NHS
Imperial College Healthcare
NHS Trust

2022/23

Annual report

Our annual report for 2022/23 is dedicated to the commitment and expertise of all of our people. We pay special recognition to our colleagues who have died this year and celebrate their lives and contribution to the NHS:

- Adassa Clarke
- Andrea Francis
- Andrew Wooley
- Anthony Vecsey
- Belinda Adjapong
- Benigno Antonio Alvarado
- Dora Osei
- Janet Akintola
- Juliet Chanayil
- Liza Baculio
- Mark Mason
- Mary (Ikponmwosa) Adeyemi
- Prafful Bharkhda
- Professor Justin Mason
- Shirley Eccles
- Terence (Terry) Facey
- Thomas Howley

Contents

Welcome

Matthew Swindells, Chair

When I took up my new role last April, I knew it would be an interesting mix of challenge and opportunity. It has already surpassed my expectations – on both counts.

As with the rest of the NHS, many of our challenges are deep rooted – financial pressures, difficulties in recruitment, an aging estate. But there are more recent ones too. Though the pandemic is now officially over, its impact remains. We see it in our waiting lists the increasing complexity of need amongst our patients and wide inequalities in health and access to healthcare within our communities.

Allied to the growing needs of our population is the mental and physical exhaustion of our workforce. The expertise and commitment to patients is still very much there but there is also a tiredness that comes from the equivalent of a three-year major incident and, as indicated by the recent waves of industrial action, a growing dissatisfaction with pay and conditions.

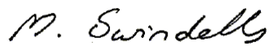
The answers to many of these challenges have also been taking form during the pandemic. Greater collaboration, an openness to new ways of working and a firm commitment to evidence-based improvement, helped us tackle Covid-19 and it is helping us now as we recover from the impact of the pandemic.

My appointment last April was to a new role – the first chair in common for all four acute NHS trusts in north west London. In the year that has followed, we have become a formal collaborative with a board in common and increasingly close working across our executive and clinical teams. We know there is more to do to get the right balance of collaborative and local oversight and to empower our staff on the frontline while also driving strategic change. But I have already been hugely impressed by how well the four trusts have responded to thinking at scale while remaining firmly anchored in their own communities.

In the past year, the Collaborative has played a key role in ensuring north west London is one of the highest performing sectors in the NHS in terms of returning to pre-pandemic levels of planned care activity. In partnership with our stakeholders, we have led on sector-wide changes to inpatient orthopaedic surgery that will make better use of our collective resources so that we can provide better care, for more people, more quickly. And by aligning performance management, we are now routinely identifying important, new areas for improvement and spreading best practice more rapidly. The roll out of a common electronic patient record system this summer will support a further step change in integrated working across all 12 of the Collaborative's hospitals.

For staff, too, the Collaborative is bringing benefits, from greater and more varied career and development opportunities to increased potential for helping to shape and implement new models of care and new roles. And, drawing on lessons from the pandemic again, we are committed to using our collective resources and collaborative approach to do more to support staff health and wellbeing, to be fairer, more inclusive employers and to show how much we value our people.

The past year has demonstrated how much we can achieve by bringing together our amazing staff to work with, and for, our local communities towards common goals. I feel even more sure than I did this time last year that we can create one of the best health systems in the world. Thank you to all our staff, our leadership team and board and our many partners, volunteers and, of course, patients.



Matthew Swindells, Chair
29 June 2023

PERFORMANCE REPORT

Overview

Professor Tim Orchard, Chief executive

The performance overview gives a summary of our performance in 2022/23 including an outline of the Trust's purpose and activities.
If I had to sum up 2022/23 in one, simple message, it would be – it's been another tough year but we're continuing to make some great progress. It often feels like two steps forward, one step back, but it is still movement in the right direction. In such an uncertain environment, this is no small achievement.

Tackling the tough issues

The tough issues that we, like the rest of the NHS, are dealing with are well documented. The pandemic has left us with a big and growing waiting list for planned care – 98,000 people as of March 2023, compared with 82,500 in March 2022 – and some associated data quality challenges, which we are focusing on as a priority as outlined in the annual governance statement. We have done well to increase our activity to, or very near to, pre-pandemic levels and this has helped us to virtually eliminate two year waits and we're not far off doing the same for over 78-week waits.

