the Covid-19 pandemic response and commitment to caring for patients and staff members
- The efforts and role of the Trust in the biggest vaccination programme in the history of the NHS

In addition, we note and understand the rationale for the Quality priorities chosen for 2021/22 and offer our ongoing support to the Trust to help make progress in these areas.

We are particularly pleased to see a commitment to improved end of life care planning and discussions that will ensure DNR conversations are handled sensitively and in a timely way so as to avoid some of the concerning patient experiences Healthwatch is aware of nationally over the course of this last year. We look to support the Trust in getting this right for patients and their families in Hammersmith & Fulham.

While we note the Trust's overall CQC rating remains requires improvement we provide the following feedback from our own Healthwatch intelligence gathering

during 2020/21 and confirm that we are working with the Trust to ensure these issues are being taken into account through 2021/22.

During 2020/21 Healthwatch Hammersmith & Fulham gathered 353 patient experience comments for Imperial College Healthcare NHS Trust hospital sites and urgent care centres. Of these, 70 per cent of the feedback was positive, 16 per cent negative, and 14 per cent neutral.

- Overall the Trust scored an average star rating of 4 out of 5.
- For quality of food, the Trust scored 1.5 out of 5.
- For ease of gaining an appointment; convenience of appointment; and how easy is it to get through on the phone, the Trust scored 3 out of 5.
- For waiting time the Trust scored 3.5 out of 5.
- For cleanliness, staff attitude, and treatment explanation, the Trust scored 4 out of 5 stars
- For quality of care the Trust scored 4.5 stars out of 5.

In addition to the star ratings highlighted above Healthwatch Hammersmith & Fulham receives more detailed patient feedback from individuals. This is analysed for themes. A summary of the high and low performing areas is provided below:

Areas where the Trust is doing very well:
Staff/staff attitude – 89 per cent positive feedback
Treatment and care – 86 per cent positive feedback
Facilities and cleanliness – 74 per cent positive feedback

Areas requiring more attention:
Administration – 68 per cent positive feedback
Access to services incl waiting times – 59 per cent positive feedback

Areas requiring improvement:
Cancellation – 5 per cent positive feedback
Communication – 38 per cent positive feedback

Overall, Healthwatch Hammersmith & Fulham welcomes Imperial College Healthcare NHS Trust's quality improvement measures and we look forward to continuing to work in partnership to improve the care and support of patients and service users.

Healthwatch Hammersmith & Fulham
info@healthwatchhf.co.uk
1 June 2021

London Borough of Hounslow's Health and Adults Care Scrutiny Panel Response

The London Borough of Hounslow's Overview and Scrutiny Committee (the 'Committee') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust (the 'Trust') Quality Account 2020-21 which provides a report on progress made and identifies future priorities.

The Committee would like to thank the Trust and its staff for continuing to provide services, albeit quite differently in some cases, through the Covid-19 pandemic, and for preparing the Quality Account for comment.

2020-21 Quality Account

Improvement priorities

- We note the improvement methodology and the plans to continue it in the new year.
- We note the improvement priorities for next year, however, the table does not set out the baseline for improvement which might help to monitor improvements. It might also be useful to have some benchmark against other comparable trust or national statistical averages.
- We note and support the work on falls prevention which has also been a focus for Hounslow over the last two years.

Progress against 2020/21 goals:

1. To improve the Friends and Family Test (FFT) response rate
    - We note this was significantly affected by the coronavirus pandemic but recognise that responses in March 2021 were almost back to pre-pandemic levels and the plans to improve measurement of patient experience.
2. To improve the percentage of staff who feel they can make improvements in their area
    - We note the impact of the pandemic, and the decrease in staff saying they believe they can make improvements.
    - We note the work of the improvement team on supporting others to do this in their teams and plans to develop this work.
3. To improve incident reporting rates
    - We note the drop in rates and ask that this is reviewed regularly.
4. To reduce temporary staffing spend
    - We note the progress towards this goal, and commend this happening against the backdrop of the pandemic.
5. To reduce the number of patients with a length of stay of 21 days or more
    - We acknowledge the impact of the pandemic on the work towards this goal but also note that the Trust is an outlier among NHS trusts with regards to this and stress the importance of continued work to address this.
6. To reduce avoidable harm to our patients
    - We acknowledge the operational pressures resulting from the pandemic and focus areas to target this but still stress the importance of the percentage of incidents going down.

Covid-19 Quality improvement activities

- We note the organisational changes made to respond to the pandemic.
- We note enhancement to infection prevention and control.
- We stress the importance of learning from the hospital-onset Covid-19 infections in response to the infections at the trust but also note changes made in response to this.
- We note work to increase uptake of vaccines among staff, however, suggest that inequalities should also be considered in this work,

Statements of assurance from the board

- We note the participation in 46 national clinical audits and confidential enquiries and the number of local clinical audits, as well as consideration of national enquiries and reports,
- We note the Trust's research participation, and in particular commend research on Covid treatments and use of data,
- We note that the Trust's CQC rating is ' Requires improvement' and ask that this continues to be a priority.
- We note and commend the work on data quality and the progress towards seven day hospital service.

Reporting against core indicators

- While the impact of the pandemic on progress is understandable, we also want to stress the importance of ensuring that the impact of Covid-19 on wider health is mitigated and it doesn't lead to longer-term health impacts.
- We note the low mortality ratios across the Trust.
- We note improvement in staff recommendation to friends and family but stress that there could still be further improvements to this. We note the plans to address this.
- We note the unequal progress on some measures and ask that this is a priority, such as hospital infection and note some measures where progress is made but numbers are still significantly below national best performance, such as patient safety incidents. We note with concern the spike in incidents in 2020/21 and ask that this is addressed.

We noted in 2019 that the format of the report could be made more accessible and an executive summary added for ease of engagement. We would like to make this suggestion again and believe a more accessible report and more understandable data would make it easier for residents and others to engage meaningfully with the report. We also would like to request that in the future the draft report is shared with us at an earlier stage to allow more time to engage with it – LB Hounslow is a committed local partner and a key stakeholder in the health and wellbeing of the borough and we remain keen to provide purposeful, supportive scrutiny to the Trust.

Health and Social Care Policy and Accountability Committee response to Imperial College Healthcare NHS Trust – Draft Quality Accounts 2020/21

H&F Council's Health and Social Care Policy and Accountability Commmittee (HISPAC) has been asked to respond to Imperial College Healthcare NHS Trust's draft Quality Accounts 2020-2021. The below response has been written in collaboration with the H&F Council Business Intelligence (BI) Service.

The Committee is grateful for the Trust's continued dedication and excellent performance during the Covid-19 crisis. We recognise the acute pressures this has caused and appreciate the candid manner in which the coronavirus pandemic has been discussed.

The Trust has shown clear leadership and a commitment to improving services for staff and patients alike. Much in the report is impressive, though we would particularly like to highlight:

- the areas where the Trust is performing above average against national indicators (hip replacements, breast-feeding, CT/PET scans etc.);
- the success of the Trust's vaccination programme (data provided – March 21); and
- the individualisation of services for patients (parents and those with a DNACPR in particular).

The report does indicate areas of potential concern which we submit require further explanation or attention, including:

- the Trust's overall CQC rating of 'Requires Improvement', particularly given some of the 'Good' and 'Outstanding' ratings on CQC audits listed in the 2019-20 accounts;
- the increase in the number of incidents causing patient harm linked to hand hygiene practices – particularly concerning in light of the pandemic; and
- the percentage of beds occupied for 14-day stays or more compared to other London NHS Trusts (despite considerable efforts in this area).

We have provided more general comment on certain areas below. We would like these to be reviewed as part of HISPAC's work next year:

Progress against our 2020/21 improvement priorities

The pandemic has posed significant challenges to the Trust and, understandably, directed focus away from the six priority improvement areas for 2020/21. We would like to understand whether these priorities remain in light of the ongoing pandemic and the Trust's recovery from it. The first, fifth and sixth aims are most important to Hammersmith & Fulham residents and – in our view – merit the most attention, therefore.

Hospital-associated Covid-19 infection and transmission

The Trust's establishment of a surveillance system for hospital-onset Covid-19 infections (HOCI) and associated clinical incident management systems has been vital in identifying key learning points to improve the response to future Covid-19 outbreaks. The process has enabled faster decision making to appropriately deal with outbreaks based on past experiences.

The Trust's proactive response has been exemplified by changes implemented following the first wave of the pandemic, including testing all contacts of patients diagnosed with Covid-19 for 14-days following exposure.

Personal Protective Equipment (PPE) helper programme

The introduction of the PPE helper programme has been pivotal in reducing levels of staff anxiety concerning the correct use of PPE and infection control practices. It is essential that as cases of Covid-19 decrease, staff and management remain vigilant to the correct use of PPE to prevent sporadic outbreaks.

Health and wellbeing helpline

The establishment of the health and wellbeing helpline has started to address the physical and mental exhaustion felt by staff throughout the pandemic. The Trust will need to undertake an evaluation of the helpline to understand whether it effectively addresses the needs of staff and consider the possibility of setting up a dedicated support programme for staff mental health in the future.

Testing

Covid-19 testing has been consistently high across the Trust since March 2020. The collaboration between the Trust and North West London Pathology has built a flexible and responsive testing programme for patients and staff and demonstrates the benefits pooling of resources from different organisations.

Patients

The pre-elective screening procedure has enabled the Trust to minimise the risk of patients due to undergo procedures triggering Covid-19 outbreaks. This should be continued as the vaccination coverage increases.

Vaccination

While the vaccination efforts of the Trust are to be commended, concerns remain around staff vaccine uptake. In addition to remaining focused on increasing uptake, a review of the success of the interventions implemented to improve vaccination uptake would be useful to identify learning points for future vaccination programmes.

Data quality

The Covid-19 waiting list and data quality framework has allowed the Trust to have oversight of patients waiting for treatment enable decision making. It would be helpful to understand whether the Trust has set a timeframe to reduce the waiting list.

Response prepared by LBHF officers:

Jack Brady, National Management Trainee; and Charlotte Bexson, Public Health Intelligence Analyst

Response from North West London Clinical Commissioning Group

Thank you for sharing the Imperial College Healthcare NHS Trust Quality Account for 2019/20 which we received on 24/05/2021.

We would normally share the account within our CCGs and associates for their review and comment. However, as you will appreciate, the work of the CCGs is focused on supporting the restoration of services following the pandemic.

As such, we are not in a position to comment fully on the account with our stakeholders as we normally would. However, my direct team has reviewed the account and made the following comments, which I support:

- Where we can check, the data in the account appears to be accurate.
- We wish to congratulate the Trust and the staff for working tirelessly to support patients and the wider community against the unprecedented challenge of Covid-19. We note the significant improvements achieved in 19/20 by developing

innovative ways of working, piloting new models of care alongside high level clinical support (Clinical Reference Group and Clinical Decision Support for example) that have improved the therapeutic environment for staff and patients.

- The Trust's CQC rating of "Requires Improvement" remains unchanged. It was noted that the CQC have reviewed services in line with their updated process during the pandemic and no new areas of concern have been noted.
- Progress on the Trust's quality priorities has been reviewed for 19/21. It is noted that under the current pandemic, not all of these been completed.
- We note that the Trust has continued some of last year's priorities into 21/22 whilst refreshing these in light of the changes brought by the pandemic. We look forward to receiving updates on the progress the organisation makes via the quality improvement commitments that the Trust is undertaking.
- We note that the organisation has identified areas of improvement in the prevention of harm relating to a zero tolerance of injurious falls, where there have been incidences of these in the past year and Category 2, 3 and 4 hospital pressure ulcers. We look forward to seeing the results of these work streams.
- We note the organisations self-assessments against the Paterson, Cumberlege and Ockenden inquiries and reports and that there are action plans in place to address any outstanding areas. We look forward to receiving the outputs from these action plans.
- We have noted the good progress that the organisation has made against national audits and where issues have been highlighted improvement programmes have been put in place.
- We look forward to working closely with the Trust in the coming year and ensure that we continue to champion the quality, safety and safeguarding agendas together, for the benefit of the commissioned services for patients.

Yours sincerely

Diane Jones

Chief Nurse / Director of Quality

North West London Clinical Commissioning Group

Annex 2: Statement of directors' responsibilities for the quality account

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

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report. In line with national guidelines, we moved to adopt the same requirements for NHS foundation Trust boards in 2019/20 and have continued this year.

In preparing the quality account, 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:
    1. board minutes and papers for the period April 2020 to May 2021
    2. papers relating to quality reported to the board over the period April 2020 to May 2021
    3. feedback from Clinical Commissioning Groups
    4. the annual governance statement May 2021
    5. feedback from local Healthwatch and local authority overview and scrutiny committees
    6. the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    7. the national staff survey 2020
    8. the Head of Internal Audit's annual opinion of the trust's control environment May 2021
    9. Mortality rates provided by external agencies (NHS Digital and Dr Foster).
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our Audit, Risk and Governance Committee held in May 2021, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the board

Date: 25 June 2021

Bob Alexander
Chair

Date: 25 June 2021

Professor Tim Orchard
Chief executive

Annex 3: Participation in national clinical audits and confidential enquiries 2020/21

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
Antenatal and newborn national audit protocol 2019 to 2022	Public Health England	✓	**100%**
BAUS Urology Audits	British Association of Urological Surgeons	✓	**Ongoing collection**
Case Mix Programme	Intensive Care National Audit and Research Centre	✓	**100% and ongoing collection**
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	**100%**
Elective Surgery (national PROMs programme)	NHS Digital	✓	**Ongoing collection**
Emergency Medicine QIPs	Royal College of Emergency Medicine	✓	**57%**
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians London	✓	**No percentage available. Cases submitted: FLS – 691 NHFD — 186 NAIF – 8**
Inflammatory Bowel Disease Registry (IBD) Audit	Inflammatory Bowel Disease Registry	✓	**Ongoing collection**
Mandatory Surveillance of HCAI	Public Health England	✓	**Ongoing collection**
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRACE-UK	✓	**Ongoing collection for Perinatal and Maternal Surveillance workstreams. Did not participate in maternal morbidity confidential enquiry and twins perinatal mortality confidential enquiry.**
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	**100%**
National Asthma and COPD Audit Programme	Royal College of Physicians	✓	**Ongoing collection**
National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	**Ongoing collection**
National Audit of Cardiac Rehabilitation	University of York	✓	**Ongoing collection**
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	✓	**Data collection suspended during 20/21**
National Audit of Dementia (NAD)	Royal College of Psychiatrists	✓	**Data collection delayed during 20/21 due to Covid-19**

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
National Audit of Pulmonary Hypertension	NHS Digital	✓	**Ongoing collection**
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health	✓	**100%**
National Bariatric Surgery Register (NBSR)	British Obesity and Metabolic Surgery Society	✓	**Data collection suspended due to Covid-19**
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	✓	**100%**
National Cardiac Audit Programme	Barts Health NHS Trust	✓	**Ongoing collection**
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	NHS Blood and Transplant	✓	**Data collection suspended due to Covid-19**
National Diabetes Audits – Adults	NHS Digital	✓	**97.1 percent**
National Early Inflammatory Arthritis Audit	British society for Rheumatology	✓	**Ongoing collection**
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	**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	✓	**N/A, data is not collected directly from Trusts**
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	✓	**100%**
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	✓	**100%**
National Vascular Registry	Royal College of Surgeons	✓	**Ongoing collection**
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	✓	**N/A, data is not collected directly from Trusts**

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections	Public Health England	✓	**Project closed due to Covid-19**
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	University of Warwick	✓	**N/A, data flows from ambulance services**
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	✓	**Ongoing collection**
Perioperative Quality Improvement Programme	Royal College of Anaesthetics	✓	**Ongoing collection**
Sentinel Stroke National Audit Programme (SSN/AP)	King's College London	✓	**100%, 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	✗	**Did not participate, non-mandatory audit. Data collection delayed due to Covid-19**
Surgical Site Infection Surveillance Service	Public Health England	✓	**100%**
The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)	✓	**100%**
UK Registry of Endocrine and Thyroid Surgery	British Association of Endocrine and Thyroid Surgery (BAETS)	✓	**Ongoing collection**
UK Renal Registry National Acute Kidney Injury programme	UK Renal Registry	✓	**100%**

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 Department of Health and Social Care guidance for NHS Trusts in the manual 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 corporate governance report includes the Trust's annual governance statement
- the remuneration and staff report sets out the Trust's remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce
- the Trust's external auditor also provides a report of its audit of the annual accounts, remuneration and staff report and annual report

Corporate Governance Report

Directors' Report

The Trust board and its committees

The Trust board is accountable, through the chair, to NHS England and Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board at 31 March 2021 consisted of the chair, seven non-executive directors, chief executive officer, medical director, director of nursing, and chief financial officer, as outlined below. In addition we have one additional non-voting non-executive director who provides additional expertise to the board. The Trust also participates in the NExT Director programme, which gives participants experience of the role and responsibilities of being a non-executive director, therefore we have one additional observer at board and committee meetings.

