

Welcome to our AGM 2018

Please take a seat,
the AGM is about to begin

A photograph of three healthcare professionals standing in a clinical setting. On the left is a woman in a maroon uniform, in the center is a man in a dark blue uniform, and on the right is a man in a grey uniform. They are all smiling. The background shows medical equipment and a bright, clean environment.

Welcome

Sir Richard Sykes
Chairman

Agenda



Part I

- 2017/18 review and a look ahead
- Our finances 2017/18
- Questions and answers

Part II

- The stroke care revolution

A healthcare professional in a grey uniform is smiling and talking to a patient in a hospital bed. In the background, there is a medical monitor on a stand displaying vital signs. The scene is set in a bright hospital room with windows in the background.

2017/18 review and a look ahead

Professor Tim Orchard
Chief Executive

Our Trust in numbers 2017/18

1,125,000

Patient contacts

(including inpatients, outpatients and day cases)



299,000

Emergency attendees

(including A&E and AEC)



39,000

Operations

(including day and inpatients)



97%



Inpatients who would recommend us to their friends and family

A top **5** Trust
with lowest mortality ratios

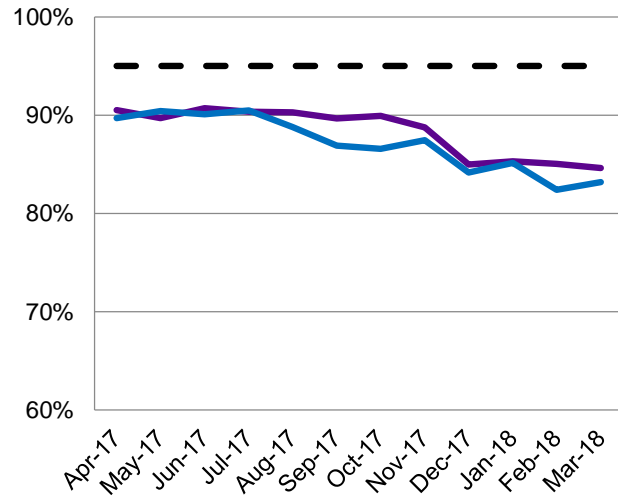


£43m

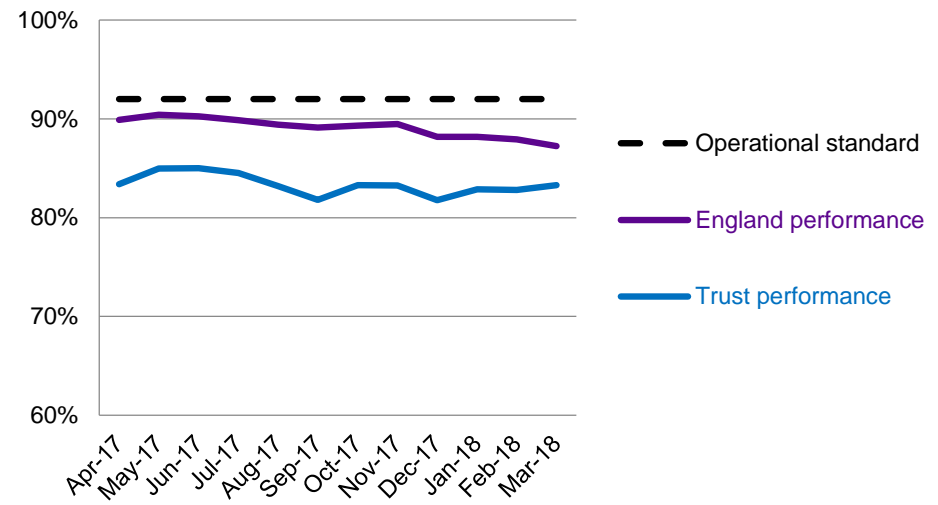
Cost improvements

Operational performance 2017/18

4-hour A&E access

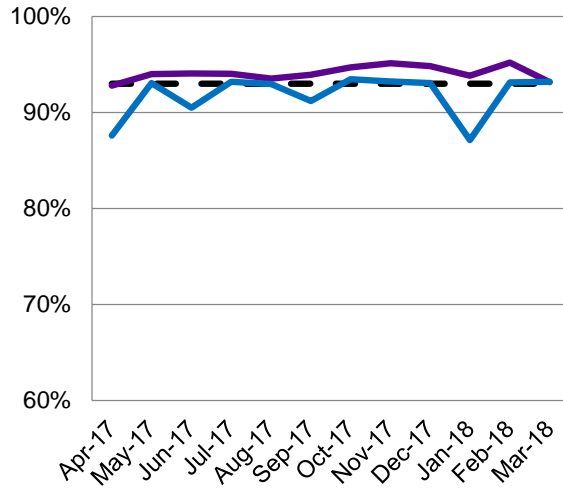


18 week referral to treatment

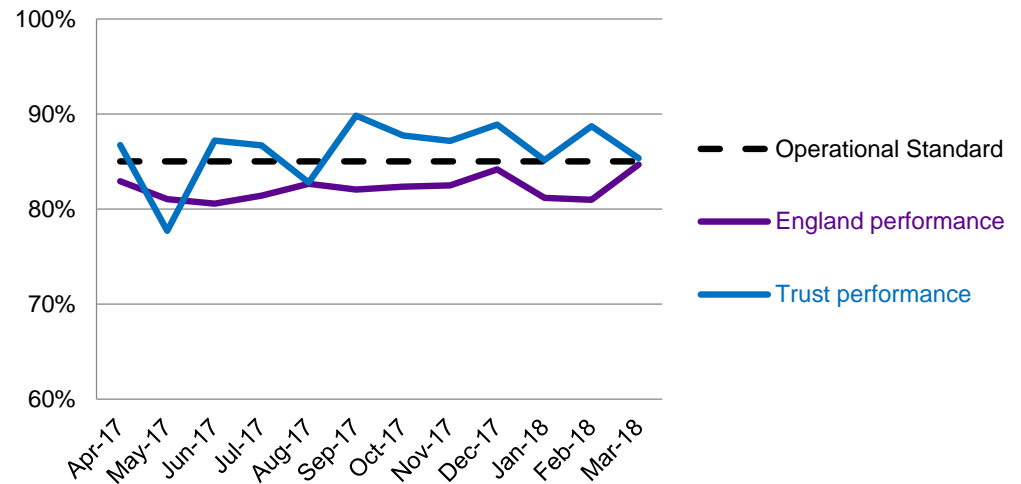


Operational performance 2017/18

Cancer: 2 week wait from urgent GP referral



Cancer: 62-day wait from urgent GP referral



Responding to challenges and opportunities

- Quality improvement
- Estate and service developments
- Our staff and volunteers
- Research and innovation
- Transformational change

Responding to challenges and opportunities

Quality improvement



**Spotlight on:
Alert to sepsis**

Responding to challenges and opportunities

Estates and service developments



**Outpatients
Charing Cross**



**Thistlethwayte
St Mary's**



LINAC scanner

Responding to challenges and opportunities

Our staff and volunteers

Spotlight on: NHS70 campaign



“I was always brought up knowing my grandfather, late Prime Minister Clement Attlee’s, involvement with the introduction of the NHS and I feel passionately about it. I have a good hard working team who are striving to help patients, and I think one of the things I am known for is to always put patients first.”

Belinda Johnston, programme manager, West London Bowel Screening, Charing Cross Hospital



“The best part of my job is when we perform a successful procedure on someone who would otherwise not have survived the heart attack. We have to keep a level head and try not to get emotional, because every patient we see in the heart attack centre is in a life-threatening situation. One day you might save five lives, another day you might lose a patient.”

Dr Ramzi Khamis, consultant interventional cardiologist, Hammersmith Hospital



“I remember speaking to one mum and her partner and they didn’t have a clue about breastfeeding at all. It took quite a while but if you had seen the look on the mum’s face, she was so happy. You couldn’t buy that. It was so great that we had made such a difference in that mum’s life.”

Carmella Obinyan, Imperial Health Charity volunteer, Queen Charlotte’s & Chelsea Hospital

Responding to challenges and opportunities

Research and innovation



Rare genetic eye diseases



Pioneering prostate treatment



BMJ award for PREPARE for surgery

Responding to challenges and opportunities

Transformational change

- Organisational culture - vision and values
- Clinical strategy refresh
- Integrated care
- Estates redevelopment
- Digital strategy
- Patient and public involvement

A close-up, slightly blurred photograph of a person's hand typing on a black computer keyboard. The hand is positioned over the right side of the keyboard, with fingers resting on keys like '8', '9', '0', and 'End'. The background is a soft, out-of-focus light grey.