We have also struggled to meet national waiting times standards for cancer care but a spectacular effort this winter saw us achieve – and maintain – performance well above the faster diagnosis target. The latest data, for March 2023, showed that three out of four patients referred to us with cancer symptoms now have a definitive diagnosis within 28 days of referral. That is hugely important for our patients, whatever their outcome, and I am determined that we make similar progress in reducing waits for the treatment stages of our cancer pathways.

Demand for our accident and emergency services has remained high throughout the year. Many of our patients have complex needs and, in particular, we have found patients with mental health problems are spending longer in our A&E departments. Again, our current performance data is unrecognisable from our regular data reporting before the pandemic. After a break, while we were part of a national pilot, we've recently returned to reporting on the proportion of A&E patients who are admitted, or treated and discharged, within four hours of arrival – as of May 2023, we were at 74 per cent, against a national target of 76 per cent. Before Covid-19, we regularly achieved the then national target of 95 per cent.

Clearly, we have some way to go but it's important to recognise that our A&E performance is moving in the right direction. I also want to highlight the great efforts by the teams at both Charing Cross and St Mary's A&E who have consistently delivered some of the fastest ambulance handover times in London. This is important because it means that ambulances are released to go back on the road to help patients. All of this has been down to hard work and sustained focus, within our emergency departments and across our wider services and partnerships. We have also continued to develop alternatives to A&E and hospital admission and to improve care for those who are waiting. That includes expanding our same day emergency care (SDEC) units, that are now seeing more than 100 patients a day as 'urgent outpatients'; establishing a route for London Ambulance Service to take suitable patients directly to SDEC, bypassing A&E; increasing our use of 'virtual wards', with over 1,600 patients benefiting last year from staying in their own home while having their treatment and being monitored digitally; and new safe spaces – including one just about to open on our own campus at St Mary's Hospital – for A&E patients with mental health needs.

One of our toughest challenges arose at the end of the year and has continued into our new year – the biggest ever wave of industrial action in the NHS. As of May 2023, we have had to postpone over 13,000 appointment and operations due to strikes over the past few months. We support the right of our staff to strike and have focused on continuing to deliver safe care during the periods of industrial action, making sure we are being fair in how we organise cover.

Whilst there are clearly longstanding national issues for staff, which have been the focus of industrial action, and intensified by the recent cost of living crises, at a local level we are doing more than ever to support our staff, including through our expanded wellbeing offer. We have also continued to embed our organisational values and behaviours – co-designed over several years with thousands of staff as well as lay partners and other stakeholders. I believe this is at the heart of another set of encouraging national staff survey results last year. We had our biggest ever response rate – well above the national average. And we had increased scores for the themes, 'we are compassionate and inclusive', 'we are always learning' and 'we are a team', and above average scores in five out of nine categories, up from three out of nine categories the previous year. We were third highest amongst NHS trusts in London for staff recommending their organisation as a place to work, with the joint highest in-year improvement.

Importantly, we also saw some encouraging improvement in staff perceptions of fairness and equity in the staff survey. I believe this is also down to several years of work, starting with the appointment of our first dedicated equality, diversity and inclusion team. The team, with senior leadership support, have implemented a wide range of changes. One of the most impactful has been our inclusive recruitment policy. Any manager recruiting to a role at band 7 and above must complete a short report for me, generally referred to now, slightly disconcertingly, as a 'Dear Tim letter'. It is to confirm that the interview panel was suitably diverse and to explain how they have ensured inclusivity throughout the recruitment process. The approach is helping us to improve diversity at senior levels, with the proportion of appointments to band 7 or higher roles who are from Black, Asian or minority ethnic backgrounds increasing from 44 per cent in March 2022 to 54 per cent in March 2023.

Collaboration is one of our four organisational values and it has been very much at the fore in the past year's achievements. Increasing joint working with our three acute trust partners in north west London has matured into our formal acute provider collaborative. And we have begun to deliver genuinely joint projects, the most significant so far is our detailed plan to bring together low complexity orthopaedic surgery at a new, purpose-designed elective orthopaedic centre at Central Middlesex Hospital to improve outcomes and reduce waits for patients across north west London.