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 England and 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, the self-assessment and 360 degree feedback was completed and reviewed by NHS England and 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:

- Nick Ross became substantive non-executive director on 1 June 2020 (previously designate non-executive director)

- Sir Gerald Acher's term of office ended on 30 November 2020
- Bob Alexander joined the Trust as non-executive director on 1 October 2020
- Sim Scavazza joined the Trust as associate non-executive director on 1 October 2020 and became substantive non-executive director on 1 December 2020
- Jazz Thind became substantive chief financial officer on 1 February 2021 (previously interim)

The Trust board at 31 March 2021 was as follows:

Paula Vennells	Trust 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	Non-executive director
Bob Alexander	Non-executive director
Sim Scavazza	Non-executive director
Dr Ben Maruthappu	Associate non-executive director (non-voting)
Professor Tim Orchard	Chief executive officer
Professor Julian Redhead	Medical director
Professor Janice Sigsworth	Director of nursing
Jasbir Kaur (Jazz) Thind	Chief financial officer

As per the Establishment Order, there was one vacant executive position on the board as at 31 March 2021.

Governance 'lite' during Covid-19 pandemic

From March to July 2020 and from January to March 2021 in response to the Covid-19 pandemic, the Trust implemented governance 'lite' arrangements to allow the Trust to focus on operational and system pressures. This meant pausing all non-critical meetings, including Trust board and board committees, and if held these were held virtually to discuss pressing matters and those that required decisions. Governance 'lite' arrangements were eased in between the Covid-19 surge periods with normal business meeting agendas resuming in virtual mode.

During governance 'lite' periods, a non-executive directors group was established who met on a weekly basis to receive updates on the Trust's activity and actions and aid any urgent decision-making. The executive met in 'gold command' mode on a daily basis.

Attendance at Trust board meetings: 1 April 2020 – 31 March 2021

The Trust board met five times in regular session, one meeting was cancelled due to the Covid-19 pandemic and governance 'lite' arrangements. Four board seminars were held during the reporting period. Attendance at the Trust board and attendance at the board committees is described below:

Trust board Member	Attendance (actual/possible)
Non-executive directors	
Paula Vennells, Trust chair	5/5
Sir Gerald Acher, vice chair (to 30 November 2020)	4/4
Professor Andrew Bush, non-executive director	5/5
Peter Goldsbrough, non-executive director	5/5
Dr Andreas Raffel, non-executive director	5/5
Kay Boycott, non-executive director	5/5
Bob Alexander, non-executive director (from 1 October 2020)	2/2
Sim Scavazza, non-executive director (from 1 December 2020, previously designate from 1 October 2020)	2/2
Nick Ross, non-executive director (from 1 June 2020, previously designate)	4/5
Dr Ben Maruthappu, associate non-executive director (non-voting member)	5/5
Executive directors	
Professor Tim Orchard, chief executive	5/5

Trust board Member	
Professor Julian Redhead, as medical director	5/5
Jazz Thind, chief financial officer	5/5
Professor Janice Sigsworth, director of nursing	5/5

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 a number of partners). A number of Board responsibilities are delegated either to these committees or individual directors. The Trust board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide a report to the Trust board showing how they are fulfilling their duties as required by the Trust board, and highlighting any key issues and achievements.

Audit, risk and governance committee

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

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

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

Audit, risk and governance committee member	Attendance (actual/possible)
Sir Gerald Acher, non-executive director (chair until 30 November 2020)	5/5
Bob Alexander, non-executive director (chair from 1 December 2020)	2/2
Prof Andrew Bush, non-executive director	7/7
Kay Boycott, non-executive director	7/7
Dr Andreas Raffel, non-executive director	7/7
Jazz Thind, chief financial officer	7/7
Professor Julian Redhead, medical director	7/7
Professor Tim Orchard, chief executive officer	6/7
Professor Janice Sigsworth, director of nursing	7/7

Deloitte LLP acted as the Trust's external auditors in 2020/21, having been appointed in April 2017 for an initial three year period that was extended. 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 2020/21 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 discussed the proposal to increase the focus on risk and assurance which had been identified as part of the board effectiveness survey, and implement a revised framework which would be based around a series of deep dive reviews of existing and emerging risks as part of the board committee portfolios; it was agreed that the Audit, Risk and Governance Committee would oversee the implementation of the framework on behalf of the Board.

The committee discussed the risk and assurance deep dive into Trust procurement processes (with the hotel services tender as the focus), and patient transport as part of the board assurance framework process.

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 IR35 and key financial services and the IT disaster recovery audit. The committee received an update on counter fraud activities at the Trust.

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 discussed the significant risks including 'going concern' and the impact that the Covid-19 pandemic would have on the Trust and sector as a whole and the approach being taken to manage and report Covid-19 related risks and the adaptations to financial policies and processes during the pandemic.

In August 2020, an audit of risk management practice during the acute phase of the Covid-19 pandemic was undertaken as part of the Learning and Insight Programme and reasonable assurance was found that risk management activities were maintained at the Trust during the audit timeframe and the impact of Covid-19 was captured on the Trust risk registers.

The committee received and reviewed the cyber security dashboard which would be discussed more broadly in April 2021.

The committee noted the preparations that the Trust were making alongside NHSE/I and the Department of Health and Social Care to plan for EU exit.

The committee received regular reports on losses and compensation payments, the waiver of tendering process and competitive quotations, and an update on counter fraud activities including a summary of cases of suspected fraud notified to the Trust.

Other key items of discussion included the review undertaken of the Trust's 'Raising Concerns' (whistleblowing) policy and the procedures, the raising concerns update noting the significant increase in demand on the Freedom To Speak Up (FTSU) service between April and June 2020 during the first wave of the Covid-19 pandemic; and a report on north west London back office consolidation programme. HMRC had introduced the Business Risk Review Plus (BRR+) approach to risk-assessing the tax compliance of large organisations subject to the UK tax regime, and, following an initial visit from HMRC in February 2020, an initial default rating of "moderate-high" had been assigned to the Trust and a programme of work agreed. The Committee completed a 'deep dive' risk and assurance review of contract management arrangements, including Trust procurement processes. The committee also reviewed its Terms of Reference and discussed its annual review of effectiveness self-assessment.

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 seven times during the reporting period:

Quality committee member	Attendance (actual/possible)
Professor Andrew Bush, non-executive director (chair)	7/7
Sir Gerald Acher, deputy Trust chair (to 30 November 2020)	4/5
Kay Boycott, non-executive director	7/7
Ben Maruthappu, associate non-executive director	6/7
Sim Scavazza, non-executive director (from 1 December 2020, previously designate from 1 October 2020)	3/3
Professor Tim Orchard, chief executive officer	6/7
Professor Janice Sigsworth, director of nursing	7/7
Professor Julian Redhead, medical director	7/7

The committee received updates on Covid-19 at national and local levels and more specifically the Trust's response to the pandemic, the surge, reset and recovery. It specifically discussed discharges to care homes during the first wave of the pandemic, the revised decision-making and Clinical Governance Structure in the medical director's office in support of the trust's response to Covid-19, the assurance of risk

assessments of 'at risk' staff groups, staff wellbeing, safeguarding and the uptake of the Covid-19 vaccination.

In September the risk and assurance framework was revised with each committee undertaking a deep dive at each of its committees. The quality committee continued to meet throughout the pandemic and governance 'lite' and also undertook a deep dive of recommendations arising from the Paterson report and Cumberlege Review.

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, learning from deaths, research quarterly reports, CIP QIA reports, claims and complaint data and the health and safety report. The committee also received regular reports on actions and processes relating to regulatory compliance and the flu vaccination campaign.

The committee undertook an in-depth review of outpatients reset and recovery given the backlogs of appointments as a result of the pandemic. Close attention was also paid to the progress in improving the staff influenza immunisation rates. The committee considered findings versus recommendations from external quality reviews, and had oversight of the Trust's response. This has included a review of the Trust's response and self-assessment against the Paterson report, Cumberlege review and the Ockenden review and monitoring until all actions had been completed.

The committee usually receives and considers a range of assurances regarding quality of services from patient and staff survey results, including the friends and family test (FFT), General Medical Council national training survey, adult inpatients and NHS staff survey all of which were delayed due to the focus on the Covid-19 pandemic. The committee reviewed the national cancer patient experience survey and also received assurance reports on the nursing and establishment review to ensure safe, sustainable and productive nursing and midwifery staffing levels as well as workforce annual equality, diversity and inclusion, responsible officer's report, CNST Maternity Incentive Scheme, end of life and safeguarding annual reports. The committee received regular reports on North West London Pathology Operational Performance and Governance Reports.

Other key reports received by the committee include the quality section of the annual report, the quality aspect of the strategic case for the redevelopment of St Mary's Hospital, the Implementation of the Medical Examiner Service, learning and insights. The committee also reviewed its terms of reference and discussed its annual review of effectiveness self-assessment.

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 also for ensuring the Trust's investment decisions support achievement of its strategic objectives. We also focus 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 important in achieving our strategic goals.

The committee met eight times in during the reporting period:

Finance, investment and operations committee member	Attendance (actual/possible)
Dr Andreas Raffel, non-executive director (chair)	8/8
Peter Goldsbrough, non-executive director	6/8
Bob Alexander, non-executive director (from 1 October 2020)	4/4
Dr Ben Maruthappu, associate non-executive director	6/8
Professor Tim Orchard, chief executive officer	8/8
Jazz Thind, chief financial officer	8/8

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 the NHSE/I capital guidance and funding limits with separate processes in place to fund capital requirements related to the Covid-19 response. Much of the year made financial planning difficult as the national finance regime continued to unfold and the much stronger than usual uncertainty regarding next years' financial performance due to the Covid-19 impact on operations, the reconfiguration of services within the sector and the evolving financial regime from the centre. In October, the Trust adopted a new financial regime and agreed a forecast outturn with the STP. Towards the end of the year the committee were sighted on the principles/assumptions the national team were looking to apply with regard to the 2021/22 planning round. A NWL Integrated Care System a high level initial financial plan had been developed which continues to be refined as new guidance is made available.

The committee received an update on the business planning for 2021/22 to 2023/24 which had been built upon last year's process, looking more holistically at the priorities of the organisation to ensure it was aligned from Board to ward; this approach was a core part of the Imperial Management and Improvement System.

The committee received an update on the Trust's response and recovery process for restarting services following the pause of all but the most urgent activity as a response to the second surge of the Covid-19 pandemic in December 2020 to the end of February 2021.

The Committee considered various business cases for major investment throughout the year prior to approval at Trust board. The Committee also received summaries of business cases approved by the executive for capital expenditure related to the Trust's Covid-19 response. Post project evaluations were received and discussed on projects that had been implemented in the previous year.

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, noting the current focus included the recovery and reset programme and specialist services reconfiguration at sector level. Progress updates were also received throughout the year regarding the in-housing of hotel services.

The committee reviewed the financial aspects of the Strategic Outline Case for the redevelopment of St. Mary's Hospital and received an update on the financial position against the funding received as part of the Health Infrastructure Programme and the

work in progress looking at the demand and capacity modelling and associated bed numbers.

Other key reports the Committee received included the winter plan for 2020/21, the Trust's approach and process for the 2019/20 National Cost Collection (NCC) submission, updates on the proposed sector consolidation of payroll services, review of performance and strategy of Imperial Private Healthcare and regular review of the financial position of North West London Pathology. Risk and assurance deep dives into the current capital programme and the availability of funding and associated risks were also discussed.

The committee reviewed its Terms of Reference and discussed its annual review of effectiveness self-assessment.

Redevelopment committee

The committee oversees 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 committee met 10 times during the reporting period (in January an extraordinary meeting was held during governance 'lite' arrangements due to the pandemic and as it was a joint meeting with the Finance, Investment and Operations committee, the attendance is recorded in that section):

Redevelopment committee member	Board committee Attendance (actual/possible)
Paula Vennells, Trust chair and committee chair	10/10
Peter Goldsbrough, non-executive director	8/10
Nick Ross, non-executive director	9/10
Sim Scavazza, non-executive director, non-executive director (from 1 December 2020, previously designate from 1 October 2020)	5/5
Professor Julian Redhead, medical director	6/10
Professor Tim Orchard, chief executive officer	9/10
Jazz Thind, chief financial officer	10/10
Matthew Tulley, director of redevelopment	10/10

The committee discussed the programme director's report on key activities which included updates on the business case, commercial activities, technical design, capital cost, planning and decant. The Strategic Outline Case (SOC) for the redevelopment at St Mary's Hospital was discussed and agreed for submission to NHSE/I in August and later the committee discussed the feedback from NHSE/I, next steps and further work for a re-submission of the SOC. In December, the committee reflected on the Department of Health and Social Care announcement on the 40 hospital project which included St Mary's, Charing Cross and Hammersmith Hospitals and in March 2021 discussed the preliminary work and key milestones to develop a master plan and strategic case for Charing Cross and Hammersmith Hospitals. The committee also discussed the Juniper project (J Block), decant options for St Mary's Hospital and the approach to developing a life sciences proposition. The Committee received regular updates on the workstreams associated with this programme which included communications and engagement activities to support the redevelopment programme. The committee also reviewed its Terms of Reference.

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:

Remuneration and appointments committee member	Attendance (actual/possible)
Peter Goldsbrough, non-executive director and committee chair	4/4
Paula Vennells, Trust chair	4/4
Nick Ross, non-executive director	4/4
Professor Tim Orchard, chief executive officer	4/4
Kevin Croft, director of people and development	4/4
Julian Redhead, medical director	1/1

Discussions included chief executive and executive performance reviews including objectives, the process and pay review for very senior managers, impact of NHS pensions lifetime allowances, recruitment and appointment of executive directors, approach to succession planning for executive positions, establishment of a board level people committee, received the annual Trust board composition report and discussed a consultant planning matter as delegated by the Trust board. The committee also reviewed its Terms of Reference and discussed its annual review of effectiveness self-assessment.

People committee

With the growing responsibilities of the Quality committee/agenda further impacted by the response to the Covid-19 pandemic, and placing focus on the People agenda, it was agreed in quarter four to establish a people committee from May 2021. This would allow sufficient Board focus on the cultural and organisational development of the Trust, and on the strategic performance and impact of the Trust as a significant employer, educator and partner in health and care.

Hammersmith & Fulham Integrated Care Partnership (ICP) 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 four times during the reporting period. Between April and August the formal ICP governance structure was stood down and replaced with a more frequent meeting structure to facilitate closer partnership working during the first wave of the pandemic. The ICP Board reconvened in September and has continued to meet every other month since then. 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	1/4
Anna Bokobza, integrated care programme director	3/4

The year saw a number of significant changes to the Hammersmith & Fulham Integrated Care Partnership (ICP) leadership arrangements and work programme reflecting the impact of the pandemic on local communities and in line with the direction of travel of the north west London integrated care system. In September, the ICP Board reconvened for a 'reset' and at which, the London Borough of Hammersmith & Fulham council was agreed as part of a new co-chairing arrangement signalling a renewed commitment to working together with health, community, and voluntary sector partners to improve the health and wellbeing of residents through the delivery of integrated care.