Financial accounts 2017/18

Richard Alexander
Chief financial officer

Agenda

2017/18

- headlines
- context
- financial snapshot
- investments and savings

2018/19

- looking ahead

2017/18 headlines

Reported surplus £3m	Capital expenditure £57.4m
Savings delivered £43.1m	Underlying deficit cut by £12m

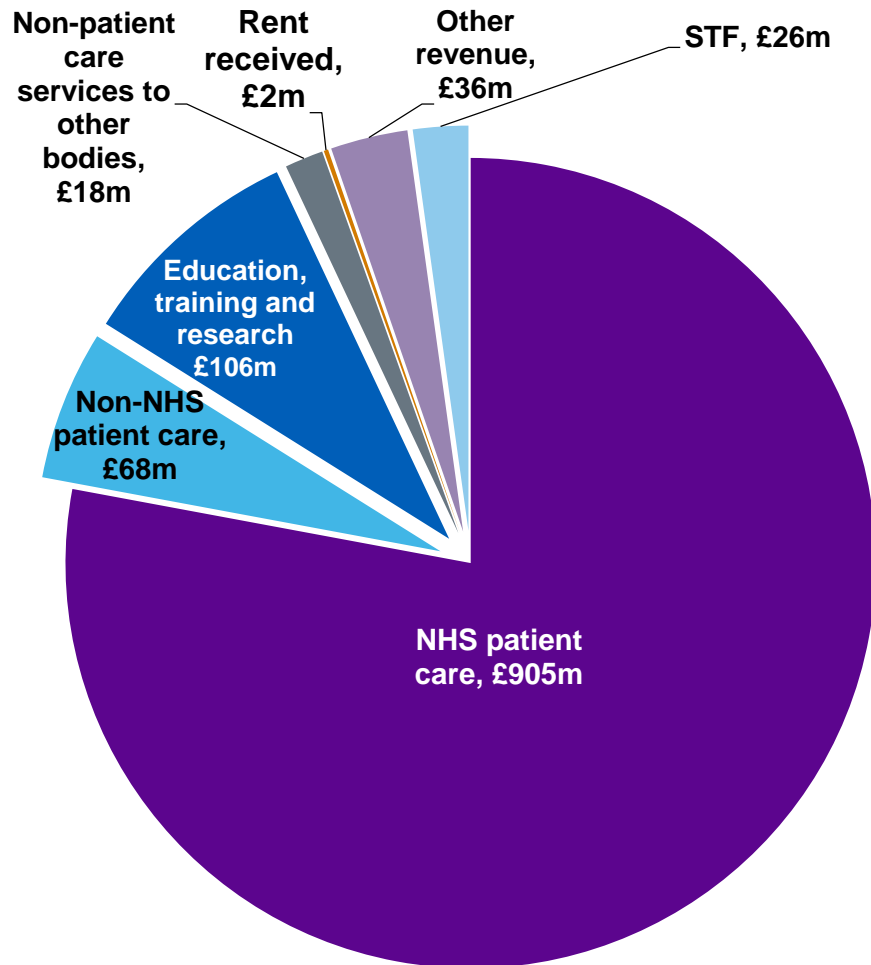
2017/18 in context

	2015-16	2016-17	2017-18
	£'m	£'m	£'m
Revenue from patient care activities	832.2	890.1	974.0
Other operating revenue	187.7	181.0	161.3
Sustainability and transformation funding (STF)	-	25.5	25.5
Total revenue	1,019.9	1,096.6	1,160.8
Employee benefits	(582.7)	(600.0)	(640.0)
Other operating costs*	(470.9)	(491.5)	(501.1)
Operating surplus/(deficit)	(33.7)	5.1	19.8
Net financing costs	(0.6)	(1.1)	(1.1)
Public dividend capital payable	(11.5)	(12.2)	(10.1)
Donated asset adjustment	(2.2)	(7.2)	(5.5)
Surplus/(deficit) for the financial year	(47.9)	(15.3)	3.0

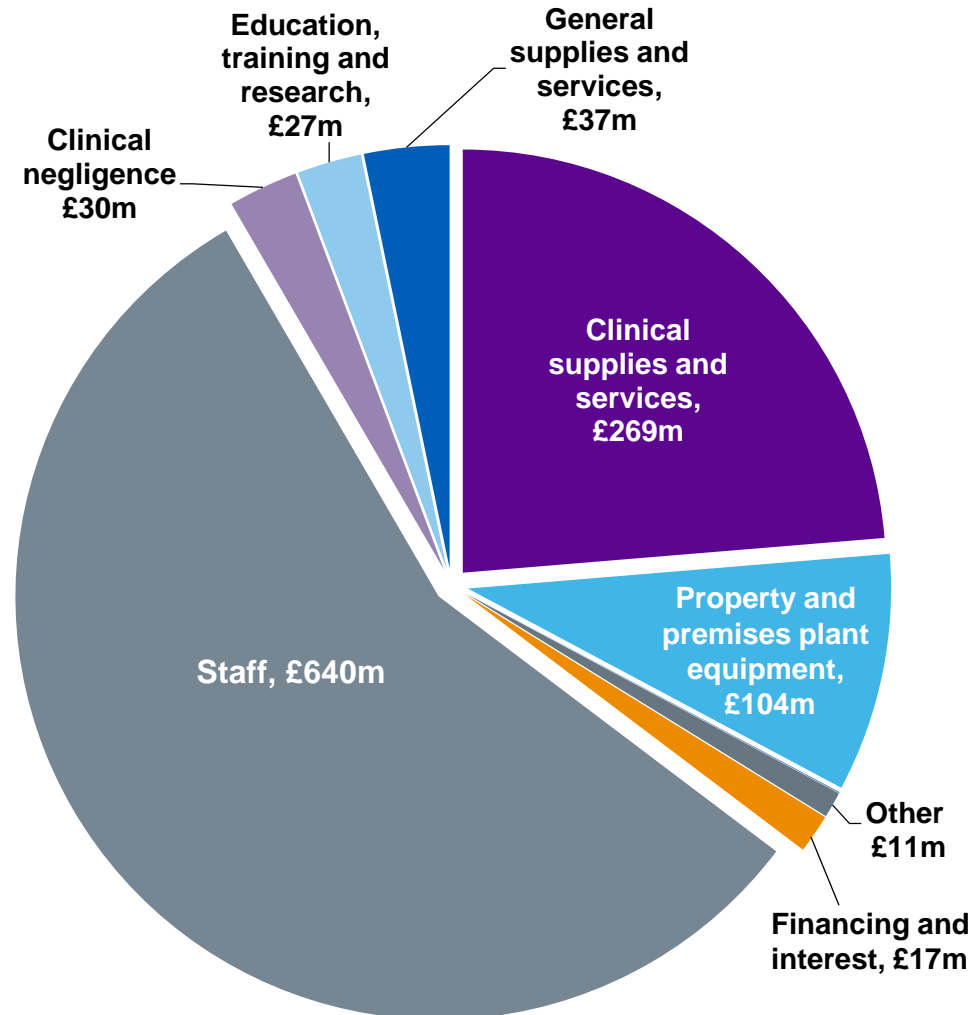
* Adjusted for fixed asset revaluation

2017/18 financial snapshot

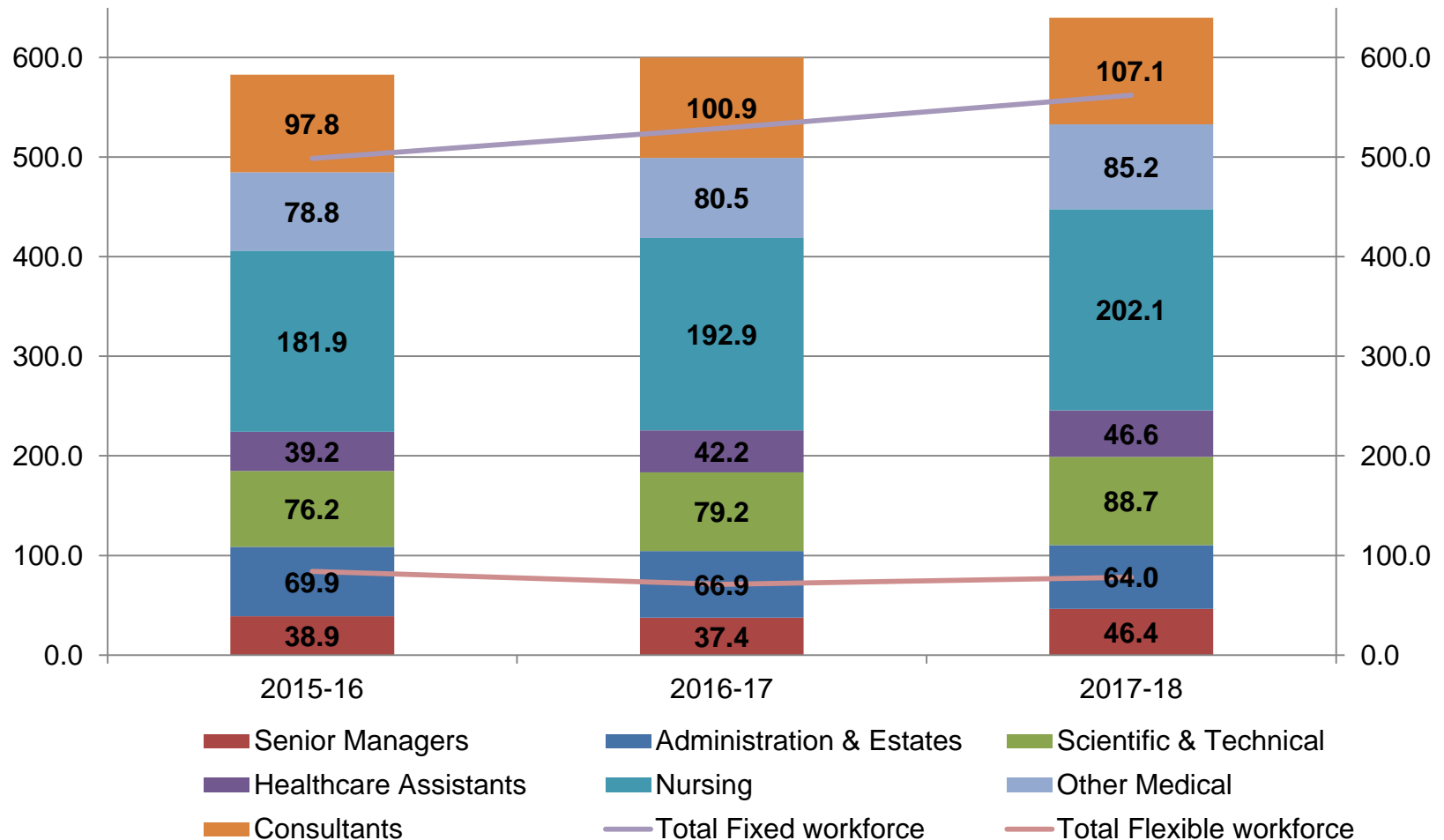
Where do £s come from?