Research and innovation are core to our mission and last year saw a significant increase in funding from the National Institute for Health and Care Research (NIHR) for the Imperial Biomedical Research Centre, our partnership with Imperial College to translate scientific breakthroughs into new treatments, diagnostics and medical technologies. Our latest five-year funding of £95m was NIHR's largest award in the programme and we were praised for evidence of collaboration, our responsiveness to patient needs and commitment to greater inclusion. I was particularly delighted by this achievement – it is a validation of our changing organisational culture and will enable our ground-breaking research to have even more impact and engage even more people.

Strong foundations to support continuing progress in an uncertain future

As we look ahead to the coming year and beyond, we will continue to focus on achieving sustainable change rather than short-term fixes. As well as our ongoing operational challenges, our finances are much tighter and there is a worrying backdrop of growing public dissatisfaction with the NHS. According to analysis of the annual British Social Attitudes Survey by the Nuffield Trust and The Kings Fund, overall satisfaction with the NHS now stands at 29 per cent, a drop of seven percentage points on the previous year and the lowest ever level since the survey began in 1983. Over two-thirds of respondents chose long waiting times for GP and hospital appointments as one of the top reasons for dissatisfaction.

I also want to highlight the growing risk to our estate as we struggle to progress our plans for redevelopment. All three of our main hospitals are part of the government's New Hospital Programme, but any redevelopment will take time. Our estates team have done a brilliant job in maintaining our aging facilities as best they can and our clinical teams – and patients – continue to endure some pretty terrible environments (with special mention to staff and patients of the Western Eye Hospital, where we had to close most of the facilities last year to allow urgent remedial works – we are delighted that this will be reopening with a new operating theatre). With an expenditure of over £18m a year now on the most urgent of repairs, we need to be able to progress our plans for building and refurbishment very soon.

Looking ahead

Given everything I have said, our priorities for the coming year are therefore very similar to the previous year. They are a clear reflection of our long standing strategic vision – to achieve better health, for life – and our three strategic goals. They also reflect our commitment to focus as much on how we achieve our priorities as on what they are intended to achieve.

We will tackle the longer waits in planned care as well as delays in our pressured urgent and emergency care pathways; progress plans to build a motivated, healthy and inclusive workforce for the long term; and find a way to progress much needed redevelopment while mitigating the deterioration of our aging estate as best we can. In terms of the 'how', we will continue to strengthen our focus on the needs of our patients and wider 'users', reduce health inequity, join up care across providers, especially as part of our acute provide collaborative; and use our financial and other resources more sustainably.

The tough issues aren't going to go away and some – like our financial pressures – will be even tougher this year. But, by making the best use of our collective resources and expertise, within our own organisation and in partnership with others, we know we can continue to make progress.

Professor Tim Orchard, Chief executive
29 June 2023

North West London Acute Provider Collaborative

The four acute trusts in north west London came together formally as an acute provider collaborative, with a chair and board in common, on 1 September 2022. This approach means each trust remains an independent organisation, working closely with our local authorities, patient groups, and other partners, while also being able to make more effective use of our collective resources to provide better care, for more people, more fairly.

The Collaborative is strengthening and expanding achievements we had begun to make through closer partnership working during the Covid-19 pandemic. Over the past year, our collaborative approach has helped us to:

- Offer patients waiting for an operation in a trust where capacity for a particular service is limited, the chance to have their operation sooner, in a hospital managed by one of the other partners where there is more capacity for that service. All four trusts virtually eliminated waits of more than two years last year and are now focusing on eliminating waits of more than 18 months.
- Develop and progress plans to bring together much of the routine, inpatient orthopaedic surgery for north west London in a purpose-built centre of excellence at Central Middlesex Hospital. Establishing this new, 41-bed, elective orthopaedic centre will help us improve outcomes and reduce waiting times for all orthopaedic surgery. The plans drew on feedback from a 13-week public consultation and were approved by NHS North West London in March 2023. The new centre is set to open in autumn 2023.
- Set up a clinical peer review process to share best practice and innovation within specific services more systematically. The peer review of accident and emergency services involving senior clinicians from all seven A&E departments run by the Collaborative took place between October and December 2022. Seven broad themes for collaborative improvement were identified plus a range of more immediate actions to help progress key goals, such as reducing delays.
- Develop and progress plans for three community diagnostic centres to provide additional capacity for north west London and to improve access, especially for communities living in areas with the highest deprivation who have traditionally been less well served. The new centres – in Willesden, Wembley and Ealing – are set to open in the coming year and provide a range of services, including x-ray, CT, ultrasound and MRI scans.
- Prepare to roll out the same electronic health record system that is already in place at Imperial College Healthcare and Chelsea and Westminster Hospital to The Hillingdon Hospitals and London North West University Healthcare. The implementation – due to take place this summer – will support a further step change in integrated working across all 12 of the Collaborative's hospitals, with huge benefits for both staff and patients.