During the last six months, the ICP had engaged in 'resetting' its priorities to ensure it continued to address the health and wellbeing challenges in the borough and tackle the health inequalities highlighted by the pandemic through a 'grass roots' approach of engagement with residents via virtual workshops within primary care networks to understand the patient and resident perspective on integrated care and inform the renewed areas of focus.

Alongside this, the north west London Integrated Care System implemented a leadership framework for borough partnerships across the north west London sector. In January, the ICP leadership team for Hammersmith & Fulham assumed responsibility for leading integration in the borough and led the development of five priorities for the ICP to address that meet the identified needs of Hammersmith & Fulham residents across the life-course, with a central aim of preventing and reducing health inequalities that have been exacerbated by the pandemic and building on the learning from the increased collaborative working between health, social care and community and voluntary sector partners during the last year. The priorities are:

- Staying well — We support people of all ages to live well and support communities and voluntary organisations to develop & mobilise support/community assets.
- Living with illness — Keep people of all ages well at home, avoid admissions unless necessary and ensure good transitions between care sectors.
- All age mental health — Partners unite to rapidly tackle the impact of Covid-19 on mental wellbeing across the lifecourse with a long-term focus on the development and delivery of holistic mental wellbeing support.
- Recovery — Restoration of health and care services based on learning from Covid-19 and most pressing needs.
- ICP and PCN development — Develop the ICP to be delivery focused with primary care networks (PCNs) at the heart of local communities.

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 to the Trust board annually; the register is available to the public on the Trust website at https://www.imperial.nhs.uk/about-us/who-we-are/our-board. 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 1406 staff, approaching 65 per cent, had been returned at the end of March 2021. The Trust publishes on its website a list of those staff considered to hold clear decision-making roles; of these 100 staff, 74 per cent had declared at the end of March 2021.

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.

Date: 25 June 2021

Professor Tim Orchard
Chief executive

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.

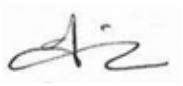
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Trust board

Date: 25 June 2021

Professor Tim Orchard
Chief executive

Date: 25 June 2021



Jazz Thind
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 2020/21 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 2021 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. Due to the size and complexity of Imperial College Healthcare NHS Trust, there are three main levels 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.

The Trust board takes collective responsibility for setting out the strategic direction of the Trust, including setting the risk appetite, i.e. the amount of risk that the organisation is prepared to carry in any risk area. The executive directors are full-time employees who manage the daily running of the Trust, and they are held to account by the board for the Trust's performance.

The Trust board, in turn, is accountable for upholding high standards of governance and probity. The chairman and non-executive directors provide 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), where quality, safety and performance reports are reviewed and issues and risks are escalated, as appropriate.

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, in the form of risk and assurance deep dives, which provide assurance to the Board that risks are managed effectively.

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

The effectiveness of the risk management system is monitored by the Executive Management Board monthly through regular updates and monitoring of risk management performance. The Audit, Risk and Governance Committee oversee the risk management process at the Trust, including the risk and assurance deep dives process.

The Trust risk appetite is agreed by the executive team and Board, taking into account current risk exposure, strategic objectives and risk capacity. The appetite is then cascaded to the whole organisation via an operational framework.

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 England/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 Management Board (EMB) is the executive decision-making body in the Trust. It meets monthly to review progress against strategic objectives, setting and deploying strategy, managing performance, prioritising initiatives against organisational capacity, ensuring it supports the Trust's overall promise of 'Better health, for life', and aligns with our clinical and corporate strategies and the north west London sustainability and transformation plan. The EMB also acts as the Trust executive risk committee.

The EMB provides assurance to the Trust board that the mitigations are effective and the risks are adequately controlled and monitored. Risk and assurance deep dives are presented to each of the Board committees focusing on existing risks on the corporate risk register and emerging risks. 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, in the form of risk and assurance deep dives, 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 2020/21 and as it enters 2021/22, further detail on each is provided later in the report:

- delays for patients requiring planned interventions due to Covid-19 surges
- impact of the COVID-19 pandemic on staff's health and wellbeing
- estates and redevelopment
- failure to achieve financial sustainability

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 2020/21.

In response to the first wave of the Covid-19 pandemic, in March 2020, the CQC suspended all routine activity and routine inspections remained suspended for the duration of 2020/21. The CQC introduced a temporary regulatory framework, called the Transitional Regulatory Approach (TRA) which included two virtual assessments for the Trust: one for infection prevention and control in July 2020 and one for Urgent and emergency services in November 2020. The CQC did not raise any concerns in relation to either assessment, and the Trust was not asked to take any action. Some routine CQC activity was undertaken with the Trust between July 2020

and March 2021, including engagement meetings and requests for incident reports (as part of the CQC's mandate for learning from deaths).

The Trust has not participated in any special reviews or investigations by the CQC during the year. All trusts are captured in CQC patient surveys, however, and the outcomes from the 2019 Adult Inpatient Survey were published in July 2020. One area where we performed worse than expected, "*staff discussing additional equipment or home adaption needs*" was not substantiated by the Trust's own surveys, which are responded to by significantly more patients (141 in the CQC survey compared to more than 30,000 to the Trust's own). The other area where we performed worse than expected was "*feeling well looked after by non-clinical staff*"; this was attributed primarily to general dissatisfaction among hotel services staff at the time, which was a known issue and has hopefully been improved by bringing hospitality services in-house in April 2020. Patient surveys were undertaken on a delayed schedule during 2020/21 and therefore outcomes from them will not be published until 2021/22.

Integrated performance management

In 2020 the Trust introduced the new Imperial Management and Improvement System (IMIS) to help deliver organisational goals and objectives. The initial focus has been on updating executive and board routines as well as new integrated scorecards. Scorecards have been designed to align more clearly with strategic objectives and priority programmes whilst continuing to maintain oversight of statutory national standards.

The scorecards consist of a suite of metrics covering quality, workforce, operational response and recovery and finance. Performance data are discussed routinely through the meetings of the Trust board, board committees, executive management board, executive subgroups and divisional oversight meetings. This framework allows detailed reviews and assurances to be given where potential issues are identified, with instigation of quality improvement plans and escalations. This is being extended to include specialty and directorate arrangements.

These scorecards have been developed to differentiate between areas where there is a need to prioritise resources for key improvements (driver metrics) and highlight activities where performance can be reliably maintained but visibility is important (watch metrics). For each metric, the relevant scorecard triggers the type of update required from each operational lead. This ranges from sharing successes, giving structured verbal updates or presentation of a countermeasure summary with trend analysis and improvement actions.

External oversight

The single oversight framework remains the external mechanism for NHS England and NHS Improvement to oversee organisational performance and identify any support needed to deliver high quality, sustainable healthcare services.

With the introduction of integrated care systems (ICSs), there is an increasing emphasis on the role of systems in supporting improvement and delivery of integrated care. As systems mature they are expected to take greater shared responsibility for the overall quality of care, outcomes and use of resources across their population. As a result, over the last year provider oversight meetings have transitioned to leadership by the ICS with support from the NHS England and NHS Improvement regional team.

Trusts are segmented according to the level of support needed across themes of quality, finance and use of resources, operational performance, strategic change and leadership. Each Trust is segmented into one of four categories ranging from 1 (greatest autonomy) to 4 (mandated intensive support). The Trust is in segment 2.

The approach to system-based performance will be further supported through publication of a new NHS oversight framework in June 2021.

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 a finance and performance reports monthly to the executive management board and bi-monthly to the finance, investment and operations 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 usually 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. Due to the Covid-19 pandemic, most of these reviews were suspended in 2020/21, being reported on once in September 2020, however the Trust did maintain internal controls to ensure efficiency and effectiveness, including executive approval of business cases which were reviewed by the finance, investment and operations committee for oversight at Board level.

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 three most significant risks relate to delays for patients requiring planned interventions due to Covid-19 surges, financial sustainability and our estates and redevelopment.

Delays for patients requiring planned interventions due to Covid-19 surges

The Covid-19 pandemic has had a significant impact on the delivery of elective care at the Trust and, as a result, on the lives of many of our patients who have been waiting for treatment.

During the first wave of Covid-19 admissions, between March and May 2020, the Trust had to suspend most elective care, in order to create capacity for the increased level of demand, and to minimize the risk of contracting the virus for other patients. After elective care was reintroduced, it became obvious that the backlog of patients

who needed our services had grown substantially, with many patients waiting longer than 52 weeks. Our main objective is to ensure that patients are safe and therefore, while the first wave was at its peak, we introduced processes and reviews to ensure that patients would not come to unnecessary harm due to delays in their care. All appointments cancellations and rescheduling were vetted by consultants for time sensitive procedures and a clinical harm review was undertaken for all patients who had to wait over 44 weeks for their appointment, to ensure there was no adverse impact to their health.

Where possible, telephone and video-conference appointments have replaced outpatients appointments, which has helped us continuing to see patients when they were unable to attend our hospital sites.

In May 2020 the Trust started planning its 'Reset and recovery' programme, and by the end of October all services were back to normal. To support this, those patients who needed more urgent treatment, or had been waiting longer, were offered treatment within the independent sector.

A methodology to prioritise patients through a clinical harm matrix was introduced for use by all clinicians. This allows the clinician to assess the level of potential or actual harm associated with waiting for the procedure and alter the patient's surgical priority rating accordingly, allowing appropriate prioritisation and scheduling. The process is documented through CERNER. The Federation of Surgical Specialty Associations produced a Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic to support allocation of surgical priority to patients, with priorities from priority 1a (Emergency) to Priority 4. The Trust has made the decision to expand on the clinical prioritisation framework by adding two further categories. These categories will be used to record instances where a patient (or their guardian) requests to defer their treatment. A request to defer treatment for reasons related to or Covid-19 any other exceptional event are to be assigned as Priority 5 (P5), whilst any other reasons are to be categorised as Priority 6 (P6).

The concept of mapping clinical priorities with individual patient harm, enables a rapid means of quantifying individual patient care requirements and drives wider patient safety. This concept and principle is not new and is familiar to most clinicians, however, the defining and wider application to drive equity of care is new. The principles are based on the actual or potential organ or life risk based on the proposed priority category and takes into account if there has been harm due to the current wait or whether the proposed wait could lead to harm. The clinical prioritisation matrix underpinning this clinical SOP has been designed to be applicable across all specialities – cancer, non-cancer, outpatients, and diagnostics (imaging / endoscopy). It should be used, where appropriate, with other guidelines and standards (e.g. the elective access policy). It is the responsibility of clinical teams and services to complete these reviews every time a patient is reviewed, or on request. The clinical harm is individual to the patient and relies on clinical judgement. This may modify the original priority or waiting time. The matrix indicates the new priority rating and confirms to investigate and treat a patient.

Embedding this methodology remains a priority, educational resources have been developed to support clinicians with this process and this is an ongoing process. The monthly clinical harm review process – outlined in the clinical harm review of overdue prioritisations standard operating procedure – is ongoing. This outlines the process for patients who become overdue having not had their procedure completed within the initial priority timeframe. To date no harm has been identified. The scope of

reviews is under constant review due to the increasing number of overdue patients being identified.

During the second wave of the pandemic, with subsequent surge of admissions between December 2020 and February 2021, the Trust was able to maintain elective activity for patients categorised as priority 1 and 2. Imaging services were also maintained during the latest surge and our unplanned diagnostic performance has returned to one per cent breach, which is within target.

Due to the need to redeploy staff, some elective activity still had to be suspended for patients categorised as priority 3 and 4. The clinical harm reviews continued throughout this period and show that no patients have come to harm.

The Trust was on track to report zero patients waiting over 52 weeks in March 2020 but due to the suspension of elective surgery in response to the first surge of hospital admissions as a result of Covid-19 pandemic the Trust reported 10 and this number increased month on month to a high of 1259 in September 2020.

This situation has left the Trust with a larger than ever waiting list, and we have now developed a new plan to see all patients, including new referrals. Elective capacity has been increased in line with the Critical Care de-surge and as staff de-deployment has permitted. With the re-opening of Surgical Innovation Centre, full theatre capacity was restored from 19 April 2021.

Following the introduction of clinical harm review and prioritisation last year a full review of the theatre schedule was completed to ensure that specialty session allocations were aligned with waiting list size and clinical priorities. With all theatres now reopen, this revised schedule has been restarted. Waiting list size and backlogs by priority are being kept under review and closely monitored at Director level. A robust planning and coordination process will continue to ensure that capacity allocation is then adjusted where necessary.

In parallel with these internal actions, the Trust has worked closely with the North West London Integrated Care System (NWL ICS) team throughout the second wave to monitor and manage sector elective demand and available capacity. This close collaboration continues through such initiatives as providing mutual aid and the continued development of fast track surgical hubs for high-volume, lower complexity surgical cases.

In the short-term, planning for a potential third wave is being coordinated with NWL ICS and will incorporate the broad approach taken during the second wave and that minimised the impact on elective patients. In the longer term, the development of sector-wide initiatives, such as common waiting lists and clinical harm review and prioritisation will ensure optimum use is made of all available capacity.

In response to Phase three recovery plans the Trust submitted a trajectory based on the anticipated length of time to treat the backlog of long waiting patients whilst managing the number of pathways tipping over into 52 weeks each month (average of 440 per month). The trajectory did not include any adjustment for a second surge in Covid-19 and the Trust performed well against the trajectory until December 2020 when elective activity was once again suspended in response to a second surge in the number of Covid-19 related hospital admissions and as a result the Trust will report a high of 2374 patients waiting longer than 52 weeks in March 2021.

As elective activity resumes the Trust is focusing recovery in three areas to reduce the 52 week backlog;

- eradicate non-admitted 52 week wait pathways
- eradicate admitted 52 week pathways across six specialties with high volume low concentration (HVLC) cohorts
- to ensure no patient is waiting longer than 78 weeks for treatment regardless of specialty or admission status

Impact of the COVID-19 pandemic on staff's health and wellbeing

The intense demand that the pandemic has made on the Trust has also presented an increased risk to both the physical and mental health of Trust staff.

At a time when prevalence of Covid-19 was at its highest in the community, this reflected on the number of staff that were infected with the virus, or at higher risk of severe illness. The peak of staff absence due to Covid-19 first occurred at the beginning of April 2020, when over 1,750 staff reported absent from work. The second wave saw a much lower incidence of Covid-19 related absence, with the peak in-mid January 2021, when 681 staff reported absent from work. These figures include both staff who were ill, shielding or self-isolating.

Following any outbreak of Covid-19 among our staff, our infection prevention and control, occupational health and health and safety teams alongside the service concerned, collectively review the incident and workplace risk controls, in the process

agreeing whether the incident is reportable to the Health and Safety Executive under RIDDOR (Reporting of Injuries Diseases and Dangerous Occurrences Regulations).

To prevent the risk of staff contracting the virus at work, the Trust has implemented a wide range of controls, reviewed the response following the first wave and implemented any learning outcome when preparing and responding to the second wave.

In June 2020, the Trust launched a process for individual risks assessments with regard to staff contracting and becoming seriously ill from Covid-19. All staff were required to complete and record their risk assessment, and, where needed, confirm that actions or mitigations had been put in place with their manager. The Trust achieved 95 per cent completion and has maintained a consistent position of over 90 per cent since then. Any staff who identified high risk status were referred to Occupational Health for review and, where necessary, they were redeployed to either work from home or to a low risk work area.