Where do £s go?



2017/18 investing in staff (£m)



2017/18 investing in estates and equipment



Trust wide	£44.6m
Backlog maintenance	£17.9m
ICT	£6.4m
Global digital excellence	£4.1m
Medical equipment	£4.0m
Other equipment	£4.1m
Outpatient re-development	£2.9m
Building maintenance	£2.7m
Other schemes	£2.5m



Charing Cross Hospital	£5.1m
LINACS	£4.2m
7 North	£0.7m
Emergency department	£0.2m

2017/18 investing in estates and equipment



Hammersmith Hospital	£1.6m
2 x SPEC CT machines	£0.6m
Energy schemes	£1.0m



St. Mary's Hospital	£6.2m
Bed capacity	£0.1m
Paediatric inpatients	£0.2m
PICU	£4.7m
Critical care provision	£0.2m
A&E reconfiguration	£1.0m

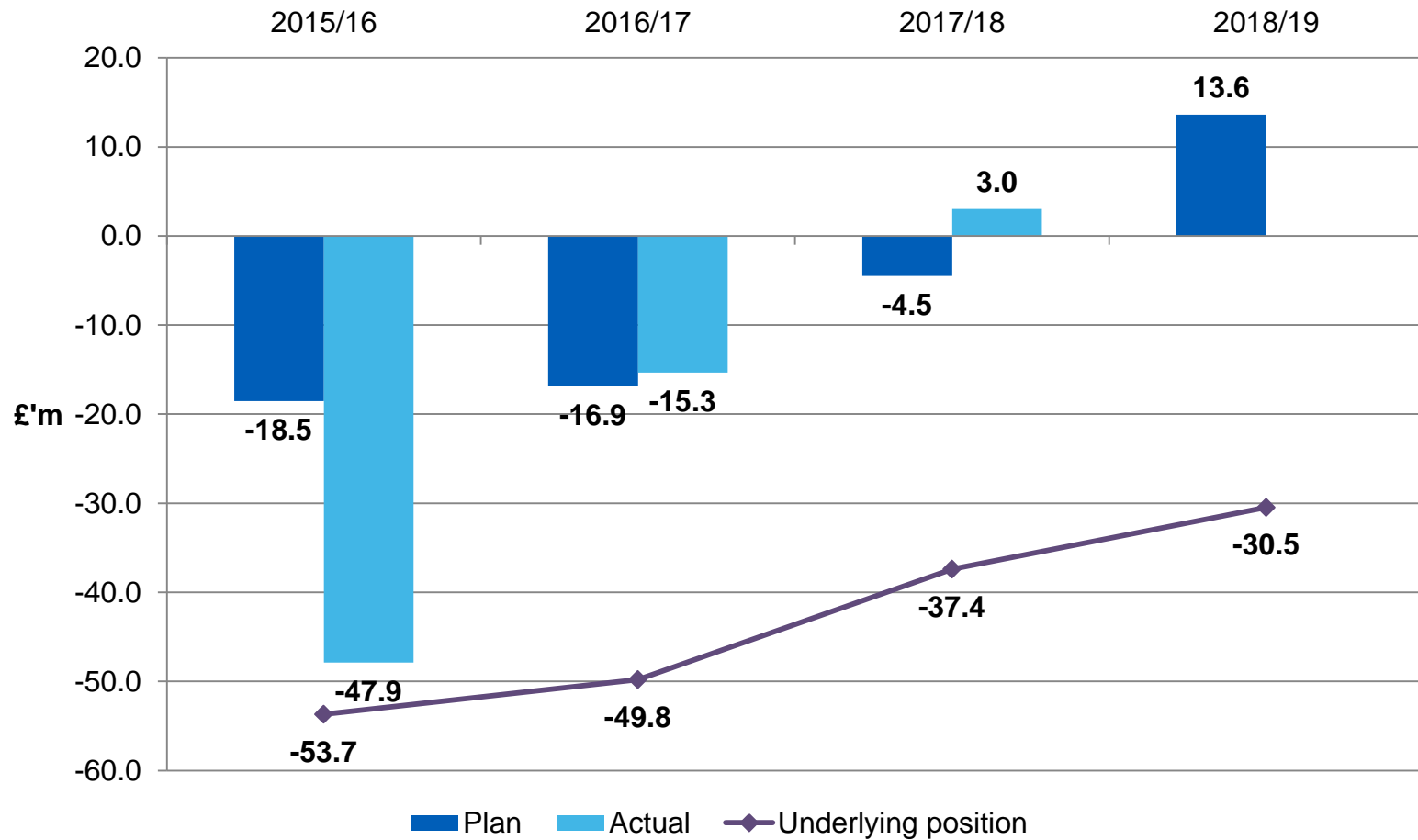
2017/18 savings summary

	Clinical	Corporate	Total
Savings delivered £m	34.1	9	43.1
<u>of which is Income:</u>			
Acute Income	18.8	3	21.8
Acute New Care Models & Community	3.2	0	3.2
Private Patients	1.9	0	1.9
Other Income	0.2	0.1	0.3
Income Total	24.1	3.1	27.2
<u>of which is Pay:</u>			
Bank, Agency & Overtime	2	0.4	2.4
Non-Clinical / Admin	0.7	0.7	1.4
Clinical Related Pay Savings	1	0.1	1.1
Pay Total	3.7	1.2	4.9
<u>of which is Non-Pay:</u>			
Procurement & Contracts	4.4	2.5	6.9
Medicines Management/Drugs	1.2	0	1.2
ICT / Digital Transformation	0.1	1.1	1.2
Consumables & Waste Reduction	0.1	0.2	0.3
Consultancy	0.3	0.4	0.7
Other Non-Pay Cost Reductions	0.2	0.5	0.7
Non-Pay Total	6.3	4.7	11

2018/19 looking ahead

	2017/18 Actual	2018/19 Plan	Change
	£m	£m	£m
Income	1,135.3	1,136.8	↑1.5
STF	25.5	34.2	↑8.6
Expenditure	(1,157.8)	(1,157.4)	↑0.4
Surplus/(deficit)	3.0	13.6	↑10.6
Savings	43.1	48.0	↑4.9
Capital	57.4	76.9	↑19.5
Year-end cash	24.5	25.2	↑0.7

2018/19 looking ahead



2018/19 Looking ahead

- challenging financial position in 2018/19 and beyond
- addressing the underlying financial challenge is key and we have to be prepared to change
- we continue to invest in maintaining and improving our estate and equipment but redevelopment is now critical

Prof Tim Orchard, chief executive

Prof Julian Redhead, medical director

Richard Alexander, chief financial officer

Prof Janice Sigsworth, director of nursing

Dr Frances Bowen, interim director - medicine and integrated care

Prof TG Teoh, divisional director - women's children's and clinical support

Prof Katie Urch, divisional director - surgery, cancer and cardiovascular

Questions and answers



The stroke care revolution

Dr Soma Banerjee

Consultant stroke physician

Dr Kyri Lobotesis

Consultant interventional neuroradiologist

Epidemiology and burden of stroke

- second commonest cause of death in the world
- largest single cause of severe disability
- >100,000 people will suffer a stroke in England each year
- more common with increasing age
- cost to NHS: £1.7bn

What is a stroke?