Our leadership teams are also now working together more systematically, focused on four areas: quality; people; finance and operational performance; and infrastructure. With each work area led by one of the trust chief executives, we are aligning our approach to measuring performance and impact and gathering user insights to help us identify and prioritise shared and local challenges as well as solutions and best practice. Already this more integrated working has helped all four trusts to deliver our financial plans for 2022/23 and agree coordinated financial plans for the year ahead, while also being one of the highest performing sectors in the NHS in terms of returning to pre-pandemic levels of planned care activity.

Our Collaborative priorities for next year include:

- **Quality:** improving care for deteriorating patients and end of life care; standardising processes for clinical harm and mortality reviews; more effectively gathering and responding to the needs and preferences of our patients and local communities; building on our inpatient orthopaedic surgery programme, to co-design improved ways of working on other clinical pathways to increase quality and reduce unwarranted variation.
- **Infrastructure:** improving the quality and efficiency of core administration and other common IT systems through standardisation and integration wherever appropriate; exploring opportunities for better use of our collective estate; developing shared solutions to help us meet carbon emission targets.
- **Finance and operational performance:** exploring further consolidation of shared functions, including securing the anticipated benefits from a new, north west London procurement hub; improving discharge planning and ensuring patients are able to be discharged as soon as they are medically ready to go home or to community-based services.
- **People:** establishing a shared recruitment hub to help reduce hard-to-fill vacancies; developing a shared careers hub and staff transfer scheme; improving use of the apprenticeship levy; joint approaches to tackling violence, aggression, bullying and discrimination.

About the Trust

At Imperial College Healthcare NHS Trust we provide acute and specialist healthcare to over 1.3 million people a year. Formed in 2007, we are one of the largest NHS trusts in the country, with more than 15,000 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 offer private healthcare in dedicated facilities on all our sites.

We are a member of the North West London Acute Provider Collaborative, a collaborative partnership with the other acute NHS trusts in the sector – Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust. We work together to make the most effective use of our collective resources to provide better care, for more people, more fairly. Between us, we run 12 hospitals, employ 33,000 staff and serve a local population of over 2.2 million. We remain independent organisations with separate trust boards; however, we share a chair in common across the four acute providers and the boards operate within a board in common structure. More detail on the governance structure of the collaborative is included in the corporate governance report.

With 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 the 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, Hammersmith: provides 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 an important hub for integrated care in partnership with local GPs and community providers.

Hammersmith Hospital, Acton: 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, Acton: 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, Paddington: 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, Marylebone: a specialist eye hospital with an A&E department and outpatients, inpatients, day case and inpatient surgery services.

We run eight renal satellite units.

Private Care

Our Private Care division offers a wide range of services in dedicated facilities across our sites. These include The Lindo Wing at St Mary's Hospital, Thames View at Charing Cross Hospital and the Sainsbury Wing at Hammersmith Hospital. Our Private Care division allows us to extend our offer to those who are not eligible for NHS services or who choose private care for a variety of reasons. The income from private care is reinvested into all our services.

In the past year, we have been preparing to re-position our Private Care division to make it more clearly aligned with everything we do as a major teaching and research NHS hospitals trust. We also want to do more to explain and demonstrate the benefits this brings to both private and NHS patients and to our staff and local communities. We will be rolling out a new look and feel for our private care services this summer to reflect this positioning and help us build on our excellent reputation and have even more impact within London's growing private healthcare market.

Other developments last year to help us extend our offer include implementing a significant upgrade to our billing system, to improve patient and payer experience and reduce administration, and launching online reviews in partnership with Doctify to increase our online reputation and provide valuable patient insights.