Workplace risk assessments were also introduced in June 2020 to ensure that those staff continued attending our sites were not exposed to the risk of infection due to overcrowding, lack of ventilation, etc. Clear guidance was provided, including measures to be implemented to ensure staff safety (i.e. maximum number of room occupants, provision of wipes, hand gel, etc.). This baseline assessment was completed and at the end of March 2021, compliance was 98.28 per cent of workplaces have been assessed, and 94.89 per cent of workplaces have been deemed Covid-secure. There is remaining work underway for space that belongs to Trust tenants.

All staff who attend an area of the Trust where they don't usually work and all frontline staff are required to use personal protective equipment (PPE). The Trust has been following national guidance for the use of PPE and a programme has been underway to ensure that all staff who work in clinical areas have a correctly fitting FFP3 mask. This includes on-site dedicated areas for testing, as well as availability of fit testers within the wards. At the end of March 2021, 81 per cent staff have a recorded FFP3 mask on our Health Roster system and 83 per cent staff in aerosol generating procedures (AGPs). Since the beginning of pandemic the Trust has identified some areas for improvement in the recording process for fit testing, which currently occurs manually. The trust is now developing a more robust electronic recording system.

Another important actor in the mitigation of risk to staff and patients' infection from Covid-19 has been the use of lateral flow testing. Kits for lateral flow antigen testing were first provided to patient-facing staff in November 2020. Staff have been advised to test themselves twice a week while they do not have symptoms of Covid-19; this allows identifying staff who may have Covid-19 as early as possible and in many cases before they show symptoms, so that they can self-isolate to protect themselves, patients and their colleagues. We have reported more than 150,000 test results to Public Health England and have identified nearly 700 staff infected with Covid-19 via the lateral flow-testing programme.

When the Covid-19 vaccine finally became available, we started vaccinating our staff in line with government's guidance. As of the end of March 2021, over 85 per cent staff designated as frontline had been vaccinated. This includes staff who have advised us that they have been vaccinated outside of the Trust and those not eligible to be vaccinated. Over 12,000 all people working at the Trust were vaccinated by that time.

Throughout the pandemic, focus has been put on staff wellbeing, to ensure staff received enough support while they worked relentlessly and under extreme pressure. A comprehensive well-being plan was developed in April 2020, and further enhanced in the second wave, in January 2021, to support both emotional and psychological well-being, practical well-being, financial, spiritual, physical and social wellbeing.

From April 2020 to March 2021, over 882 staff accessed of our onsite counselling team, which was expended from 3 to 12 full time posts, 3840 attended a weekly emotional wellbeing group in high pressures wards and 465 managers attended one of the key training interventions to help them manage staff wellbeing as well as a range of other interventions such as webinars for shielding staff, single topic webinars, Filipino support network, provision of free SATS monitors for staff off sick with Covid, hotel accommodation, free car parking

The process for managing de-deployment as staff moved into the recovery phase was critical; a number of measures were put into place to ensure that the de-deployment was smooth, including de-deployment meetings and wellbeing conversations.

All staff have been offered two extra days of leave this year; one to be taken between 5 March and 30 June 2021 to encourage all staff to take a break to support their own wellbeing, and the second one to be taken on or around their birthday.

In September 2020, we announced a new £1.7m programme of practical and wellbeing support directly inspired by feedback from staff after the first wave of Covid-19, designed to take a more strategic, long-term approach to the health and wellbeing of our staff.

Initial work has focused on improving staff spaces, including breakrooms, kitchens, changing rooms and showers that were in need of refurbishment. We also have plans to create 'flagship' staff lounges on each of our sites, where any member of staff can go to rest 24/7, get refreshments, meet with colleagues or check their emails.

A longer term transformation to our on-site food and retail offer is also due to begin in summer 2021, with the aim to support an improvement in staff's health and wellbeing through our variety of goods and access to them.

From April 2020 to March 2021,

over 882 staff

accessed our on-site counselling team, which we expanded from three to 12 full-time posts

Estates and redevelopment

The Trust's capital plan for 2021/22 is once again extremely challenging due to the level of backlog maintenance, ICT infrastructure, and medical equipment replacements required to mitigate Trust level risks. This is in addition to divisional capital projects which are essential for the quality and safety of our services.

The Trust has the largest backlog maintenance liabilities of all NHS or foundation trusts, principally due to the age of its estates. ERIC data published in 2016 showed the Trust had nearly 25 per cent of all NHS risk adjusted backlog maintenance costs, with a fully built up backlog liability of £1.3bn. The Trust is part way through a board-approved plan to spend a minimum of £131m over eight years on the highest priority backlog items. The amount in the 2021/22 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 2021/22 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 2021/22. 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 the autumn of 2019 the Trust was included within the DHSC Health Infrastructure Plan. The Trust submitted a SOC to DHSC in August 2020. The HIP programmes has been succeeded by the 40 New Hospital Programme (NHP), which was announced in Autumn 2020. St Mary's Hospital and Charing Cross/Hammersmith were part of this announcement. The NHP has confirmed that the "case for change for St Mary's has been made. The highest priority is to deliver a new hospital on the St Mary's site. The Trust are identifying the feasibility of delivering a new hospital within the context of a wider redevelopment and regeneration of the Paddington Basin area. The Trust is planning on resubmitting the St Mary's SOC in Spring 21. Business cases will commence for Hammersmith and Charring Cross Hospitals during 2021/22.

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.

Failure to achieve financial sustainability

In response to the Covid pandemic, the financial regime under which the Trust operated previously was significantly altered. Once central funding for all cost pressures arising in the year is taken into account, the Trust reported a break even position for 2020/21, and this has been achieved without the requirement to deliver the historic level of efficiencies. This also resulted in a favourable impact on cash, with commissioner income being paid on a block contract basis and no year-end settlement discussions being necessary to close the position.

This financial regime has enabled the Trust to respond to the operational pressures linked to the pandemic without adversely affecting cash or the underlying sustainability of the organisation, allowing for suppliers to continue to be paid on a timely basis, whilst maintaining the integrity of the balance sheet. This was a welcomed approach enabling focus on the operational response required to deliver safe care.

The Trust's review of its internal governance resulted in the implementation of a 'governance lite' processes and procedures. Daily Executive Huddles were convened to provide due focus and attention to operational performance whilst ensuring the Executive had a robust line of sight on, and the ability to respond to any emerging issues, and maintain financial control of any decision-making.

The 2020/21 financial year was split into two distinctive halves featuring alternative regimes for each. Top up payments were received during the first half in order to allow Trusts to break even, and a budget setting process was undertaken in the second half of the year to agree envelopes with the ICS. In addition, "out of envelope" costs such as additional pathology testing and vaccination centres were funded separately by NHSE/I.

The Trust planned for a £16m deficit for the period October 2020 to March 2021, which was achieved. This deficit related largely to the loss of non NHS income (private patients, overseas visitors, car parking etc.) where the Trust was not able to continue to generate income from these sources either due to newly established restrictions or change in policy. Since agreeing the plan the Department of Health and Social Care has agreed to fund this loss such that the Trust will now be reporting a breakeven position.

In addition, the Trust is, as usual, required to account for any annual leave entitlement not taken at the end of the financial year. In recognition of the fact that for 2020/21 a greater number of staff would not be able to take leave to pre Covid levels, national agreement was reached that where staff who have been unable to take annual leave due to operational commitments, up to 20 days of leave could be now carried forward into 2021/22. This is 15 days above the normal carried forward allowance. The Trust's assessment increases the annual leave accrual by an additional £11.8m (average of 6 additional days of leave), which has also been funded.

Although the favourable funding regime in 2020/21 is continuing into the first half of 2021/22, it is anticipated that the Trust (and by virtue of this the ICS) will need to revert to achieving the previously published control total trajectories and that central

funding (e.g. Covid, top-up etc) will cease. This will result in the need to deliver a higher level of efficiency to cover the historic deficit position, as well as any new costs introduced this year (e.g. cleaning changes linked to Public Health England guidance), amendment to care pathways and enhanced personal protection, all of which were introduced to reduce risk of Covid exposure. Therefore, the Trust has resumed its focus on cost control and identification and delivery of efficiency opportunities with immediate effect.

In summary although 2020/21 has been a relatively stable year and cash levels have improved, the forward view for the first half of the next financial year (challenging but deemed deliverable) will require the Trust to continue to seek out sustainable cost savings; maintain a cash buffer; and pragmatically manage the on-going concerns with the fabric of the estate.

Efficiencies

Despite central funding being available for the first half of 2021/22, a minimum efficiency of two per cent is required to set a break even plan before the risk associated with the recovery of loss of non-nhs to 2019/20 levels from quarter two and cost response to Ockendon are excluded. To keep the Trust on a path to financial sustainability and meet the requirement of achieving a control total trajectory of £0.5m (deficit) in the second half of the financial year, a greater CIP pipeline will need to be developed and concluded before the end of September 2021.

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

Cash

The new funding regime has enabled the Trust to significantly improve its cash position in 2020/21, however, any underlying deficit will put this position at risk if efficiencies are not delivered such that the Trust can continue to breakeven. Whilst, with the planned approach, cash is within a manageable range, consideration will also be given to the Trust's ability to withstand unforeseen events.

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

Data security and protection structure

The Trust has a published data protection framework designed to deliver compliance with the General Data Protection Regulation (GDPR), Data Protection Act 2018 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 divisional 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) / 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

Data security and protection toolkit

The NHS Digital Data Security and Protection (DSP) 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 3 leadership obligations, 10 Data Security Standards 42 mandatory assertions and requires 111 mandatory evidence items, mandatory standards are either *"met"* or *"not met"*.

Due to the first wave of the COVID-19 pandemic the 19/20 DSP Toolkit Return deadline was extended to 30/09/2020. However, Imperial College Healthcare NHS Trust submitted the return on 19/03/2020. 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.

Due to the unprecedented circumstances of the second wave COVID-19 pandemic the 2020/21 DSP Toolkit Return deadline was extended until 30/06/2021. The Trust has already undertaken an interim independent audit in anticipation of a full term independent audit of the toolkit return to be undertaken in June 2021 prior to submission.

DSP Training

One mandatory evidence DSP Toolkit requirement is for 95% of staff to complete annual mandatory data security and protection training. This target was achieved on 31/10/2019 for the purposes of the 2019/20 financial year. There is a plan in place to achieve the annual mandatory training target for the 2020/21 financial year by 30 June 2021.

Data security and protection incidents 2020/21

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.

Due to the unprecedented impact of the Covid-19 pandemic the reporting term for 20/21 will be taken from 01/04/2020 – 30/06/2021. It is envisaged that the reporting term for future DSP Toolkits will be in 12 month intervals 1 July – 30 June thereafter.

Table of data security and protection incidents 2020/21

Table 1: Incidents reported 01/04/2020 – 28/02/2021

Grade of incident	Number
Incident reported to the ICO and Department of Health	6
Trust level incident	78
Incidents under investigation yet to be classified	26
Total *+	110

***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.*

+ Full Year Plus three months reporting *- A second table will be produced detailing incidents reported between 28/02/2021 and 30/06/2021*

Analysis of types of Incidents (not mutually exclusive)

The following are categories of incident. This analysis provides a high level overview of the areas of work creating greatest concern. It is intended that the final year analysis will be used to undertake a series of process reviews to determine how best to mitigate against future incidents.

Category of incident	Number
Email	43
Paperwork	23
Patient held record	19
Data quality	14
Incorrect upload	11
Postal	8
Abuse of authorised access	7
Counter fraud	5
Loss / theft	5
Subject access request	4
Hacking	3
Unauthorised disclosure	3
Telephony / mobile	1

Incidents reported to the ICO and Department of Health (*Total = 6)

- Bulk upload of patient data to CIE incorrectly administered

(Kidney Transplant Patients)

- allegations of abuse of authorised access (icl haematology)
- upload of patient data to cie incorrectly administered (endocrinology)
- subject access request incorrectly administered (haematology)
- subject access request incorrectly administered (cie)

(Maternity)

- Confidential email sent in error to vestigial distribution list

(Nursing Directorate)

Summary of incident	Bulk Upload of Patient Data to CIE Incorrectly Administered (Kidney Transplant Patients)
Incident details	There was an error in the bulk upload of a new spreadsheet of patients from the Transplant Kidney Care Team into the Care Information Exchange environment. This upload was undertaken to ensure that patients with CIE records / PKB accounts are provided access to information about their clinical care as Transplant Kidney Care Team patients. An automatic email was then generated that notified the patients that the Transplant Care Kidney Team had been provided access to their records within CIE. Each patient received an email nominally addressed to a different full name. However, the record in CIE was correctly attributed to the correct patient and patient email address. The error occurred due to the misalignment of names and NHS Numbers within the spreadsheet leading to incorrect assignment of information to each record. In summary, all affected patients are Transplant Kidney Care Team patients, but each have been addressed in correspondence using the full name of another Transplant Kidney Care patient.
Actions taken by the ICO	ICO Reviewed the incident and responded in writing confirming no further action.

Summary of Incident	Allegations of Abuse of Authorised Access (ICL Haematology)
Incident Details	A complaint was made by a Trust patient that a person working at the Trust had accessed her CERNER records and disclosed information to a third party. The third party had referred to the disclosed clinical information during an abusive phone call. An investigation revealed that the patients record had been accessed by an individual working in the Haematology department of the Trust. The individual is an employee of Imperial College London, who is working for the Trust under an honorary contract. An investigation was undertaken and the issue is now being dealt with under the disciplinary procedures of Imperial College London.
Actions taken by the ICO	The ICO have reviewed the initial report of the Trust and have referred the matter to their criminal investigation bureau. The Trust is continuing to engage with the ICO and is awaiting the outcome of the ICL Investigation.

Summary of incident	Upload of Patient Data to CIE Incorrectly Administered (Endocrinology)
Incident details	A Trust patient accessed their Care Information Exchange (CIE) health record and found a PDF of a concatenated document containing clinical information relating to her and other patients had been uploaded to her record. This included Endocrinology Outpatient clinic information relating to six other patients. The document included: • patient name • DOB • MRN • detailed Health information including diagnoses The patient noticed the incorrect upload of the concatenated document within 30 minutes of upload to CIE and emailed the Trust to make a complaint. The Trust was also aware of the concatenated document and was working on the removal of the document from CIE when the complaint was received.
Actions taken by the ICO	The ICO reviewed the initial report from the Trust and decided that no further action was required by them. They did recommend that the Trust; • monitor the risk to the affected data subjects and where appropriate, identify whether any further steps need to be taken to address this • consider whether any additional technical measures or controls need to be implemented to prevent a recurrence

Summary of incident	Subject Access Request Incorrectly Administered (Haematology)
Incident details	A subject access request was submitted by a patient who was taking part in the National Inquiry of Infected Blood. These records were partly held in paper format in off-site paper storage. The records were then collated and scanned electronically into a file. This file was subsequently uploaded to the Care Information Exchange (CIE) (patient-held record system) as per the SOP for Subject Access Requests. The SAR was completed in April 2020. In December 2020 the Trust was informed that the patient's legal counsel had found documents within the record that did not pertain to the patient, and in fact referred to other people. An investigation was undertaken and it was found that information pertaining to a total of 36 other patients had been incorrectly appended to the records of the patient. This information was not patient information but appeared to relate to research being undertaken in 1985. There was also a letter from a solicitor to another patient concerning a high court writ pertaining to an HIV incident. There was also an unrelated chemical pathology report unconnected with Haematology and HIV pertaining to another patient. Further investigation revealed that the records provided were incomplete and that there were other records held in a storage system called "MediViewer" that had not been included in the Subject Access Request. The information found in MediViewer also contained clinical information relating to another person.
Actions taken by the ICO	The ICO submitted 28 questions for the Trust to answer in order to support their detailed review. The response from the Trust to these questions will determine whether the ICO undertakes further enforcement or monitoring actions. There is already a planned ICO review of Trust processes pertaining to SARs and other compliance issues due to take place in January 2022.