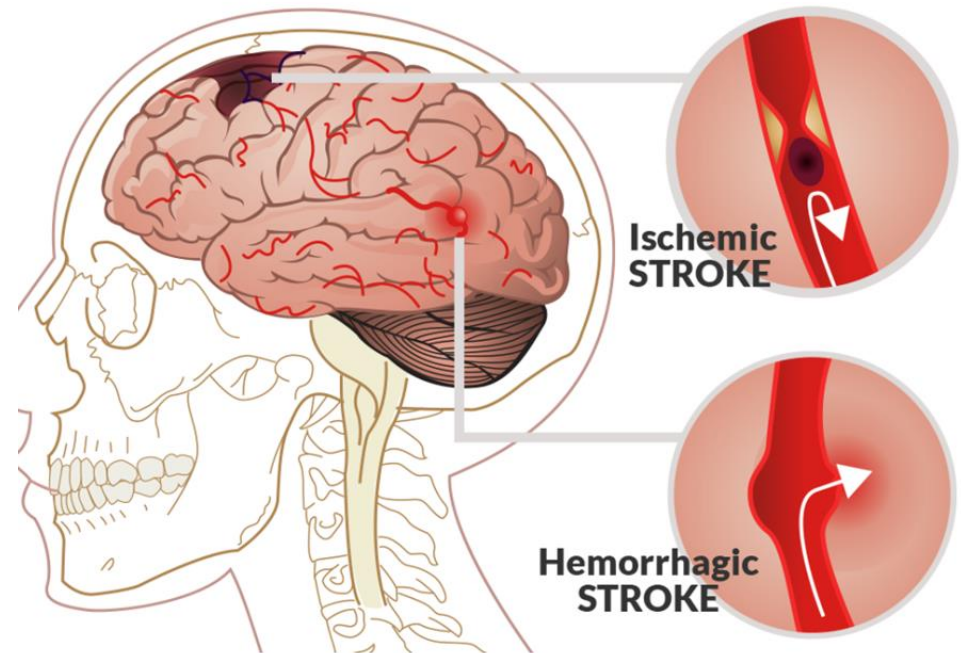
- brain attack
- occurs when there is an interruption of blood supply to part of the brain
- this means there is a lack of oxygen delivered to the affected part of the brain
- brain cells (neurons) in the area affected start dying within minutes



Types of stroke

Ischaemic (80%)

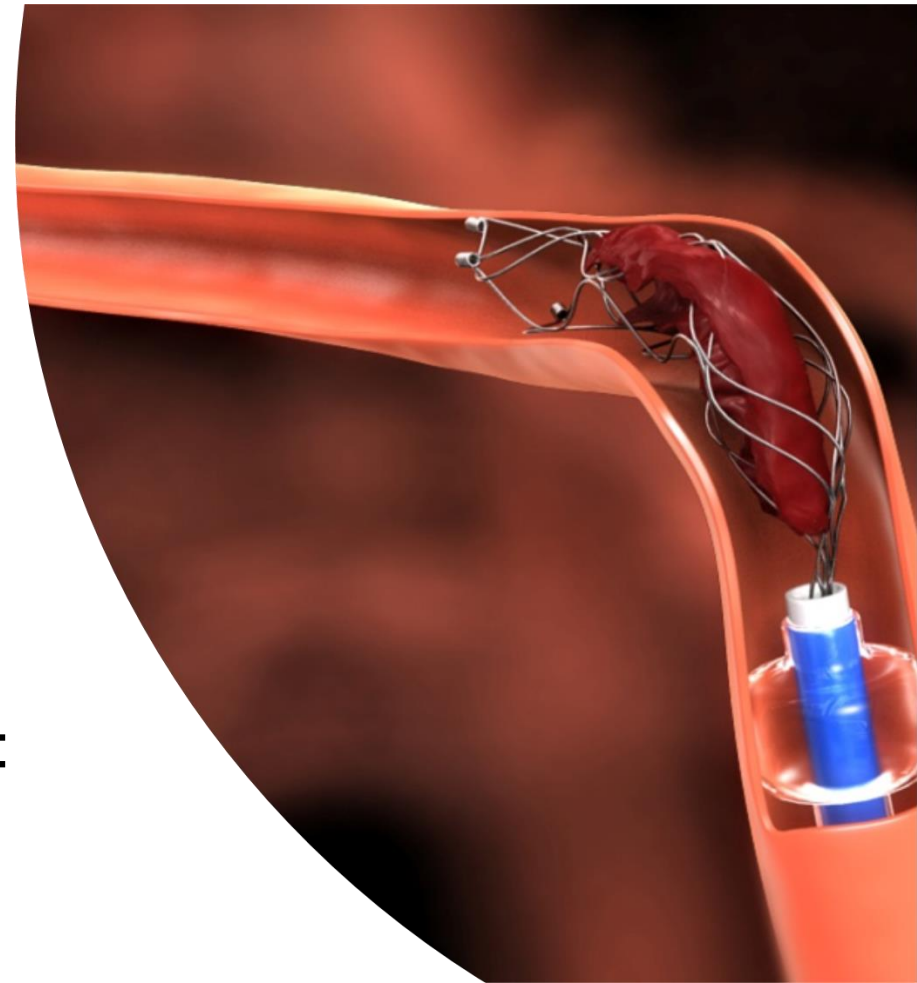
Haemorrhagic (20%)