Full-year revenue from our Private Care division in 2022/23 totalled £37.3m, compared to £37.7m in 2021/22. In 2022/23, our private care facilities and staff also supported the NHS more directly by providing over 1,500 bed nights of care for NHS patients across all three sites to help respond to emergency pressures.

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.

NIHR Imperial BRC was awarded £95.3 million investment by the NIHR in 2022. The five-year award will be used to support research that translates scientific discoveries into new treatments, diagnostics and medical technologies in order to improve patient care, locally and around the world.

Between April and November 2022, the NIHR Imperial BRC supported 789 clinical research projects across 14 different disease areas. Further information about the BRC's research activities through to April 2023 will be published in their annual report later this year.

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 2022/23, some 1,221 Imperial College London medical undergraduates trained with us. We had 572 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 2022/23, the Charity invested £4.6m in a wide range of initiatives for the benefit of patients and staff (full audited accounts will be available in the Charity's annual report).

The Charity funds major redevelopments, research and medical equipment at our hospitals 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 2022/23, we also received continued support both from COSMIC (formed by the merger of Children of St Mary's Intensive Care and the Winnicott Foundation) which raises 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.

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 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 guide and oversee our patient and public involvement strategy. It brings 12 lay partners together with senior staff from across the Trust and representatives from Imperial College and Imperial Health Charity, meeting formally every two months.

Lay partners on the forum and beyond are involved in a wide range of strategic programmes, projects and discussions. As of the end of 2022/23, the Trust had 72 lay partner roles supporting 38 projects. Since November 2016, we have engaged with 201 lay partners on various projects.

North West London Integrated Care System

The North West London Integrated Care System brings together all health and care organisations in the eight boroughs of north west London. 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 integrated care systems (ICSs).

The North West London Integrated Care System aims to deliver four key objectives, to:

- improve outcomes in population health and health care
- prevent ill health and tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader economic and social development.

The Integrated Care Board in North West London is called NHS North West London. It is the statutory NHS organisation responsible for developing a plan that meets the health needs of the local population, managing the NHS budget and arranging for the provision of health services in north west London.

Our regulators

The CQC is the independent regulator of health and adult social care in England. The CQC monitors NHS trust services using five quality domains: safe, effective, caring, responsive and well-led. Additionally, the CQC uses a well-led framework specifically for NHS trust executive teams and boards, which it developed and uses in conjunction with NHS England.

While the CQC continued to monitor trusts during 2022/23, it did not undertake any routine inspections this year. Inspections were only carried out if the CQC had serious concerns; the Trust was not subject to any such inspection apart from taking part in a national inspection programme of maternity services. This programme was launched in August 2022 for all maternity services in England that had not been inspected since April 2021, and involves assessment of two of the CQC's five domains: safe and well-led. As the Trust's last maternity inspection took place in 2019, we were included in the national inspection programme and our inspection took place in March 2023, covering our maternity services at St Mary's Hospital and Queen Charlotte's & Chelsea Hospital, including those delivered by Imperial Private Healthcare. The outcomes from this inspection are expected to be finalised in summer 2023.

The CQC inspects and awards ratings by site:

- any changes to the rating for the safe and/or well-led domain at St Mary's Hospital will not impact the overall ratings for these domains at this site, or for the site overall. There are a large number of services at this site and in light of the current ratings for the remaining services, changes to ratings for the maternity service will have no impact
- if the outcomes of our maternity inspection result in changes to the rating for the safe and/or well-led domain at Queen Charlotte's & Chelsea Hospital, the overall ratings for these domains at this site and for the site overall could be impacted, as there is only one other service at this site:
  - if the safe and/or well-led domain rating increase to 'outstanding', the overall rating for the domain at this site would also increase to 'outstanding'. There would be no change to the site overall rating, however, as the site overall rating is already 'outstanding'
  - if the safe and/or well-led domain rating drops to 'requires improvement' or 'inadequate', the overall rating for the domain at this site would also decrease and this would be expected to subsequently impact the overall rating for the site.