Summary of incident	Subject Access Request Incorrectly Administered (CIE) (Maternity)
Incident details	A subject access request was submitted by a patient who requested maternity notes. The records were then collated and scanned electronically into a file. This file was subsequently uploaded to the Trust's patient-held record system, called the Care Information Exchange (CIE). This is the normal practice for subject access requests. The patient contacted the Trust Subject Access Request Team on 08/03/2021 to complain that there were detailed clinical records enclosed within the file that related to another patient. This included 4 pages of records in relation to another patient's still-birth.
Actions taken by the ICO	None at this stage. The Trust is expecting to receive further correspondence from the ICO.

Summary of incident	Confidential Email sent in Error to Vestigial Distribution List (Nursing Directorate)
Incident details	Staff member, in error, emailed correspondence of a confidential nature regarding a former member of staff to a vestigial distribution list of 122 email recipients. All the email recipients were working in the NHS; 120 were still working within the Trust and 2 were working elsewhere within the NHS. Email contained employment tribunal information, allegations of victimisation, health information and financial settlement details. This was caused by a "keystroke error" the staff member accidentally hit the # key which unwittingly added the distribution list of 122 recipients and pressed send using the return key. The data subject was already in the process of an employment tribunal to which the Trust was a respondent. The breach was notified to the tribunal and the Trust solicitors. Unfortunately, one of the recipients of the email forwarded a copy of the email to the data subject before the Trust had an opportunity to deal with the situation. The sender of this second unauthorised disclosure was not identified.
Actions taken by the ICO	ICO conducted an investigation and confirmed no formal regulatory action to be taken in reference to this incident.

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 the Trust has a Board approved Green Plan with a named Director to lead on its implementation. The Trust ensures that its obligations under the Climate Change Act, the Delivering a Net Zero NHS and Adaption Reporting requirements will be complied with.

Annual Quality Account

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

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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 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:
    1. board minutes and papers for the period April 2020 to May 2021
    2. papers relating to quality reported to the board over the period April 2020 to May 2021
    3. feedback from Clinical Commissioning Groups
    4. the annual governance statement May 2021
    5. feedback from local Healthwatch and local authority overview and scrutiny committees
    6. the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    7. the national staff survey 2020
    8. the Head of Internal Audit's annual opinion of the trust's control environment May 2021
    9. Mortality rates provided by external agencies (NHS Digital and Dr Foster).
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our Audit, Risk and Governance Committee held in May 2021, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

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, which continued during the pandemic, have provided assurance from substantial assurance to limited assurance; following the audit reports, management have accepted, and taken action to address, recommendations made. Management improvement plans for all audits given limited assurance are reviewed by the audit, risk and governance committee.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that each has taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.
- The Trust board reviews risks to the delivery of the Trust performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety and quality, and workforce.
- The board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed. Internal audit have rated the framework as providing substantial assurance.
- The audit, risk and governance committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed recorded and escalated as appropriate. The committee regularly receives reports on internal control and risk management matters from the internal and external auditors.

- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- During 2020/21, the Trust has continued to engage with the CQC through regular engagement meetings.
- 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

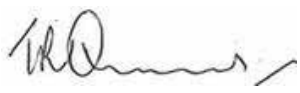
The Trust board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. The board is also committed to ensuring that serious incidents, as well as the incidence of non-compliance with standards and regulatory 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 2020/21 are detailed in the body of the annual governance statement above, namely:

- delays for patients requiring planned interventions due to Covid-19 surges
- impact of the Covid-19 pandemic on staff's health and wellbeing
- estates and redevelopment
- failure to achieve financial sustainability

Actions to address each of these areas is detailed in the relevant section of the corporate governance statement.

Date: 25 June 2021



Professor Tim Orchard
Chief executive

Remuneration and staff report 2020-21

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 2020/21 are set out in the staff report.

The Trust has taken advantage of flexibilities offered in the agenda for change to offer spot salaries to 30 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 banded remuneration (shown as the mid-point of the applicable £5k band) of the highest paid director in the financial year 2020/21 was £287,500 (£282,500

in 2019/20). This was 6.91 times (6.75 times in 2019/20) the median remuneration of the workforce, which was £41,633 (£41,814 in 2019/20). The change in the ratio from 6.75 (2019/20) to 6.91 this year is primarily due to the increased numbers of staff at lower grades who are now employed directly by the Trust following the transfer of previously outsourced hotel services staff and other recruitment as part of the pandemic response.

In both 2019/20 and 2020/21 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £16,069 to £287,500 (£9,590 to £282,500 in 2019/20).

Remuneration tables

Salary and pension disclosure tables: information subject to audit

Remuneration report 2020/21

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 [1] (bands of £2,500)	Total Remuneration (bands of £5,000)
Name and title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Non-executive director						
Paula Vennells, chair [2]	55-60	0	0	0	0	55-60
Sir Gerald Acher, deputy chair [3]	10-15	0	0	0	0	12.5
Bob Alexander, non-executive director [4]	5-10	0	0	0	0	5-10
Prof. Andrew Bush, non-executive director	10-15	0	0	0	0	10-15
Peter Goldsbrough, non-executive director	10-15	0	0	0	0	10-15
Andreas Raffel, non-executive director	10-15	0	0	0	0	10-15
Nick Ross, designate non-executive director	10-15	0	0	0	0	10-15
Kay Boycott, non-executive director	10-15	0	0	0	0	10-15
Sim Scavazza, non-executive director [5]	5-10	0	0	0	0	5-10
Dr.Ben Maruthappu, associate non-executive director	10-15	0	0	0	0	10-15
Executive Director						
Prof. Tim Orchard, chief executive [6]	270-275	0	15-20	0	60-62.5	345-350
Prof. Julian Redhead, medical director [7]	250-255	0	0	0	0	250-255
Prof. Janice Sigsworth, director of nursing	185-190	0	0	0	40-42.5	225-230
Jazz Thind, chief financial Officer [8]	155-160	0	0	0	105-107.5	260-265
Richard Alexander, chief financial officer [9]	20-25	0	0	0	0	20-25

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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2020	Real increase in cash equivalent transfer value [10]	Cash Equivalent Transfer Value at 31st March 2021	Employer's contribution to stakeholder pension
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-executive directors								
Paula Vennells, chair [2]	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Bob Alexander, non-executive director [4]	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
Nick Ross, designate non-executive director	0	0	0	0	0	0	0	0
Kay Boycott, non-executive director	0	0	0	0	0	0	0	0
Sim Scavazza, non-executive director [5]	0	0	0	0	0	0	0	0
Dr.Ben Maruthappu, associate non-executive director	0	0	0	0	0	0	0	0
Executive directors								
Prof. Tim Orchard, chief executive [6]	2.5-5	0	105-110	155-160	1,558	63	1,685	0
Prof. Julian Redhead, medical director [7]	0	0	70-75	180-185	1,413	0	1,435	0
Prof. Janice Sigsworth, director of nursing	2.5-5	7.5-10	90-95	280-285	2,118	98	2,277	0
Jazz Thind, chief financial officer [8]	5-7.5	5-7.5	55-60	75-80	777	87	900	0
Richard Alexander, chief financial officer [9]	0	0	0	0	0	0	0	0

[1] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

[2] Paula Vennells left the board on 31st March 2021.

[3] Sir Gerald Acher left the board on 20th November 2020

[4] Bob Alexander joined the board on 1st October 2020.

[5] Sim Scavazza joined the board on 1st October 2020.

[6] Prof. Tim Orchard - £50–55k of his salary relates to payment for his clinical role.

[7] Prof. Julian Redhead - The amount of £55-60k of his salary relates to payment for clinical role.

[8] Jazz Thind became the Trust Chief Financial Officer on 1st February 2021, prior to which time she was Interim Chief Financial Officer on secondment from Oxleas NHS Foundation Trust. The figures disclosed for her cover remuneration for the whole year including time on secondment and time as Chief Financial Officer.

[9] Richard Alexander led strategic finance projects for the Trust from January 2020 until he left the Trust on 27th April 2020. He was not a member of the pension scheme during this time.

[10] 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.

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

Remuneration report 2019/20

Salaries and Allowances (Restated)	(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 1 (bands of £2,500)	Total Remuneration (bands of £5,000)
Name & title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Non-executive director						
Paula Vennells, chair [2]	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 [3]	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 [4]	5-10	0	0	0	0	5-10
Dr.Ben Maruthappu, associate non-executive director [5]	5-10	0	0	0	0	5-10
Executive director						
Prof. Tim Orchard, chief executive [6]	265-270	0	15-20	0	877.5-880	1,160-1,165
Prof. Julian Redhead, medical director [7]	245-250	0	0	0	355-357.5	600-605
Prof. Janice Sigsworth, director of nursing	175-180	0	0	0	0-2.5	175-180
Richard Alexander, chief financial officer [8]	215-220	0	0	0	0	215-220
Jazz Thind, interim chief financial officer [9]	35-40	0	0	0	0	35-40

Pension benefits (Restated)	(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 [10]	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 [2]	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 [3]	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 [4]	0	0	0	0	0	0	0	0
Dr.Ben Maruthappu, associate non-executive director [5]	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	641	1,558	0
Prof. Julian Redhead, medical director [7]	15-17.5	45-47.5	70-75	185-190	1,028	327	1,413	0
Prof. Janice Sigsworth, director of nursing	0-2.5	2.5-5	90-95	270-275	1,996	49	2,118	0
Richard Alexander, chief financial officer [8]	0	0	0	0	0	0	0	0
Jazz Thind, interim chief financial officer [9]	0	0	0	0	0	0	0	0

[1] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

[2] Paula Vennells joined the board on 1 April 2019.

[3] Victoria Russell left the board on 30 June 2019.

[4] Kay Boycott joined the board on 1 September 2019.

[5] Dr. Ben Maruthappu joined the board on 1 September 2019.

[6] Prof. Tim Orchard - £50–55k of his salary relates to payment for his clinical role

[7] Prof. Julian Redhead - The amount of £55-60k of his salary relates to payment for clinical role.

[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.

[9] 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

[10] 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.

[11] The 2019/20 remuneration report has been restated to remove the proportion of the gain in Cash Equivalent Transfer Value that was due to the impact of inflation, thereby reflecting only the real gain.

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

Staff report

The headcount data is at 31 March 2021 and is for clinical and corporate divisions and R&D (excluding hosted and contracted services).

Workforce composition by staff group

At the end of 2020/21 the Trust employed 14,535 staff (an increase of 1,616 from 2019/20). Approximately 63 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in table titled 'headcount by Trust staff group' below.

Headcount by Trust staff group	Headcount
Admin and clerical	2,023
Allied health professional (qualified)	772
Allied health professional (Unqualified)	110
Ancillary	1,073
Doctor (career grade)	38
Doctor (consultant)	1,216
Doctor (training grade)	1,790
Nursing (qualified)	4,053
Nursing (unqualified)	1,277
Pharmacist	154
Physician associate	4
Scientific and technical (qualified)	841
Scientific and technical (unqualified)	375
Senior manager	809
Trust total	**14,535**

Workforce composition by sex

69 per cent of our workforce is female and 31 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 2020/21 women accounted for 57 per cent of senior managers, 39 per cent of executive directors and 57 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	10,025
Male	4,510
Trust total	**14,535**

Gender - Senior Managers	Headcount
Female	454
Male	344
Trust total	**798**

Gender - Board of Directors	Headcount
Female	8
Male	6
Trust total	**14**

Gender - Executive Team	Headcount
Female	7
Male	11
Trust total	**18**

Workforce composition by age and ethnicity

Age Group	Headcount
16-19 years	25
20-29 years	2,836
30-39 years	4,322
40-49 years	3,353
50-59 years	2,820
60 years and over	1,179
Trust total	**14,535**

Ethnic Origin	Headcount
White - British	3,333
White - Irish	394
White - Any other White background	1,711
Mixed - White & Black Caribbean	98
Mixed - White & Black African	82
Mixed - White & Asian	119
Mixed - Any other mixed background	221
Asian or Asian British - Indian	1,086
Asian or Asian British - Pakistani	302
Asian or Asian British - Bangladeshi	188
Asian or Asian British - Any other Asian background	1,367
Black or Black British - Caribbean	549
Black or Black British - African	1,564
Black or Black British - Any other Black background	458
Chinese	219
Any Other Ethnic Group	1,057
Undefined	1,383
Not Stated	404
Trust total	**14,535**

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 31 March 2021.

Average Staff Numbers	Total	Permanently Employed	Other	Total Prior Year	Prior Year Permanently Employed	Prior Year Other
Medical and dental	2,262	2,258	4	2,177	2,165	12
Ambulance staff	0	0	0	0	0	0
Administration and estates	3,749	3,665	84	2,707	2,665	42
Healthcare assistants and other support staff	1,883	1,841	42	1,715	1,680	35
Nursing, midwifery and health visiting staff	4,321	4,241	80	4,242	4,111	132
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	1,109	1,033	76	1,110	985	124
Social care staff	621	621	0	632	632	0
Healthcare science staff	0	0	0	0	0	0
Other	6	6	0	6	6	0
TOTAL	**13,951**	**13,665**	**286**	**12,589**	**12,244**	**345**
Staff engaged on capital projects (included above)	30	30	0	32	32	0

The analysis of staff costs is shown below:

	2020-21			2019-20		
	Permanent	Other	Total	Permanent	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	629,891	57,614	687,505	526,896	71,189	598,085
Social security costs	63,265	6,424	69,689	58,502	3,469	61,971
Apprenticeship levy	2,794	335	3,129	2,585	184	2,769
Employer contributions to NHS BSA	94,759	7,096	101,855	88,383	1,361	89,744
Other pension costs	72	3,240	3,312	78	28	106
Termination benefits	0	0	0	0	0	0
Total employee benefits	**790,781**	**74,709**	**865,490**	**676,444**	**76,231**	**752,676**
Employee costs capitalised	2,269	0	2,269	2,646	213	2,859
Gross Employee Benefits ex. capitalised costs	**788,512**	**74,709**	**863,221**	**673,798**	**76,018**	**749,816**

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 equality, diversity and inclusion policy and its policy on supporting staff who have a disability. The Trust is a Disability Confident

Committed 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	9,984
Not declared	301
Prefer not to answer	42
Unspecified	3,977
Yes	231
Trust Total	**14,535**

Staff Turnover

Information on staff turnover is published here https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff engagement

The Trust's overall staff engagement score in NHS Staff Survey 2020 was 7.2 against an average for Acute Trusts of 7.0. This was consistent with our engagement score in 2019 which was also 7.2

Trade union facility time publication requirements report: 2020/21 (not subject to audit)

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 2020 - 31 March 2021.

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
63	59.05

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%	44
1-50%	19
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	*£81,107.82*
Provide the total pay bill	*£863,604,839 = total figure for 2020/2021 including apprenticeship levy (£3,054,851)* *£860,549,988= 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	*0.009%*

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	73%

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.

Term	Definition
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.

Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 21, for more than £245 per day:

Number of existing engagements as of 31st March 2021	9
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	-
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four or more years at the time of reporting	6

Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1st April 2020 and 31st March 2021, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	15
Of which:	
Number not subject to off-payroll legislation	1
Subject to off-payroll legislation and determined as in-scope of IR35	10
Number subject to off-payroll legislation and determined as out of scope of IR35	4
Number of engagements reassessed for compliance or assurance purpose during the year	5
Number of engagements that saw a change to IR35 status following review	1

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 2020 and 31 March 2021

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 2020/21 the Trust approved severance payments to 10 staff (2019/20: 23 staff).