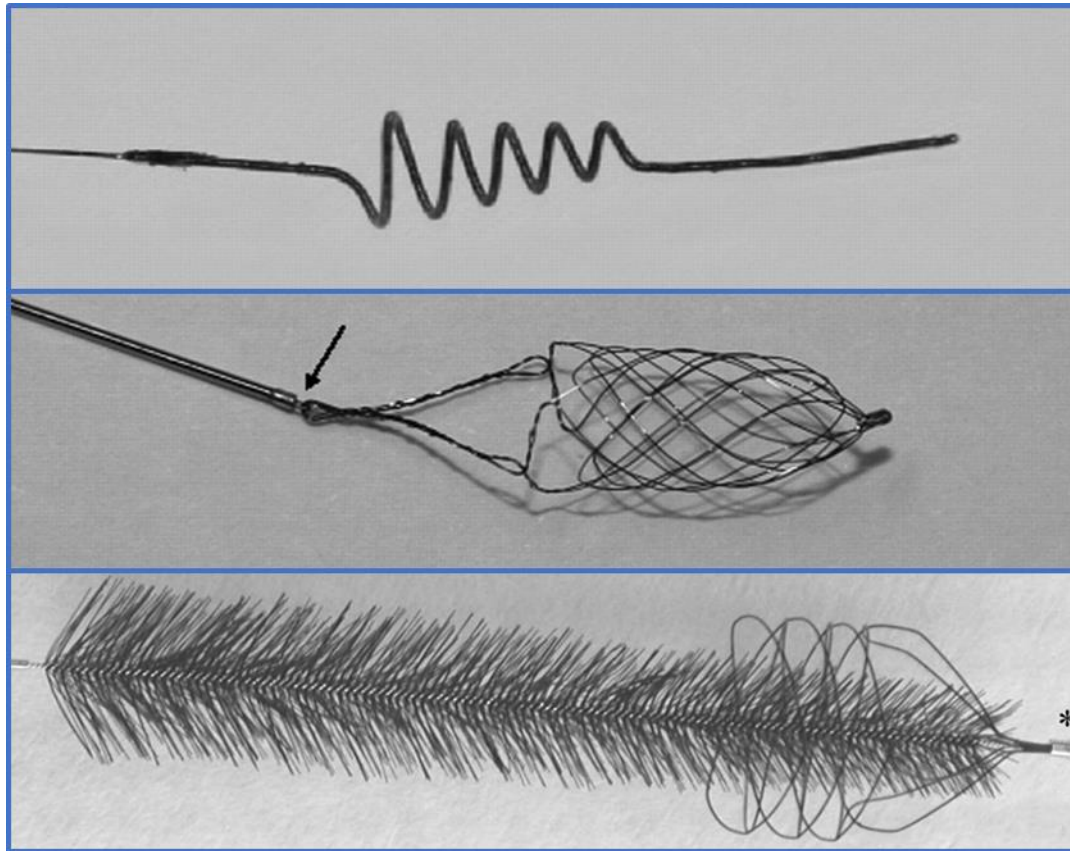
BRAIN **STROKE**

Treatment of ischaemic stroke

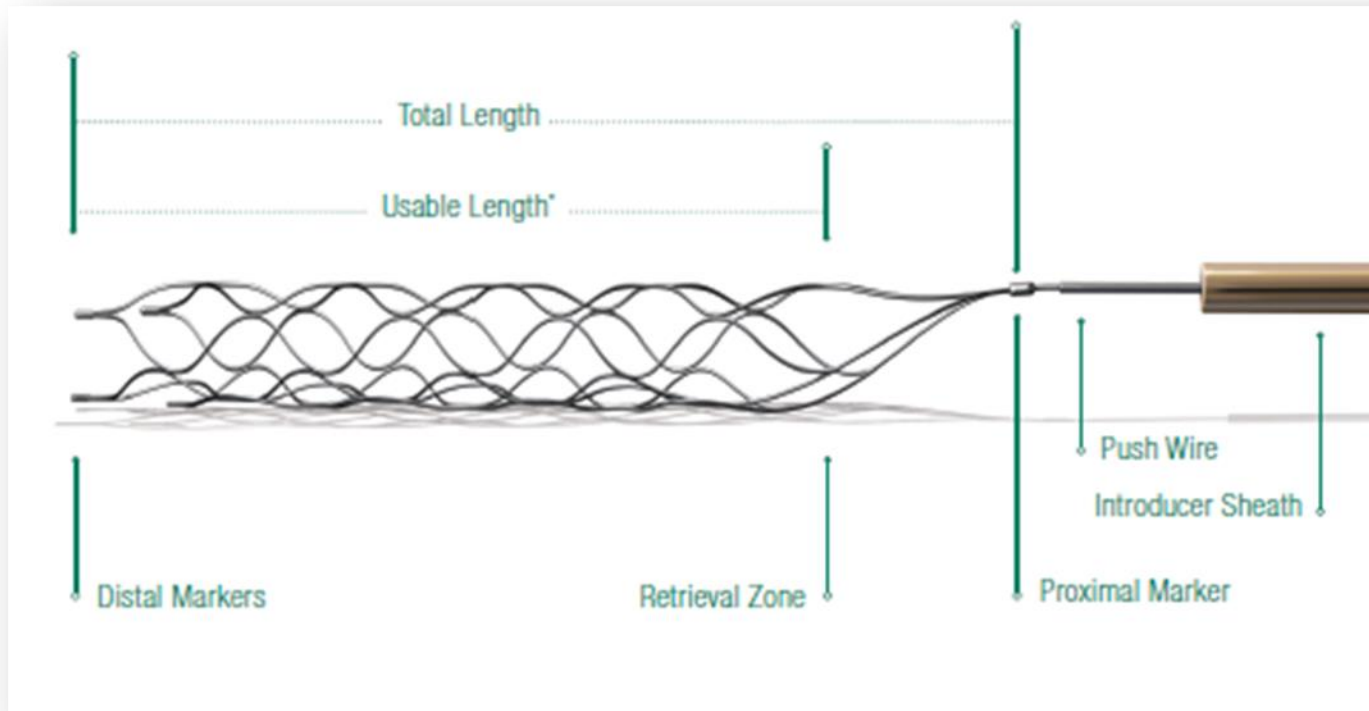
- treatments are time dependent and aim to restore blood flow to the brain
- gold standard treatment 'clot busting medicines'until recently
- new and exciting development: mechanical thrombectomy



Old generation thrombectomy devices

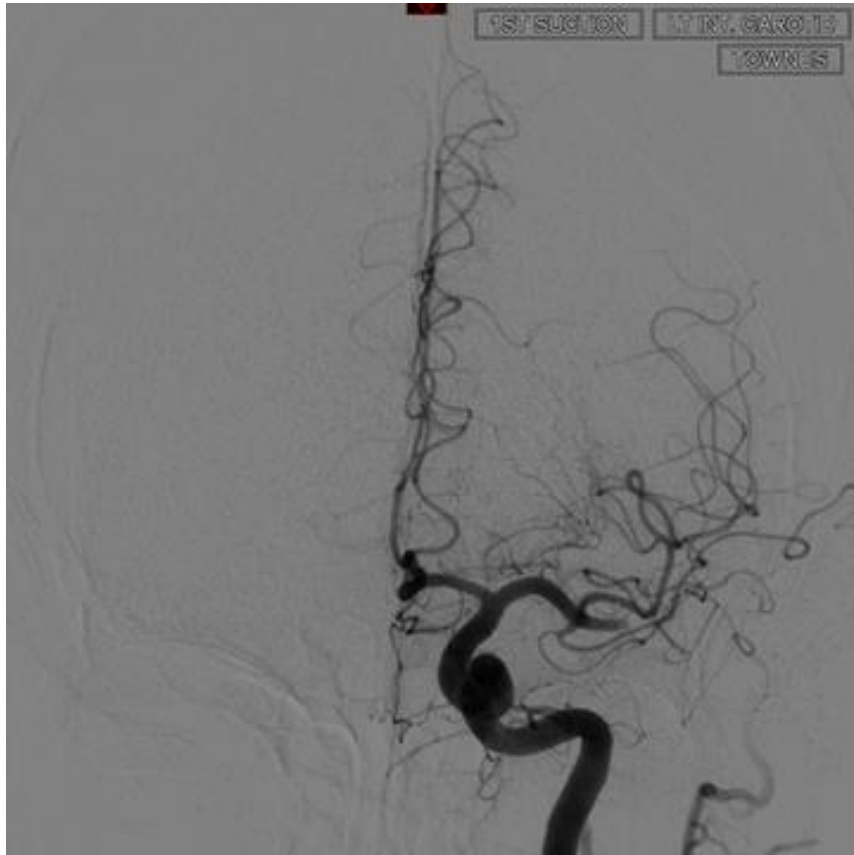


New generation devices - stentriever

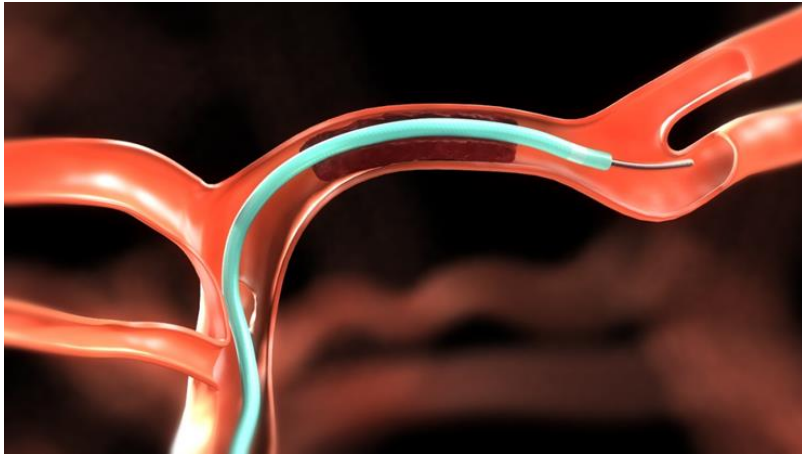


Source: 1ev3 Design Specification: PS08-001F, Solitaire FR IFU
All images are the property of ev3

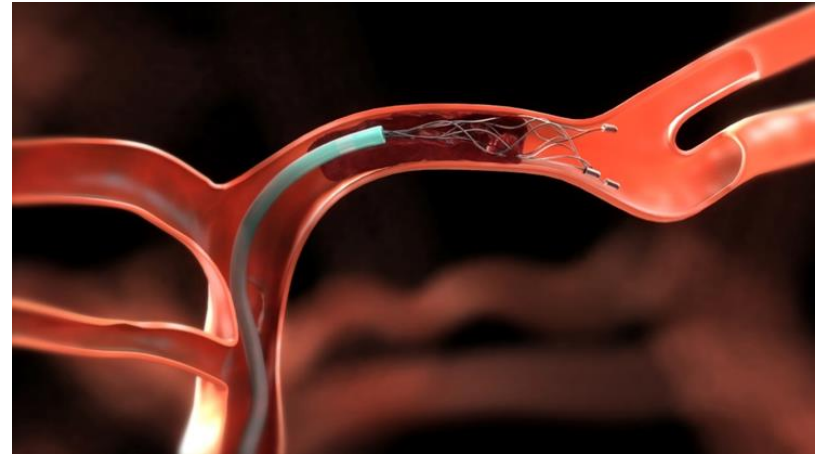
Mechanical thrombectomy



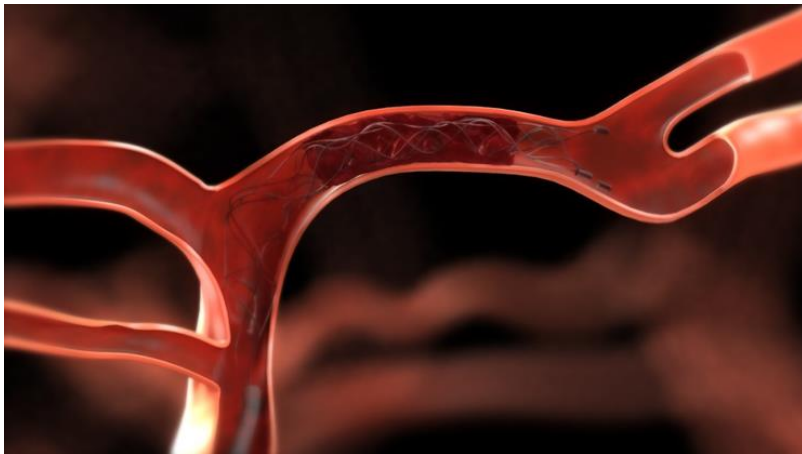
How stentriever work



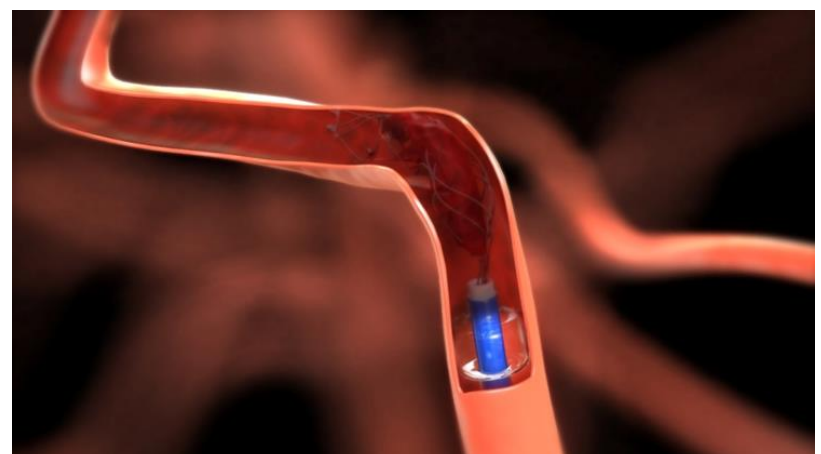
1



2



3



4

How stentriever work



What is the evidence?