The CQC has indicated that overall ratings for trusts will not be impacted by the outcomes of these maternity inspections, as only two domains in a single service are being assessed. This means that the Trust's overall ratings will remain as they were in July 2019, after its inspection covering four services in February 2019 and its last well-led inspection of the executive team and board in April 2019:

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

Trust in numbers 2022/23*

Our services

1,339,000
Patient contacts
(including inpatients, outpatients and day cases)

264,000
Emergency attendees
(including A&E and ambulatory emergency care)

9,400
Babies born

32,600
Operations

96%
Positive overall rating of care for inpatients

*all rounded

Our staff

2,108
Admin and clerical

777
Allied health professionals (qualified)

123
Allied health professionals (support)

1,090
Ancillary

48
Doctor (career grade)

1,294
Doctor (consultant)

1,913
Doctor (Trust and training grade)

4,325
Nursing and midwifery (qualified)

1,260
Nursing and midwifery (support)

159
Pharmacist

9
Physician associate

888
Scientific and technical (qualified)

437
Scientific and technical (support)

782
Senior managers

15,213
Trust total

Our students

1,221
Medical students

572
Nurses in education, pre-registration

Our finances

£0.2m surplus
Out-turn
(deficit of £32.2m before adjustments for impairments etc.*)

£1.6bn
Turnover

£15.8m
Efficiencies**

£141.7m
Capital investments, including buildings, infrastructure and IT

Research

1,000
Clinical research studies

*NHS England monitors NHS trust financial performance using an adjusted measure, which 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.
** Efficiencies represent cost improvements achieved in the year to support the delivery of the break-even plan with the unmitigated gap offset through one-off non-recurrent measures.

Performance analysis

Introduction

The purpose of this section is to outline our framework for delivering safe, high quality care, comprising details of our strategic goals and core objectives. It includes assessments of our progress against standard performance management mechanisms and measurement tools as well as information relating to quality governance and data quality in the accountability report.

We regularly review performance information through our executive management board (EMB) and our board committees via an integrated quality and performance report (IQPR) as well as the feedback about the quality and performance of our services and activities at all levels of our organisation. The IQPR contains metrics as agreed by the Trust board and provides a narrative summary where there are risks to the achievement of these metrics. 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.

While the four acute NHS trusts in north west London have come together as an acute provider collaborative under a single board in common, each organisation has continued to publish trust-level performance data to help ensure continued local transparency and accountability.

Our executive management team regularly reviews a comprehensive set of quality and performance indicators known as our Trust scorecard. Our scorecard report is aligned with the Trust's strategic goals and improvement priorities.

Our chief operating officer has the lead executive responsibility to ensure we continue to improve our operational processes and performance in a rapidly changing healthcare landscape. This role provides oversight and co-ordination across our sites and clinical divisions as we have moved towards more integrated working at sector and regional levels.

Throughout the year, Covid-19 has continued to be a factor within our hospitals. Admissions due to Covid-19 spiked during the summer as predicted then decreased until increasing again during the winter. The number of patients requiring treatment in our intensive care units or requiring a ventilator has stayed consistently low.

The challenges of returning to pre-pandemic levels of elective activity meant our services remained under pressure across all hospital sites. We committed to delivering over 100 per cent of overall pre-pandemic planned care capacity throughout 2022/23 to help us achieve a sustainable reduction in waiting times.

The Trust performed relatively well on recovery of its overall pre-pandemic activity. We have made steady progress towards reaching our pre-pandemic planned care activity, achieving 91 per cent overall as of March 2023, compared to 87 per cent in March 2022. We also delivered up to 109 per cent of our pre-pandemic outpatient activity and 99 per cent of diagnostic testing as of March 2023.

The number of patients waiting for planned care has increased significantly across the NHS. Our own waiting lists grew from over 82,500 to more than 98,000 between March 2022 and March 2023. This contributed to a rise in waiting times with more than 3,000 patients waiting over a year for planned care in March 2023, compared to 1,662 in March 2022.

We also saw an increase in the number of patients waiting to start treatment following referral to us, with 59.6 per cent waiting up to 18 weeks in March 2023 compared to 65.1 per cent in March 2022. We have, though, virtually eliminated waits of more than two years – as of March 2023 there was one patient. We have also made significant progress in reducing the next cohort of long waits; as of March 2023, 34 patients had been waiting longer than 78 weeks. The Trust remains committed to treating these patients as quickly as possible, as well as ensuring progress is made with the overall patient backlog, and that all waits of 65 weeks are eliminated by March 2024.