Exit packages

2020/21								
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	4	17,205	1	905	5	18,110	0	0
£10,000-£25,000	1	15,500	1	21,551	2	37,051	0	0
£25,001-£50,000	1	29,884	1	38,056	2	67,940	0	0
£50,001-£100,000	1	71,028	0	0	1	71,028	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
Total	**7**	**133,617**	**3**	**60,512**	**10**	**194,129**	**0**	**0**

2019-20 (Restated)								
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	29,656	4	29,656	0	0
£10,000-£25,000	4	67,913	5	90,115	9	158,028	0	0
£25,001-£50,000	1	44,305	3	119,991	4	164,296	0	0
£50,001-£100,000	0	0	5	335,509	5	335,509	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	1	179,536	1	179,536	0	0
Total	**5**	**112,218**	**18**	**754,807**	**23**	**867,025**	**0**	**0**

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

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

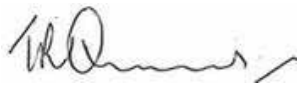
Exit packages - other departures analysis

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
- An exit package relating to one individual may appear in more than one row of the analysis provided in this table if it comprises different elements of payment

	2020-21		2019-20	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	1	159
Mutually agreed resignations (MARS) contractual costs	0	0	10	475
Contractual payments in lieu of notice	0	0	6	79
Exit payments following Employment Tribunals or court orders	3	61	2	42
Total	**3**	**61**	**19**	**755**

Date: 25 June 2021



Professor Tim Orchard
Chief executive

Chief financial officer report

Introduction and overview

The financial constructs governing NHS providers was significantly altered during 2020/21, enabling individual organisations and the systems within which they operate, to respond effectively to the operational pressures brought about by the Covid-19 pandemic without adversely impacting cash or the underlying sustainability of the organisation. The usual pressure to deliver efficiencies to cover unfunded inflation, growth or internal cost pressures was relieved through a series of top up and Covid-19 funding streams, resulting in the Trust being able to report a surplus of £47k. This revised financial regime supported the Trust being able to maintain its high level of supplier payments; ensure adequate resources were available to staff and patients; successfully deliver its plan to in-house 1,000 hotel services staff and continue its estates programme within a revised financial governance process that not only facilitated rapid decision making, but also ensured robust financial accountability was maintained.

The 2020/21 financial year was sub-divided into two distinct halves with alternative financial regimes for each six-month period. The first half was supported by a 'top up payment' arrangement that allowed all Trusts to report a breakeven positon to 30 September 2020; with the second underpinned by a budget setting process within a defined ICS cash envelope. Where costs were defined as being 'out of the envelope' these were offset via national additional NHSE/I funding. This included items such as: increased pathology testing and the establishment and running of vaccination centres.

Financial review of 2020/21

For the period October 2020 to March 2021 the Trust planned for a £15.8m deficit position: this was largely attributed to the loss of non NHS income (private patients, overseas visitors, car parking etc) where the Trust was not able to continue to generate income from these sources either due to newly established restrictions or change in policy. This was however subsequently funded by the Department of Health and Social Care resulting in the Trust ending the financial year with a small surplus (before impairment) of £47k. This outcome is also underpinned by funding that offsets the costs of Covid-19 related spend; takes account of the significantly lower expenditure related to lower than planned elective activity; includes (unlike in previous years) funding of the annual leave entitlement not taken during the year due to operational pressures; and the 1 per cent cost improvement requirement being met non-recurrently. The Trust also successfully remained within both the external financing and capital resource limits.

Despite this positive financial result, the Trust will continue to be faced with two key risks: insufficient levels of investment required to deal with its ongoing backlog maintenance (due to the on-going deterioration of the aged estate) and delivering the level of year on year efficiencies required to maintain a balanced position and financial sustainability.

The table below sets out the actual income and expenditure performance as at the 31 March 2021, including comparative information for 2019/20 and tracks this against the Trust control or agreed plan total:

Statement of comprehensive income	2020/21 £'m	2019/20 £'m
Income	1,422.8	1,300.6
Expenditure	(1,422.5)	(1,264.4)
Net financing costs	(0.5)	(0.6)
Public dividend capital payable	(10.3)	(12.3)
Surplus before revaluations and impairments	**(10.6)**	**23.4**
Adjustments for revaluations and impairments	0.1	0.7
Surplus (deficit) for the financial year	**(10.7)**	**24.1**

Performance against plan (control total in 2019/20)	2020/21 £'m	2019/20 £'m
Surplus for the year as per annual accounts	(10.7)	24.1
Remove 2018/19 post audit PSF reallocation (2019/20 only)	0.0	(1.0)
Surplus before allowed adjustments	**(10.7)**	**23.1**
2020/21 top up funding *	(84.2)	0.0
Less PSF and MRET	0.0	(27.1)
Donated asset adjustment	(7.2)	(2.2)
Adjust for revaluation and impairment	17.9	(12.2)
Surplus before PSF, donated assets and revaluation	**(84.2)**	**(18.4)**
Add Back		
2020/21 central top up support funding	84.2	0.0
MRET	0.0	10.2
Core PSF	0.0	16.8
Surplus for control total as per annual accounts	**0.0**	**8.7**
Add back unfunded Covid annual leave accural	0.0	2.6
Adjusted surplus for PSF calculation	**0.0**	**11.2**
Control total	0.0	11.1
Performance against plan (control total in 2019/20)	**0.0**	**0.1**

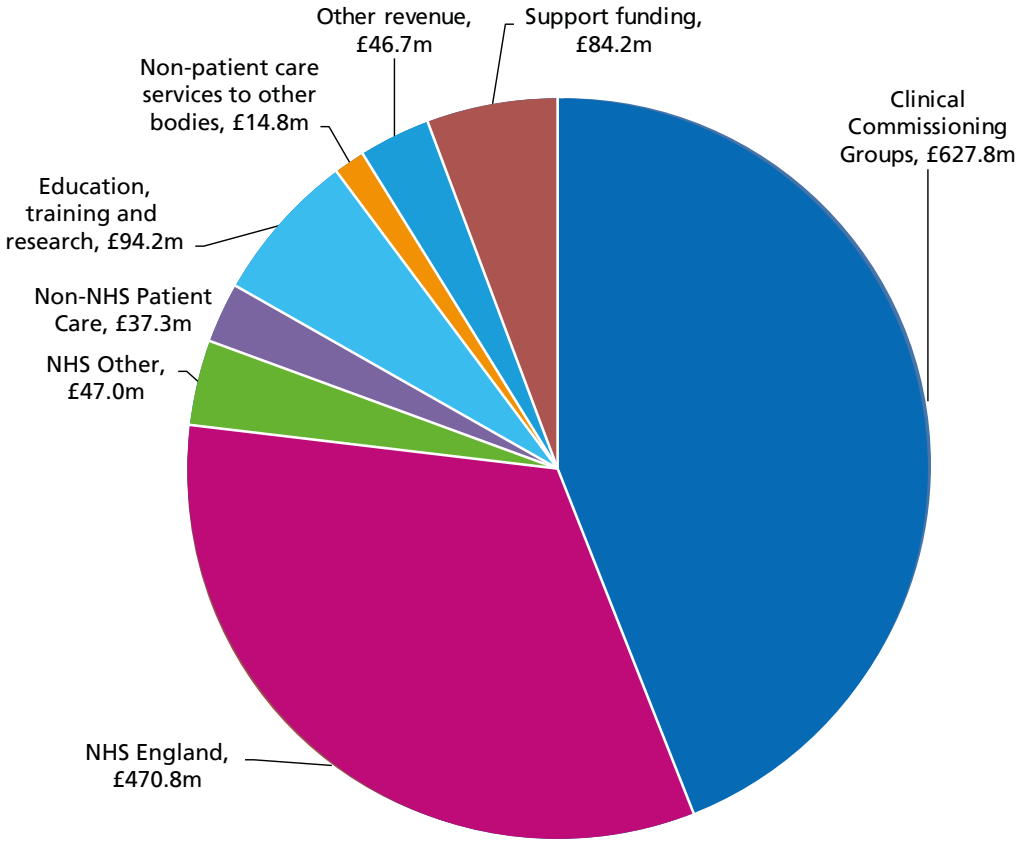
*Funding received from NHSE/I to support expenditure incurred in relation to Covid activities

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 £1,423m for 2020/21 (2019/20 £1,301m). The majority of this related to NHS patient care income for the provision of clinical services. During 2020/21 the funding regime changed in response to the Covid pandemic, with income paid on a block contract basis with top ups for shortfalls due to Covid-19 where applicable. Under this new financial regime the Trust received additional income of £84.2m to cover various pandemic related pressures, such as additional staffing costs, premises, personal protective equipment and lost non-NHS income, which enabled the Trust to breakeven and continue during the epidemic.

There are a number of other income sources including: 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.

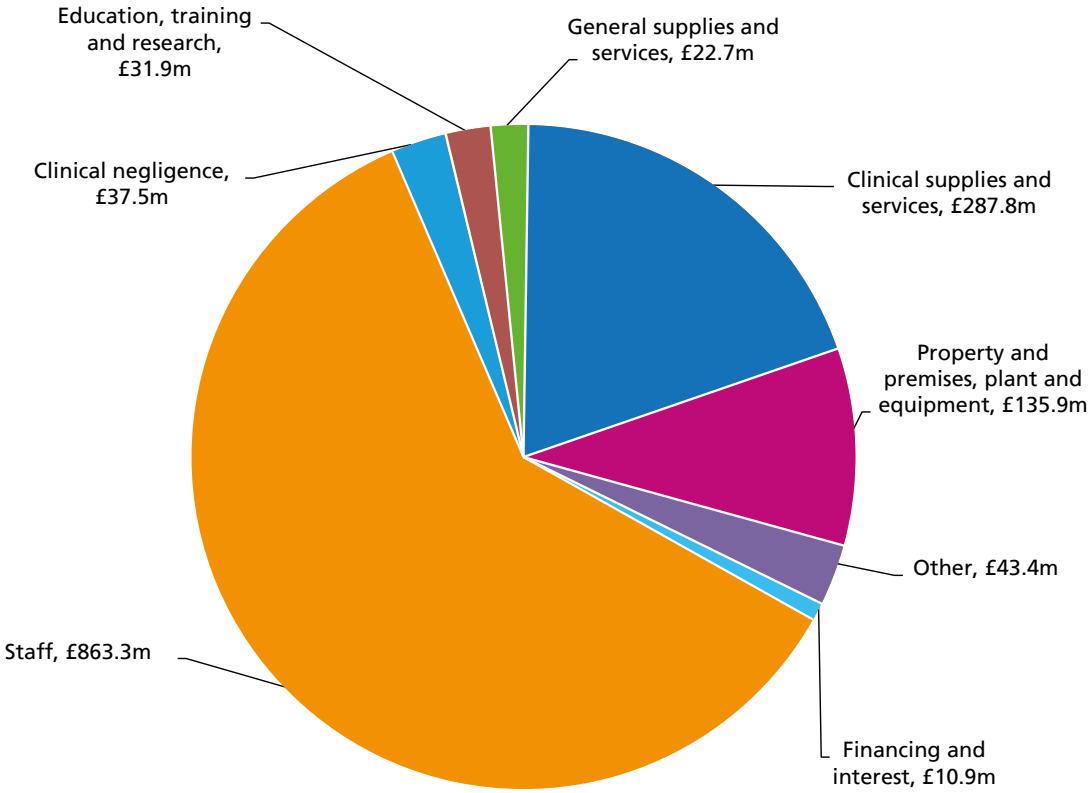


Expenditure

Excluding financing and interest costs total Trust expenditure for 2020/21 was £1,423m (2019/20 £1,264m) with staff costs accounting for 61 per cent of this spend. Pay expenditure includes the cost associated with those staff undertaking education, training and research activities.

Within this expenditure, the in-housing of hotel services has resulted in a £37m shift between pay and non-pay spend as staff were brought onto the payroll. Other expenditure in the chart below includes £17.9m of impairments which sits outside of the result for plan purposes, and the balance of this figure is made up of several smaller cost elements including legal fees, consultancy, operating lease, bad debts and inventories write downs.

To achieve our planned operational deficit of £15.8m (before funding to offset loss of non-NHS income) £6m of planned savings and efficiencies were required to be delivered during the second half of the financial year. Although the divisions were allocated an element of the savings target, and had identified arears of focus the on-set of the second wave ultimately resulted in these being achieved through non-recurrent means with savings from services stood down during the pandemic forming the bulk of the delivery this year.



Cash

The Trust continued to successfully manage its cash throughout 2020/21 thereby remaining within its external financing limit (EFL), ending the year with a cash balance of £149.1m at 31 March 2021, marked improvement on previous financial years. This strengthening of the cash positon is reflective of the changes to the funding regime during 2020/21 and the conversion of the revolving working capital facility (initially provided by the DHSC in 2015/16) of £15.8m into Public Dividend Capital, thereby allowing the one-off repayment be to be spread across future financial years.

Capital

By the 31 March 2021 the Trust invested £85.9m in capital expenditure (including £7.7m of charity funded and donated assets), key themes included:

Sources of Funds	£m
Depreciation (NWL sector allocation)	40.5
PDC and external funding	38.5
Charitable Funds	1.9
Donation of DHSC-procured assets	5.8
Total	**86.7**
Income & Donation	**-7.7**
Capital Resource Limit (CRL) funding	**79.0**

Use of funds	Actual £m
Backlog Maintenance	18.7
ICT	8.2
Replacement of Medical Equipment	7.3
Other Capital Projects	42.2
Redevelopment	4.2
Covid-19	5.3
Gross Expenditure	**85.9**
Income & Donation	**-7.7**
Expenditure against CRL	**78.2**
Expenditure as a % of funding	**99%**

Included in the total above is £1.9m of Imperial Health Charity money. 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 £78.2m, which was in line with the agreed capital resource limit target for the year.

Other capital projects include national imaging replacement schemes (£9.9m); London wide care information exchange project (£3m); urgent emergency care works (£1.4m); renal (£1.6m); pathology (£1.5m); CIR reallocations (£6.8m); Salix (£1.3m); PET CT (£3.4m); Brain FUS (£3.3m) adapt and adopt projects (£1.2m) and centrally donated assets (5.8m).

Redevelopment remains a key priority for the Trust, and confirmation of further seed funding for the HIP2 scheme business case at St Mary's Hospital is being sought.

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.

In spite of the impact of the pandemic, we have continued to publish our policies and procedures for staff to report any concern about potential fraud and this has been reinforced by sharing of fraud notices and general awareness raising by the local counter fraud specialist. 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 and the Trust has met this requirement in year. During 2020/21 95.8 per cent of invoices by value and 97.8 per cent by volume of total payables were paid within the required standard, this represents an improvement against 2019/20 which was 86.6 per cent and 93.7 per cent respectively.

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 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 has the reasonable expectation that it will continue to have access to adequate cash resources to service its operational activities in cash terms for the next 12 months. The resilience of the cash position has been further strengthened by the writing off of the working capital loan of £15.8m through a public dividend capital (PDC) award as announced by the regulator on 2 April 2020.

Block contract values have been issued to providers for the period 1 April 2021 to 30 September 2021 based on quarter three 2019/20 actuals. Access to further funding linked to sector transformation may be available, but parameters for this have yet to be set. 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.

It should be noted that whilst the financial position is currently showing improvement, the estate continues to pose a significant risk in terms of the level of backlog improvements required and potential unaffordable failures. The Trust redevelopment schemes are however included on the national 40 New Hospitals Programme (NHP) and has received one tranche of seed funding to progress the Strategic Outline Case for the St Mary's site. Although there is a balance of seed funding still intact to allow the Trust to continue to progress the development of the business case(s), no formal confirmation of additional seed funding or the commitment to cover any unexpected estates failures have been provided at the point of writing this report.

2021/22 looking ahead

- 2021/22 planning: confirmation of the funding regime has been received for the first six months of the financial year. The North West London ICS will receive similar funding levels as those in the second half of 2020/21, with providers being allocated settlements in line with quarter 3 actuals, adjusted for a 2 per cent efficiency requirement.
- Operational focus: providers have been issued with fixed activity trajectory targets for the first half of the year. The detailed planning through the weekly Trust respond and recovery has ensure services are restarted in a safe and sustainable way, with the Trust on track to meet (exceed) the trajectories set. However given the number of patients awaiting treatment the Trust is committed to the ambition that it is imperative we go above and beyond the defined trajectories and deliver care to as many of our patients as possible

thereby not only better meeting patient need but also accessing the elective recovering funding available nationally.