BACKGROUND
In patients with acute ischemic stroke caused by a proximal intracranial arterial occlusion, intraarterial treatment is highly effective for emergency revascularization. However, proof of a beneficial effect on functional outcome is lacking.

METHODS
We randomly assigned eligible patients to either intraarterial treatment plus usual care or usual care alone. Eligible patients had a proximal arterial occlusion in the anterior cerebral circulation that was confirmed on vessel imaging and that could be treated intraarterially within 6 hours after symptom onset. The primary outcome was the modified Rankin scale score at 90 days; this categorical scale measures functional outcome, with scores ranging from 0 (no symptoms) to 6 (death). The treatment effect was estimated with ordinal logistic regression as a common odds ratio, adjusted for prespecified prognostic factors. The adjusted common odds ratio measured the likelihood that intraarterial treatment would lead to lower modified Rankin scores, as compared with usual care alone (shift analysis).

RESULTS
We enrolled 500 patients at 16 medical centers in the Netherlands (233 assigned to intraarterial treatment and 267 to usual care alone). The mean age was 65 years (range, 23 to 96), and 445 patients (89.0%) were treated with intravenous alteplase before randomization. Retrievable stents were used in 190 of the 233 patients (81.5%) assigned to intraarterial treatment. The adjusted common odds ratio was 1.67 (95% confidence interval [CI], 1.21 to 2.30). There was an absolute difference of 13.5 percentage points (95% CI, 5.9 to 21.2) in the rate of functional independence (modified Rankin score, 0 to 2) in favor of the intervention (32.0% vs. 18.5%). There were no significant differences in mortality or the occurrence of symptomatic intracerebral hemorrhage.

CONCLUSIONS
In patients with acute ischemic stroke caused by a proximal intracranial occlusion of the anterior circulation, intraarterial treatment administered within 6 hours after stroke onset was effective and safe. (Funded by the Dutch Heart Foundation and others; MR CLEAN Netherlands Trial Registry number, NTR1804, and Current Controlled Trials number, ISRCTN10888758.)

The New England Journal of Medicine
Downloaded from nejm.org on June 15, 2016. For personal use only. No other uses without permission.
Copyright © 2015 Massachusetts Medical Society. All rights reserved.



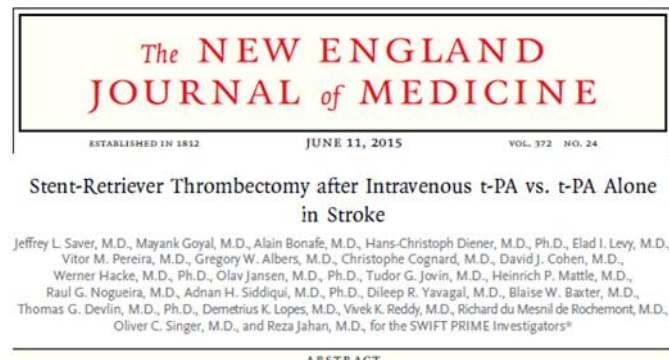
BACKGROUND
In patients with acute ischemic stroke due to occlusions in the proximal anterior intracranial circulation, less than 40% regain functional independence when treated with intravenous tissue plasminogen activator (t-PA) alone. Thrombectomy with the use of a stent retriever, in addition to intravenous t-PA, increases reperfusion rates and may improve long-term functional outcome.

METHODS
We randomly assigned eligible patients with stroke who were receiving or had received intravenous t-PA to continue with t-PA alone (control group) or to undergo endovascular thrombectomy with the use of a stent retriever within 6 hours after symptom onset (intervention group). Patients had confirmed occlusions in the proximal anterior intracranial circulation and an absence of large ischemic-core lesions. The primary outcome was the severity of global disability at 90 days, as assessed by means of the modified Rankin scale (with scores ranging from 0 [no symptoms] to 6 [death]).

RESULTS
The study was stopped early because of efficacy. At 39 centers, 196 patients underwent randomization (98 patients in each group). In the intervention group, the median time from qualifying imaging to groin puncture was 57 minutes, and the rate of substantial reperfusion at the end of the procedure was 88%. Thrombectomy with the stent retriever plus intravenous t-PA reduced disability at 90 days over the entire range of scores on the modified Rankin scale (P<0.001). The rate of functional independence (modified Rankin scale score, 0 to 2) was higher in the intervention group than in the control group (60% vs. 35%, P<0.001). There were no significant between-group differences in 90-day mortality (9% vs. 12%, P=0.50) or symptomatic intracranial hemorrhage (0% vs. 3%, P=0.12).

CONCLUSIONS
In patients receiving intravenous t-PA for acute ischemic stroke due to occlusions in the proximal anterior intracranial circulation, thrombectomy with a stent retriever within 6 hours after onset improved functional outcome at 90 days. (Funded by Covidien; SWIFT PRIME Clinical Trials.gov number, NCT01657461.)

CONCLUSIONS
Among patients with anterior circulation stroke who could be treated within 8 hours after symptom onset, stent retriever thrombectomy reduced the severity of poststroke disability and increased the rate of functional independence. (Funded by Fundació Icnus Malaltia Vascular through an unrestricted grant from Covidien and others; REVASCAT ClinicalTrials.gov number, NCT01692379.)



BACKGROUND
Among patients with acute ischemic stroke due to occlusions in the proximal anterior intracranial circulation, less than 40% regain functional independence when treated with intravenous tissue plasminogen activator (t-PA) alone. Thrombectomy with the use of a stent retriever, in addition to intravenous t-PA, increases reperfusion rates and may improve long-term functional outcome.

METHODS
We randomly assigned eligible patients with stroke who were receiving or had received intravenous t-PA to continue with t-PA alone (control group) or to undergo endovascular thrombectomy with the use of a stent retriever within 6 hours after symptom onset (intervention group). Patients had confirmed occlusions in the proximal anterior intracranial circulation and an absence of large ischemic-core lesions. The primary outcome was the severity of global disability at 90 days, as assessed by means of the modified Rankin scale (with scores ranging from 0 [no symptoms] to 6 [death]).

RESULTS
The study was stopped early because of efficacy. At 39 centers, 196 patients underwent randomization (98 patients in each group). In the intervention group, the median time from qualifying imaging to groin puncture was 57 minutes, and the rate of substantial reperfusion at the end of the procedure was 88%. Thrombectomy with the stent retriever plus intravenous t-PA reduced disability at 90 days over the entire range of scores on the modified Rankin scale (P<0.001). The rate of functional independence (modified Rankin scale score, 0 to 2) was higher in the intervention group than in the control group (60% vs. 35%, P<0.001). There were no significant between-group differences in 90-day mortality (9% vs. 12%, P=0.50) or symptomatic intracranial hemorrhage (0% vs. 3%, P=0.12).

CONCLUSIONS
In patients receiving intravenous t-PA for acute ischemic stroke due to occlusions in the proximal anterior intracranial circulation, thrombectomy with a stent retriever within 6 hours after onset improved functional outcome at 90 days. (Funded by Covidien; SWIFT PRIME Clinical Trials.gov number, NCT01657461.)

CONCLUSIONS
Among patients with anterior circulation stroke who could be treated within 8 hours after symptom onset, stent retriever thrombectomy reduced the severity of poststroke disability and increased the rate of functional independence. (Funded by Fundació Icnus Malaltia Vascular through an unrestricted grant from Covidien and others; REVASCAT ClinicalTrials.gov number, NCT01692379.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Saver at the UCLA Stroke Center, 710 Westwood Plaza, Los Angeles, CA 90095, or at jsaver@mednet.ucla.edu.

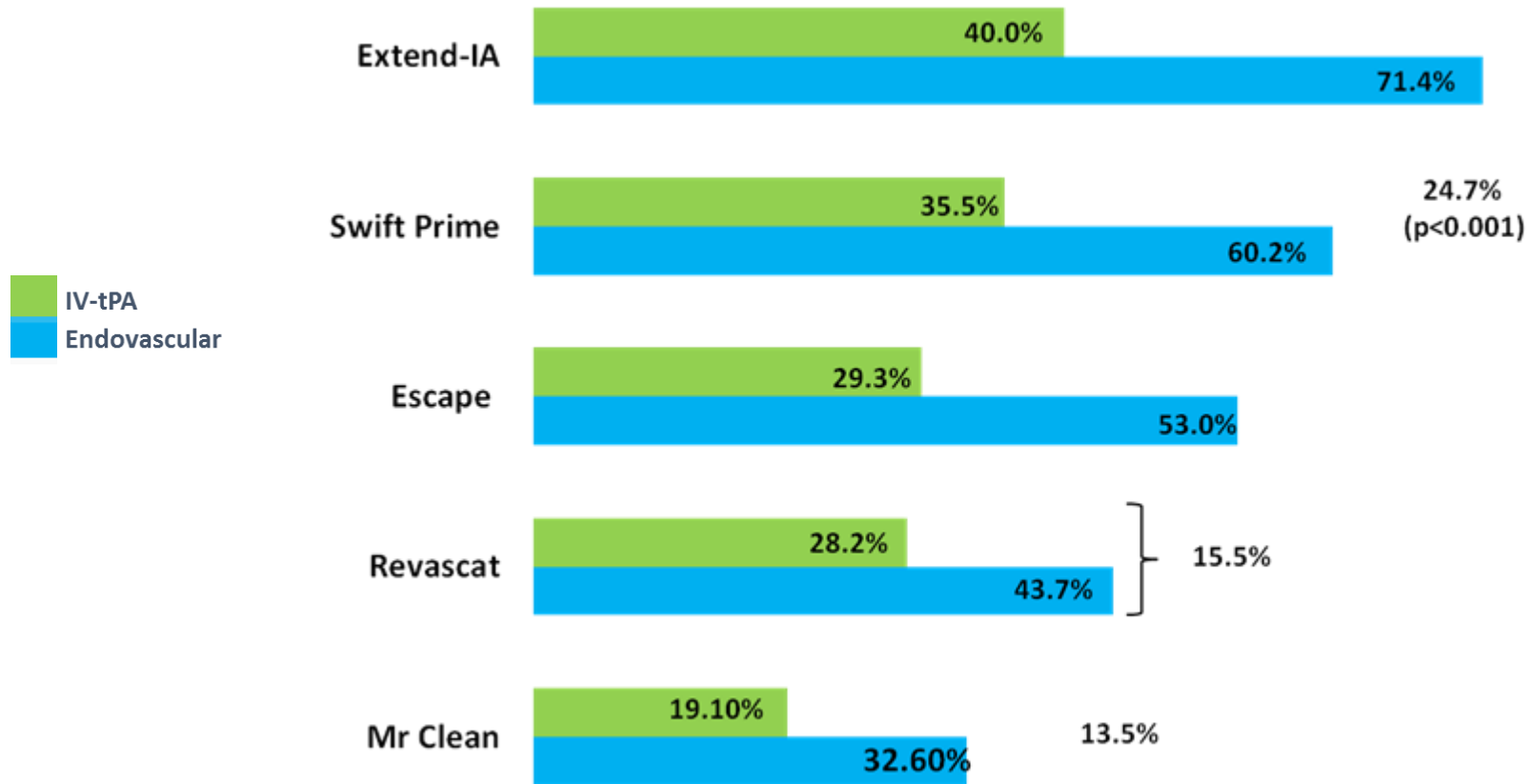
Drs. Saver and Goyal contributed equally to this article.

*A complete list of investigators in the Solitaire with the Intention for Thrombectomy as Primary Endovascular Treatment (SWIFT PRIME) trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on April 17, 2015, at NEJM.org.

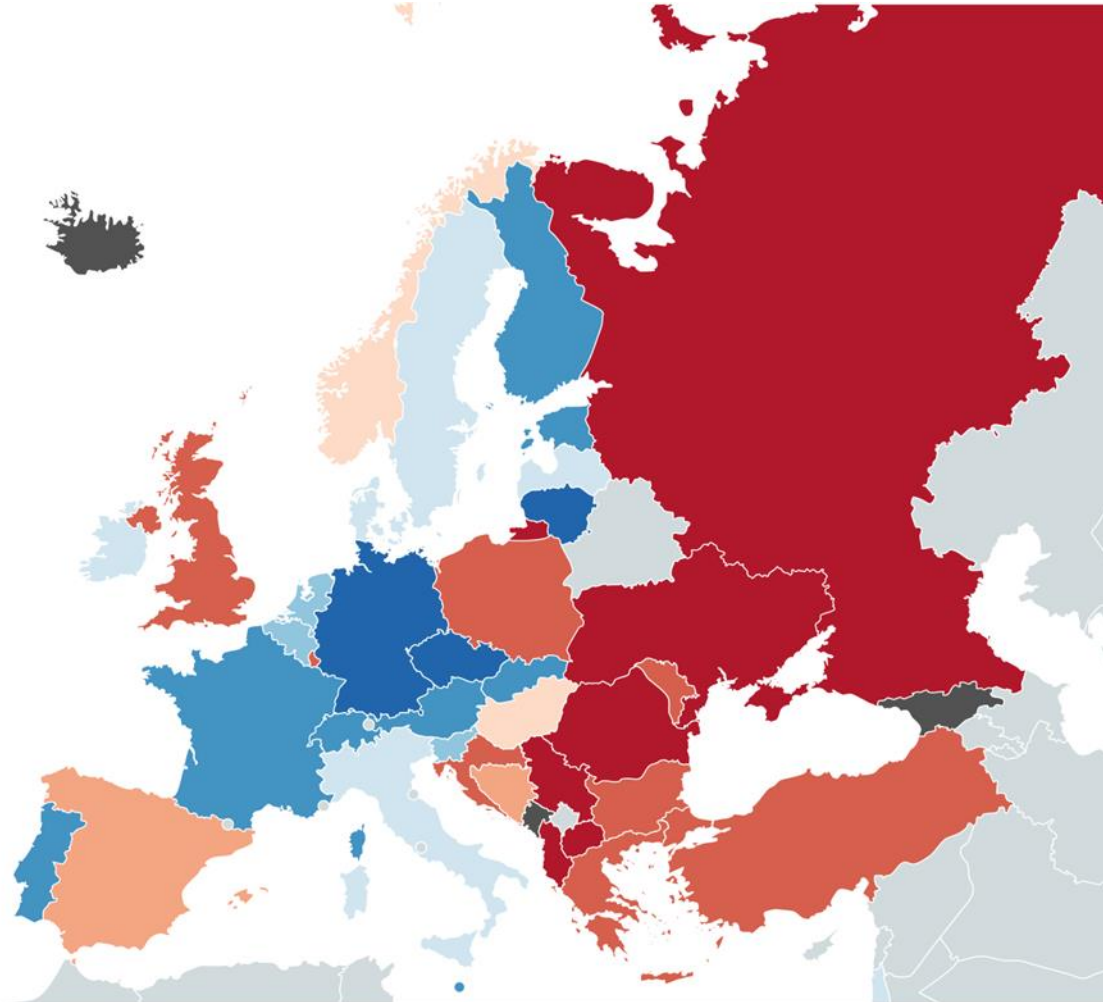
N Engl J Med 2015;372:2285-95.
DOI: 10.1056/NEJMoa1515061
Copyright © 2015 Massachusetts Medical Society.

What is the evidence?



Thrombectomy in Europe

Number of EVT/Year/1 Mio inhabitants



Created with mapchart.net ©

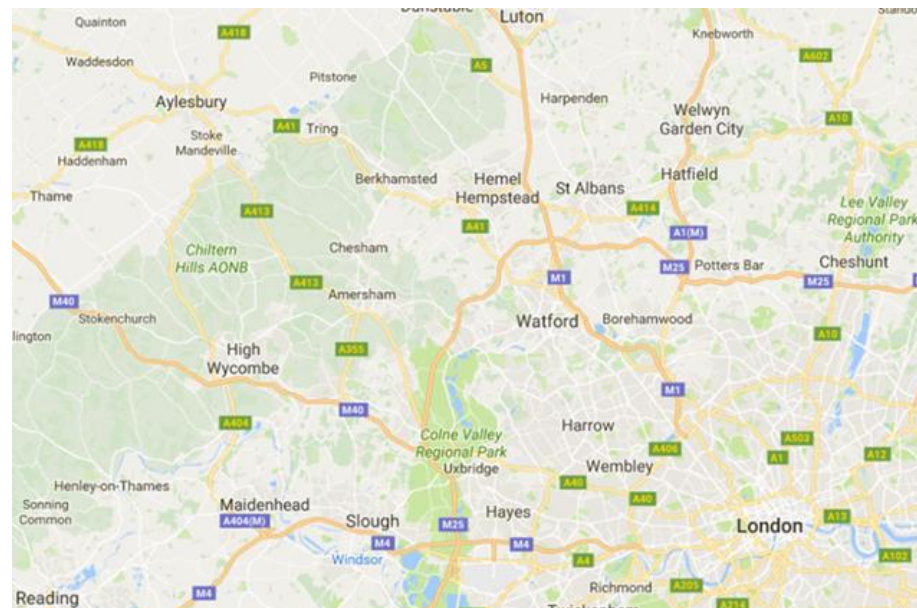
*2015

Our thrombectomy service

- available seven days a week, from 7am to 11pm
- patients need to arrive within 5 hours of onset of symptoms
- usually given clot busting drugs first
- thrombectomy is suitable if scan shows a clot in a large vessel