- Redevelopment: the submission of the redevelopment strategic outline case was slightly delayed due to the COVID-19 pandemic, however, significant progress has been made in year, and the Trust has been confirmed as part of the national "40 new hospitals" scheme. Work to finalise the strategic outline case for the redevelopment of the St Mary's Hospital site continues as the success of this project is critical to ensuring Trust is able to provide sustainable; safe, cost effective quality care into the future. This is key to the stability of the Trust. Additional HIP funding is expected to be confirmed in due course.
- Integrated care systems: during 2020/21 there was an increased focus on sector working with ICSs being given fixed funding allocations as part of the new arrangements covering 1 October 2020 to 31 March 2021. With the announcements in the white paper ICSs this funding methodology will continue not only into the first half of 2021/22, but also into the future. As a member organisation of the north west London ICS the Trust is actively engaging in the local sector level post Covid-19 'recovery and reset' thinking. Working with other member NHS organisations it is developing a set of guiding financial principles that ensure value for money and financial sustainability are secured and the population of north wwest London is able to access quality equitable care.

Although the favourable funding regime in 2020/21 is continuing into the first half of 2021/22, it is anticipated that the ICS (and by virtue of this the Trust) will need to revert to achieving the previously published control total trajectories and that central funding (e.g. Covid-19, top-up etc) will cease. This will result in the need to deliver a higher level of efficiency to cover the historic deficit position, as well as any new unavoidable costs introduced in-year, e.g. cleaning changes linked to Public Health England guidance, amendments to care pathways and enhanced personal protection, all of which were introduced to reduce risk of Covid-19 exposure. The Trust has therefore resumed its focus on cost control and identification and delivery of efficiency opportunities with immediate effect.

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.

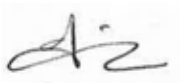
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Trust board

Date: 25 June 2021

Professor Tim Orchard
Chief executive

Date: 25 June 2021



Jazz Thind
Chief financial officer

Independent auditors' 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 2021 and of its expenditure and income for the year then ended; and
- 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 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 32.

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 and related narrative notes on page 178
- the table of pension benefits of senior managers and related narrative notes on page 179
- the table of pay multiples and related narrative notes on page 177
- the table of exit packages and related narrative notes on page 197-199

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 Code of Audit Practice, 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 (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the

audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the trust is adopted in consideration of the requirements set out in the Accounts Direction, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditors' report thereon. The directors are responsible for the other information contained within the annual report. 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.

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. 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 this regard.

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 they have been informed by the relevant national body of the intention to dissolve the trust without the transfer of the trust's services to another public sector entity.

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

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

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the trust and its control environment, and reviewed the trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, those charged with governance, internal audit, local counter fraud, about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address them are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2021, are subjective: we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, reviewing internal audit reports, and reviewing correspondence with the licensing authority.

Report on other legal and regulatory requirement

Opinions on other matters

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

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 the Code of Audit Practice and section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the 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 undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice and Auditor Guidance Note 3, we discharge this responsibility by reporting by exception if we have reported to the trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the trust's arrangements, will be reported in our separate Auditor's Annual Report.

Governance statement and reports in the public interest or to the regulator

We are also required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Trust Development Authority (NHS Improvement);
- we refer a 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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this areas is unlikely to have a material impact on the financial statements or on our value for money conclusion.

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. 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 auditors' 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 (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom

July 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2021 issued on 28 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of the trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- had 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').

Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 28 June 2021, we had not completed our work on the trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2021 issued on 28 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Imperial College Healthcare NHS Trust in accordance with requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Craig Wisdom (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
9 September 2021

Financial statements

Statement of comprehensive income

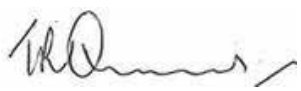
	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	1,182,827	1,114,061
Other operating income	4	239,962	186,555
Operating expenses	6, 8	(1,422,521)	(1,264,351)
Operating surplus / (deficit) from continuing operations		**268**	**36,265**
Finance income	11	14	514
Finance expenses	12	(539)	(1,131)
PDC dividends payable		(10,332)	(12,254)
Net finance costs		**(10,857)**	**(12,871)**
Surplus / (deficit) for the year		**(10,589)**	**23,394**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(85)	-
Revaluations		-	721
Total comprehensive income / (expense) for the period		**(10,674)**	**24,115**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(10,589)	23,394
Remove net impairments not scoring to the Departmental expenditure limit		17,862	(11,515)
Remove I&E impact of capital grants and donations		(5,882)	(2,237)
Remove 2018/19 post audit PSF reallocation (2019/20 only)			(968)
Remove net impact of inventories received from DHSC group bodies for COVID response		(1,344)	
Adjusted financial performance surplus / (deficit)		47	8,674

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 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	13	14,089	4,260
Property, plant and equipment	13	550,562	538,191
Receivables	16	3,200	-
Total non-current assets		**567,851**	**542,451**
Current assets			
Inventories	14	17,065	15,270
Receivables	16	90,596	125,489
Cash and cash equivalents	15	149,055	43,944
Total current assets		**256,716**	**184,703**
Current liabilities			
Trade and other payables	17	(217,456)	(158,253)
Borrowings	19	(2,492)	(17,981)
Provisions	21	(33,607)	(33,455)
Other liabilities	18	(27,932)	(19,879)
Total current liabilities		**(281,487)**	**(229,568)**
Total assets less current liabilities		**543,080**	**497,586**
Non-current liabilities			
Borrowings	19	(15,924)	(16,042)
Provisions	21	(3,200)	(0)
Other liabilities	18	(2,058)	(2,058)
Total non-current liabilities		**(21,182)**	**(18,100)**
Total assets employed		**521,898**	**479,486**
Financed by			
Public dividend capital		773,873	720,787
Revaluation reserve		2,413	2,498
Income and expenditure reserve		(254,388)	(243,799)
Total taxpayers' equity		**521,898**	**479,486**

The notes on pages 171 to 211 form part of these accounts.



Name: Prof. Tim Orchard
Position: Chief Executive Officer
Date: 15 June 2021

Statement of changes in equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**720,787**	**2,498**	**(243,799)**	**479,486**
Surplus/(deficit) for the year	-	-	(10,589)	**(10,589)**
Impairments	-	(85)	-	**(85)**
Revaluations and reversal of impairments	-	-	-	**-**
Public dividend capital received	53,086	-	-	**53,086**
Taxpayers' and others' equity at 31 March 2021	**773,873**	**2,413**	**(254,388)**	**521,898**

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 and reversal of impairments	-	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**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health 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	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		268	36,265
Non-cash income and expense:			
Depreciation and amortisation	6	45,772	38,144
Net impairments	7	17,862	(9,902)
Income recognised in respect of capital donations	4	(7,716)	(3,783)
(Increase) / decrease in receivables and other assets		32,330	23,510
(Increase) / decrease in inventories		(1,795)	(1,336)
Increase / (decrease) in payables and other liabilities		60,185	(670)
Increase / (decrease) in provisions		3,352	(260)
Other movements in operating cash flows		36	-
Net cash flows from / (used in) operating activities		**150,294**	**81,968**
Cash flows from investing activities			
Interest received		14	479
Purchase of property, plat and equipment, and investment property		(71,583)	(57,395)
Receipt of cash donations to purchase assets		1,871	3,783
Net cash flows from / (used in) investing activities		**(69,698)**	**(53,133)**
Cash flows from financing activities			
Public dividend capital received / (repaid)		53,086	4,367
Movement on loans from DHSC		(17,031)	(1,226)
Movement on other loans		631	(129)
Capital element of finance lease rental payments		(275)	(90)
Interest on loans		(519)	(1,124)
Interest paid on finance lease liabilities		(22)	(9)
PDC dividend (paid) / refunded		(11,355)	(12,140)
Cash flows from (used in) other financing activities		-	(1,232)
Net cash flows from / (used in) financing activities		**24,515**	**(11,583)**
Increase / (decrease) in cash and cash equivalents		**105,111**	**17,252**
Cash and cash equivalents at 1 April - brought forward		**43,944**	**26,692**
Cash and cash equivalents at 31 March	15	**149,055**	**43,944**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the 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 2020/21 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 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 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 has the reasonable expectation that it will continue to have access to adequate cash resources to service its operational activities in cash terms for the next 12 months. The resilience of the cash position has been further strengthened by the writing off of the working capital loan of £15.8m through a public dividend capital (PDC) award as announced by the regulator on 2 April 2020.

Block contract values have been issued to providers for the period 1 April 2021 to 30 September 2021 based on quarter three 2019/20 actuals. Access to further funding linked to sector transformation may be available, but parameters for this have yet to be set. 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.

It should be noted that whilst the financial position is currently showing improvement, the estate continues to pose a significant risk in terms of the level of backlog improvements required and potential unaffordable failures. The Trust redevelopment schemes are however included on the national 40 New Hospitals Programme (NHP) and has received one tranche of seed funding to progress the Strategic Outline Case for the St Mary's site. Although there is a balance of seed funding still intact to allow the Trust to continue to progress the development

of the business case(s), no formal confirmation of additional seed funding or the commitment to cover any unexpected estates failures have been provided at the point of writing this report.

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 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.

The Trust values its overall estate on an 'alternative site' valuation basis assumed to be held in one, notional location broadly consistent with the Hammersmith site. This assuption has been revisited in light on the redevlopment works and the Trust is satisfied that this judgement continues to be appropriate.

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 2021 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.

Note 1.2.2 Key sources of estimation uncertainty

The following are the estimations that management have made in the process of applying the 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 21 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 1.3 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).

Revenue in respect of goods or 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an ICS level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when 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. Where the grants are used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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

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, or 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 organisation 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 derecognised.

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, or 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.

In 2020/21, the Trust received inventories including personal protective equipment from the DHSC at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 longterm 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 credit loss 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 investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.14 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 21.1 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 "preaudit" 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 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

The Department of Health and Social Care GAM does not require the following Standards and Interpretations to be applied in 2020/21. These standards are either being implemented in 2021/22 or are still subject to implementation. The Trust does not anticipate a material impact on the disclosures or on the amounts reported in these financial statements:

Amendments to IFRS 3 Reference to the Conceptual Framework
IFRS 17 Insurance Contracts
IFRS 10 and IAS 28 (amendments) Sale or Contribution of Assets between an Investor and its Associate or Joint Venture
Amendments to IAS 1 Classification of Liabilities as Current or Non-current
Amendments to IAS 16 Property, Plant and Equipment—Proceeds before Intended Use
Amendments to IAS 37 Onerous Contracts – Cost of Fulfilling a Contract

Application required for accounting periods beginning on or after 1 January 2019, but owing to the coronavirus pandemic implementation has been deferred:

IFRS 16 Leases
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations, and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right-of-use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.
IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.
On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right-of-use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right-of-use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.
For leases commencing in 2022/23, the Trust will not recognise a right-of-use asset or lease liability for short-term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). right-of-use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

It is expected that adoption of this standard will have a significant effect on financial statements. It has not been possible to quantify any impact at this time.

Note 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 five divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and children's, and clinical support services; private health; and, 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)

	2020/21	2019/20
Acute services	**£000**	**£000**
Block contract / system envelope income*	927,719	842,137
High cost drugs income from commissioners (excluding pass-through costs)	121,955	118,322
Other NHS clinical income	14,832	15,093
Community services		
Block contract / system envelope income*	10,956	9,189
Income from other sources (e.g. local authorities)	95	993
All services		
Private patient income	28,082	53,839
Additional pension contribution central funding**	31,021	27,264
Other clinical income	48,167	47,224
Total income from activities	**1,182,827**	**1,114,061**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in

this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	470,802	447,456
Clinical commissioning groups	627,761	556,847
Department of Health and Social Care	99	368
Other NHS providers	46,341	41,466
NHS other	566	24
Local authorities	76	467
Non-NHS: private patients	28,082	53,839
Non-NHS: overseas patients (chargeable to patient)	2,092	5,519
Injury cost recovery scheme	2,218	2,514
Non NHS: other	4,790	5,561
Total income from activities	**1,182,827**	**1,114,061**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	**£000**
Income recognised this year	2,092	5,519
Cash payments received in-year	2,396	3,184
Amounts added to provision for impairment of receivables	2,019	1,154
Amounts written off in-year	1,323	1,245

Note 4 Other operating income

	2020/21	2019/20
	£000	£000
Research and development	40,327	50,852
Education and training	53,920	51,551
Non-patient care services to other bodies	14,761	14,765
Provider sustainability fund (2019/20 only)		17,809
Marginal rate emergency tariff funding (2019/20 only)		10,232
Reimbursement and top up funding	84,247	-
Income in respect of employee benefits accounted on a gross basis	8,672	7,861
Receipt of capital grants and donations	7,716	3,783
Charitable and other contributions to expenditure	16,820	2,708
Rental revenue from operating leases	1,667	1,940
Other income	11,832	25,054
Total other operating income	**239,962**	**186,555**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	8,162	9,638
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	3,216	4,108

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

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	17,278	15,098
Purchase of healthcare from non-NHS and non-DHSC bodies	12,753	12,784
Staff and executive directors' costs	863,115	749,049
Remuneration of non-executive directors'	137	119
Supplies and services - clinical (excluding drugs costs)	140,388	131,801
Supplies and services - general	22,708	38,088
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	117,362	124,895
Inventories written down	1,870	450
Consultancy costs	1,265	2,330
Establishment	8,879	9,260
Premises	62,016	51,470
Transport (including patient travel)	19,218	18,119
Depreciation on property, plant and equipment	42,884	36,055
Amortisation on intangible assets	2,888	2,089
Net impairments	17,862	(9,902)
Movement in credit loss allowance: contract receivables / contract assets	2,045	1,286
Audit fees payable to the external auditor	159	182
Internal audit costs	189	267
Clinical negligence	37,545	30,452
Legal fees	1,241	1,090
Insurance	539	489
Research and development	29,378	29,301
Education and training	2,537	2,165
Rentals under operating leases	3,860	3,953
Redundancy	106	767
Hospitality	2,814	346
Other services, e.g. external payroll	-	-
Other	11,485	12,348
Total	**1,422,521**	**1,264,351**

Note 6.1 Remuneration paid to the external auditor:

	2020/21	2019/20
	£000	£000
Statutory external audit fees	159	150
Additional assurance services	-	32

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / (deficit) resulting from:		
Abandonment of assets in course of construction	-	1,613
Changes in market price	17,862	(11,515)
Impairments charged to the revaluation reserve	85	-
Total net impairments	**17,947**	**(9,902)**

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	672,710	579,443
Social security costs	69,689	61,971
Apprenticeship levy	3,129	2,769
Employer's contributions to NHS pensions	101,855	89,744
Pension cost - other	3,312	106
Temporary staff (including agency)	14,795	18,642
Total staff costs	**865,490**	**752,675**
Of which		
Costs capitalised as part of assets	2,269	2,859

Note 8.1 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £115k (£81k in 2019/20).