Our external referrers

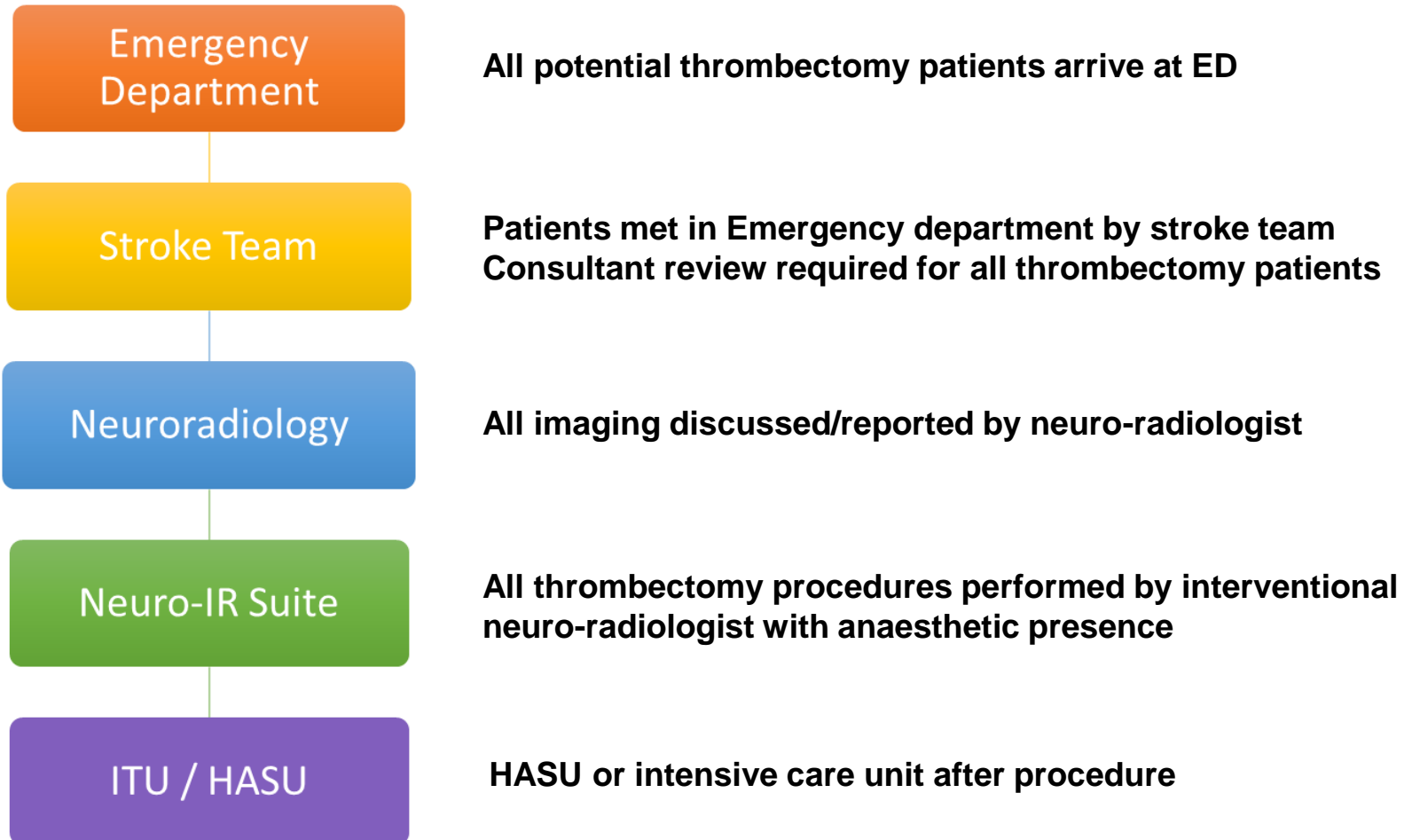
Stroke centre	Distance
Northwick Park	10 miles
Watford	22 miles
Wycombe	31 miles
Luton	37 miles
Reading	37 miles
Lister	38 miles



Our service at Charing Cross Hospital

- hyper acute stroke unit (HASU)
- neuroradiology and interventional neuroradiology
- anaesthetics and intensive care unit
- neurosurgery

Team and pathway



Case presentation

- 46-year-old right handed woman
- 11:00 am – at work, cleaning
- sudden onset of left sided weakness
- initially reluctant to call ambulance

On arrival

- right middle cerebral syndrome
- left sided weakness (face, arm, leg)
- dysarthria
- NIHSS score: 16
(a large stroke)
- urgent CT brain



Treatment

- immediate thrombolysis (clot busting drug)
- decision made to proceed with mechanical thrombectomy under local anaesthetic
- transferred to angiography suite

Mechanical thrombectomy



16:13pm

16:44pm

Post procedure progress

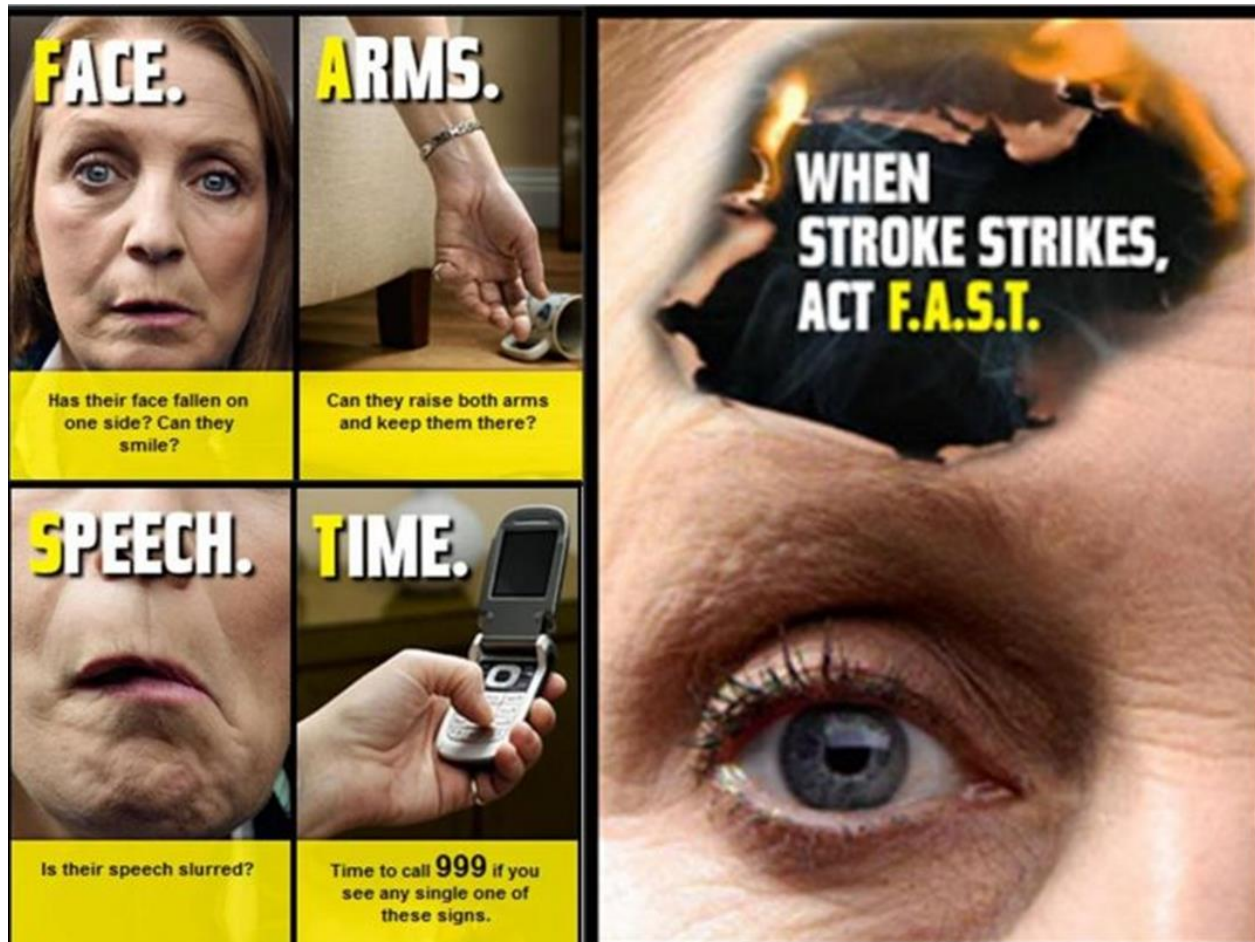
- immediate improvement whilst still in angiography suite
- able to move left side
- mild difficulty in speech
- discharged from hospital after 2 days



What could have happened



Early recognition of symptoms is vital



Public Health England FAST campaign

Conclusions

- ‘time is brain’
- thrombectomy is a ‘game-changer’ for stroke treatments
- immediate challenge is the delivery of 24/7 thrombectomy service locally & nationwide
- future NHS must continue to support research and innovation

Thank you

Sir Richard Sykes

Chairman