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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control

mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,667	1,940
Total	**1,667**	**1,940**
Future minimum lease receipts due:		
- not later than one year;	1,350	174
- later than one year and not later than five years;	4,924	1,529
- later than five years.	19,058	10,340
Total	**25,332**	**12,043**

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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	3,860	3,953
Total	**3,860**	**3,953**
Future minimum lease payments due:		
- not later than one year;	2,442	3,517
- later than one year and not later than five years;	6,043	8,746
- later than five years.	1,883	2,049
Total	**10,368**	**14,312**

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	14	514
Total finance income	**14**	**514**

Note 12 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	517	1,122
Finance leases	22	9
Total interest expense	**539**	**1,131**

Note 13 Non-current assets

Note 13.1 Non-current assets - 2020/21

	Intangible assets		
	Information technology	Total	Land
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**15,093**	**15,093**	**84,168**
Additions	-	-	-
Impairments	-	-	-
Reversals of impairments	-	-	20,756
Revaluations	-	-	-
Reclassifications	12,717	**12,717**	-
Disposals / derecognition	(2,344)	**(2,344)**	-
Valuation / gross cost at 31 March 2021	**25,466**	**25,466**	**104,924**
Amortisation/depreciation at 1 April 2020 - brought forward	**10,833**	**10,833**	-
Provided during the year	2,888	**2,888**	-
Impairments	-	**-**	-
Reversals of impairments	-	**-**	-
Revaluations	-	**-**	-
Reclassifications	-	**-**	-
Disposals / derecognition	(2,344)	**(2,344)**	-
Amortisation/depreciation at 31 March 2021	**11,377**	**11,377**	**-**
Net book value at 31 March 2021	**14,089**	**14,089**	**104,924**
Net book value at 1 April 2020	**4,260**	**4,260**	**84,168**
Net book value at 31 March 2021			
Owned - purchased			104,924
Finance leased			-
Owned - donated/granted			-
NBV total at 31 March 2021			**104,924**

Property, plant and equipment						
Buildings excluding dwellings	**Assets under construction**	**Plant & machinery**	**Information technology**	**Furniture & fittings**	**Total**	**Total assets**
£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
339,331	**55,114**	**178,734**	**63,892**	**1,611**	**722,850**	**737,943**
-	80,074	5,845	-	-	**85,919**	**85,919**
(64,372)	-	-	-	-	**(64,372)**	**(64,372)**
(1,443)	-	-	-	-	**19,313**	**19,313**
-	-	-	-	-	**-**	**-**
61,767	(116,146)	24,920	15,977	765	**(12,717)**	**-**
-	-	(5,011)	(11,695)	(103)	**(16,809)**	**(19,153)**
335,283	**19,042**	**204,488**	**68,174**	**2,273**	**734,184**	**759,650**
-	-	**137,170**	**46,509**	**980**	**184,659**	**195,492**
27,112	-	8,102	7,437	233	**42,884**	**45,772**
(23,245)	-	-	-	-	**(23,245)**	**(23,245)**
(3,867)	-	-	-	-	**(3,867)**	**(3,867)**
-	-	-	-	-	**-**	**-**
-	-	-	-	-	**-**	**-**
-	-	(5,011)	(11,695)	(103)	**(16,809)**	**(19,153)**
-	**-**	**140,261**	**42,251**	**1,110**	**183,622**	**194,999**
335,283	**19,042**	**64,227**	**25,923**	**1,163**	**550,562**	**564,651**
339,331	**55,114**	**41,564**	**17,383**	**631**	**538,191**	**542,451**
312,686	19,042	53,995	23,751	1,163	**515,561**	
-	-	-	2,172	-	**2,172**	
22,597	-	10,232	-	-	**32,829**	
335,283	**19,042**	**64,227**	**25,923**	**1,163**	**550,562**	

Note 13.2 Non-current assets - 2019/20

	Intangible assets		
	Information technology	Total	Land
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**11,902**	**11,902**	**79,161**
Additions	-	-	-
Impairments	-	-	-
Reversals of impairments	-	-	5,004
Revaluations	-	-	3
Reclassifications	3,191	**3,191**	-
Disposals / derecognition	-	**-**	-
Valuation / gross cost at 31 March 2020	**15,093**	**15,093**	**84,168**
Amortisation at 1 April 2019 - as previously stated	**8,744**	**8,744**	**-**
Provided during the year	2,089	**2,089**	-
Impairments	-	**-**	-
Reversals of impairments	-	**-**	-
Revaluations	-	**-**	-
Reclassifications	-	**-**	-
Disposals / derecognition	-	**-**	-
Amortisation at 31 March 2020	**10,833**	**10,833**	**-**
Net book value at 31 March 2020	**4,260**	**4,260**	**84,168**
Net book value at 1 April 2019	**3,158**	**3,158**	**79,161**
Net book value at 31 March 2020			
Owned - purchased			84,168
Finance leased			-
Owned - donated/granted			-
NBV total at 31 March 2020			**84,168**

Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total	Total assets
£000	£000	£000	£000	£000	£000	£000
304,992	**82,433**	**163,484**	**56,011**	**1,234**	**687,315**	**699,217**
-	55,488	-	-	-	**55,488**	**55,488**
(14,890)	(1,613)	-	-	-	**(16,503)**	**(16,503)**
-	-	-	-	-	**5,004**	**5,004**
(5,266)	-	-	-	-	**(5,263)**	**(5,263)**
54,495	(81,194)	15,250	7,881	377	**(3,191)**	**-**
-	-	-	-	-	**-**	**-**
339,331	**55,114**	**178,734**	**63,892**	**1,611**	**722,850**	**737,943**
4,234	**-**	**129,318**	**41,641**	**796**	**175,989**	**184,733**
23,151	-	7,852	4,868	184	**36,055**	**38,144**
-	-	-	-	-	**-**	**-**
(21,401)	-	-	-	-	**(21,401)**	**(21,401)**
(5,984)	-	-	-	-	**(5,984)**	**(5,984)**
-	-	-	-	-	**-**	**-**
-	-	-	-	-	**-**	**-**
-	**-**	**137,170**	**46,509**	**980**	**184,659**	**195,492**
339,331	**55,114**	**41,564**	**17,383**	**631**	**538,191**	**542,451**
300,758	**82,433**	**34,166**	**14,370**	**438**	**511,326**	**514,484**
316,497	47,758	38,999	16,124	631	**504,177**	
-	-	-	1,259	-	**1,259**	
22,834	7,356	2,565	-	-	**32,755**	
339,331	**55,114**	**41,564**	**17,383**	**631**	**538,191**	

Note 13.3 Donations of property, plant and equipment

The Trust received £6.9m of donated equipment from DHSC of which £5.9m meets the definition of capitalisable assets and is included within the notes above.

This equipment was recognised at deemed cost with the corresponding benefit recognised in income.

Note 13.4 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	Maximum
	Years	Years
Intangibles	5	5
Buildings, excluding dwellings	25	60
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	5	10

Note 14 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	7,305	8,045
Consumables	9,470	7,008
Energy	290	217
Total inventories	**17,065**	**15,270**

Inventories recognised in expenses for the year were £180,939k (2019/20: £179,535k). Write-down of inventories recognised as expenses for the year were £1,870k (2019/20: £450k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £14,854k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income.

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.

	2020/21	2019/20
	£000	£000
At 1 April	**43,944**	**26,692**
Net change in year	105,111	17,252
At 31 March	**149,055**	**43,944**
Broken down into:		
Cash at commercial banks and in hand	144	45
Cash with the Government Banking Service	148,911	43,899
Total cash and cash equivalents as in SoFP	**149,055**	**43,944**
Total cash and cash equivalents as in SoCF	**149,055**	**43,944**

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 2021	31 March 2020
	£000	£000
Monies on deposit	77	59
Total third party assets	**77**	**59**

Note 16 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	81,481	112,369
Allowance for impaired contract receivables / assets	(8,842)	(8,238)
Prepayments (non-PFI)	9,384	12,516
Interest receivable	-	35
PDC dividend receivable	672	-
VAT receivable	5,389	6,375
Other receivables	2,512	2,432
Total current receivables	**90,596**	**125,48**
Non-current		
Other receivables	3,200	-
Total non-current receivables	**3,200**	-
Of which receivable from NHS and DHSC group bodies:		
Current	80,935	73,804
Non-current	3,200	-

Note 16.1 Allowances for credit losses

	2020/21	2019/20
	£000	£000
Allowances as at 1 April - brought forward	**8,238**	**8,324**
New allowances arising	3,182	1,286
Reversals of allowances	(1,137)	-
Utilisation of allowances (write offs)	(1,441)	(1,372)
Allowances as at 31 March 2021	**8,842**	**8,238**

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 2021 is in receivables from customers, as disclosed in the trade and other receivables note. At the 31st March 2021 the main customer (excluding NHS entities) debts totalled £35.7m for which the Trust feels it has made adequate provision.

Note 17 Trade and other payables

	31 March 2021	31 March 2020
Current	**£000**	**£000**
Trade payables	51,842	48,705
Capital payables	17,742	10,320
Accruals	97,734	63,000
Social security costs	10,061	9,161
Other taxes payable	9,467	7,912
PDC dividend payable	-	351
Other payables	30,610	18,804
Total current trade and other payables	**217,456**	**158,253**
Of which payables from NHS and DHSC group bodies:		
Current	19,812	18,035

Note 18 Other liabilities

	31 March 2021	31 March 2020
Current	**£000**	**£000**
Deferred income: contract liabilities	27,932	19,879
Total other current liabilities	**27,932**	**19,879**
Non-current		
Lease incentives	2,058	2,058
Total other non-current liabilities	**2,058**	**2,058**

Note 19 Borrowings

	31 March 2021	31 March 2020
	£000	**£000**
Current		
Loans from DHSC	1,247	17,054
Other loans	656	652
Obligations under finance leases	589	589
Total current borrowings	**2,492**	**17,981**
Non-current		
Loans from DHSC	11,014	12,240
Other loans	3,472	2,845
Obligations under finance leases	1,438	957
Total non-current borrowings	**15,924**	**16,042**

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

Loan 3 - joint arrangement loan of £1.6m. Commencing 1 April 2017. Interest free loan, non-repayable subject to going concern of the arrangement

Loan 4 - energy efficiency loan of £0.95m. Commencing May 2018 and continuing until settled on 1 April 2024. Interest free loan

Loan 5 - energy efficiency loan of £1.28m. Commencing 16 October 2020 and continuing until settled on 1 October 2026. Interest free loan

Note 19.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**29,294**	**3,497**	**1,232**	**34,023**
Cash movements:				
Financing cash flows - payments and receipts of principal	(17,031)	631	(275)	**(16,675)**
Financing cash flows - payments of interest	(519)	-	(22)	**(541)**
Non-cash movements:				
Additions	-	-	1,070	**1,070**
Application of effective interest rate	517	-	22	**539**
Carrying value at 31 March 2021	**12,261**	**4,128**	**2,027**	**18,416**

Note 19.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**30,522**	**3,626**	**-**	**34,148**
Cash movements:				
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)**
Non-cash movements:				
Additions	-	-	1,322	**1,322**
Application of effective interest rate	1,122	-	9	**1,131**
Carrying value at 31 March 2020	**29,294**	**3,497**	**1,232**	**34,023**

Note 20 Finance leases

Note 20.1 Imperial College Healthcare NHS Trust as a lessor

The Trust has no future lease receipts due under finance lease agreements where the Trust is the lessor.

Note 20.2 Imperial College Healthcare NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021	31 March 2020
	£000	£000
- not later than one year;	589	275
- later than one year and not later than five years;	1,438	957
- later than five years.	-	-
Total	**2,027**	**1,232**
Net lease liabilities		
- not later than one year;	589	275
- later than one year and not later than five years;	1,438	957
- later than five years.	-	-
Total	**2,027**	**1,232**

Note 21 Provisions for liabilities and charges analysis

	Redundancy	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2020	**393**	**125**	**32,937**	**33,455**
Arising during the year	106	120	3,970	**4,196**
Utilised during the year	(386)	-	(144)	**(530)**
Reversed unused	-	-	(314)	**(314)**
At 31 March 2021	**113**	**245**	**36,449**	**36,807**
Expected timing of cash flows:				
- not later than one year;	113	245	33,249	**33,607**
- later than one year and not later than five years;	-	-	3,200	**3,200**
Total	**113**	**245**	**36,449**	**36,807**

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 21.1 Clinical negligence liabilities

At 31 March 2021, £507,862k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2020: £440,043k).

Note 22 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(111)	(67)
Net value of contingent liabilities	**(111)**	**(67)**

Note 23 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	12,126	12,381
Total	**12,126**	**12,381**

Note 24 Financial instruments

Note 24.1 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 2021 is in receivables from non-NHS customers, as disclosed in the trade and other receivables note. At the 31st March 2021 the main customer debts totalled £35.7m 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.

Note 24.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March

	2021	2020
	£000	£000
Trade and other receivables excluding non-financial assets	78,351	106,563
Cash and cash equivalents	149,055	43,944
Total at 31 March	**227,406**	**150,507**

Note 24.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March	2021	2020
	£000	£000
Loans from the Department of Health and Social Care	12,261	29,294
Obligations under finance leases	2,027	1,232
Other borrowings	4,128	3,497
Trade and other payables excluding non-financial liabilities	197,926	140,829
Total at 31 March	**216,342**	**174,852**

Note 24.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	200,575	159,307
In more than one year but not more than five years	9,816	11,806
In more than five years	6,130	6,772
Total	**216,521**	**177,885**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 25 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	26	33	38	54
Bad debts and claims abandoned	274	1,409	266	1,318
Stores losses and damage to property	11	352	12	454
Total losses	**311**	**1,794**	**316**	**1,826**
Special payments				
Ex-gratia payments	41	37	82	36
Total special payments	**41**	**37**	**82**	**36**
Total losses and special payments	**352**	**1,831**	**398**	**1,862**

There are no individual cases over 300k.

Note 26 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 2020/21 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 2021. 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 27 Events after the reporting date

There are no events after the end of the reporting period that warrant disclosure in these accounts.

Note 28 Better Payment Practice code

	2020/21	2020/21	2019/20	2019/20
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	152,470	756,093	163,773	638,300
Total non-NHS trade invoices paid within target	149,770	726,145	155,402	563,786
Percentage of non-NHS trade invoices paid within target	98.2%	96.0%	94.9%	88.3%
NHS Payables				
Total NHS trade invoices paid in the year	7,209	75,973	7,212	71,792
Total NHS trade invoices paid within target	6,360	70,906	4,826	49,310
Percentage of NHS trade invoices paid within target	88.2%	93.3%	66.9%	68.7%

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 29 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2020/21	2019/20
	£000	**£000**
Net cash (generated from)/used in operations	(150,294)	(81,968)
Net cash (generated from)/used in investing activities	69,698	53,133
Relevant cash adjustments from financing activities	11,896	13,273
External financing requirement	**(68,700)**	**(15,562)**
External financing limit (EFL)	92,803	8,195
Under / (over) spend against EFL	**161,503**	**23,757**

Note 30 Capital Resource Limit

	2020/21	2019/20
	£000	**£000**
Gross capital expenditure	85,919	55,488
Less: Donated and granted capital additions	(7,716)	(3,783)
Charge against Capital Resource Limit	**78,203**	**51,705**
Capital Resource Limit	79,038	51,846
Under / (over) spend against CRL	**835**	**141**

Note 31 Breakeven duty financial performance

	2020/21	2019/20
	£000	£000
Adjusted financial performance surplus / (deficit) (control total basis)	47	8,674
Remove impairments scoring to Departmental Expenditure Limit	-	1,613
Add back income for impact of 2018/19 post-accounts PSF reallocation		968
Breakeven duty financial performance surplus / (deficit)	**47**	**11,255**

Note 32 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12
	£000	£000	£000	£000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)
Breakeven duty cumulative position	24,775	33,877	39,023	30,604
Operating income		900,234	920,256	941,690
Cumulative breakeven position as a percentage of operating income		3.8%	4.2%	3.2%

2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
£000	£000	£000	£000	£000	£000	£000	£000	£000
9,025	15,128	15,405	(47,879)	(15,330)	3,023	32,996	11,255	47
39,629	54,757	70,162	22,283	6,953	9,976	42,972	54,227	54,274
971,274	979,312	1,000,614	1,019,905	1,096,575	1,160,803	1,212,959	1,300,616	1,422,789
4.1%	5.6%	7.0%	2.2%	0.6%	0.9%	3.5%	4.2%	3.8%

NHS
Imperial College Healthcare
NHS Trust

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