The North West London Acute Provider Collaborative takes a systematic approach to clinical prioritisation and harm reviews so that we can make sure we continue to treat those with time-critical needs whilst also targeting those waiting the longest. There is still a huge amount to do to return to acceptable waiting times across all specialties, especially as demand is set to grow further for some time to come.

Over the last year we, along with the wider health and care system, have also witnessed a significant increase in demand for urgent and emergency care. A&E attendances are now higher than they were in 2019 and continue to rise. To prepare for a busy winter period, we implemented a range of initiatives to manage these pressures and maintain safe levels of care. This included a £1.6 million targeted investment to 'keep care flowing', making sure patients received the care they needed as quickly and as safely as possible and avoiding unnecessary time in hospital. Specifically, we implemented a focused improvement programme to embed best practice ward routines to support operational flow; expanded our same day emergency care services; and implemented 'virtual wards' to monitor care for patients who are able to remain at home or in the community. These actions helped us to achieve some of the shortest ambulance handover times in London.

We continue to focus on improving performance against the 62-day cancer waiting time standard, which specifies that patients should wait no more than two months from the date of their urgent referral for suspected cancer to the start date of their treatment. As of March 2023, 69 per cent of patients received their first treatment within 62 days of a GP referral. Unfortunately, this represents a slight drop from 70 per cent at the same time last year. However, we are making good progress on the faster diagnostic standard, which ensures a minimum of 75 per cent of patients with suspected cancer receive a diagnosis within 28 days of their referral. National guidance sets out that this should be achieved by March 2024. As of March 2023, 77 per cent of our patients with suspected cancer had received a diagnosis within 28 days of referral. We are undertaking focused work to ensure we improve performance across all of our cancer performance metrics in 2023/24.

Comprehensive performance scorecards with more detailed information about our performance are available on our website: https://www.imperial.nhs.uk/about-us/how-we-are-doing/quality-and-performance-reports/monthly-performance-scorecard

Assessing performance against our strategic goals

Our 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.

We established three core objectives – drawing on our strategic goals and our current challenges and opportunities – to guide our development priorities in 2022/23:

- to tackle the longer waits that have become established in planned care as well as delays in our increasingly pressured urgent and emergency care pathways
- to progress plans to build a motivated, healthy and inclusive workforce for the long term
- to mitigate the deterioration of our aging estate while finding a way to progress much needed redevelopment.

We have also been changing the way in which we go about our work, catalysed in part by the lessons of the pandemic but also building on improvements of previous years. As well as maintaining our overarching commitment to quality and to innovation, we want to continue to do more to:

- strengthen our focus on the needs of our patients and wider 'users'
- reduce health inequalities across our local communities
- join up care across providers, especially with the other three acute NHS trusts in north west London
- use our financial and other resources more sustainably.

In this report, we examine in detail the progress we have made against our three core objectives for 2022/23, as well as the significant changes we've made to the way we work.

Our core objectives for 2022/23

1. Tackling the longer waits that have become established in planned care as well as delays in our increasingly pressured urgent and emergency care pathways

Restoring elective care and reducing long waits

During the last year we have continued to work hard with our partners across north west London to bring down the long waiting times for planned care that developed as a result of Covid-19 as quickly, safely and fairly as possible. Through ever increasing collaboration, including working across the sector to maximise our resources and make the best use of our staff, we have been able to make the most of our collective capacity.

We've also introduced a range of initiatives and innovations, including increasing our critical care capacity and expanding our use of virtual wards. We have virtually eliminated 104-week waits across our hospitals and are working to reduce the number of patients waiting 78 weeks, while continuing to provide urgent planned care for everyone who needs it. This includes monitoring waiting lists across the sector and optimising use of capacity across all acute hospitals, in some cases offering patients the opportunity to be seen more quickly in another hospital within our acute provider collaborative. In the last 12 months, almost 1,000 patients have received care more quickly through this approach.

Same day emergency care

We expanded our 'same day emergency care' services at St Mary's and Charing Cross hospitals to help us cope with increased pressures on our emergency services. These services, which see more than 100 patients a day, are dedicated units close to our A&E departments that enable patients with a range of conditions to be assessed, diagnosed and started on treatment without the need for an overnight stay. We also established a same day emergency care pathway with London Ambulance Service, allowing ambulances to bypass A&E for suitable patients. In August, we introduced 'hot' clinics to provide follow-up care to patients who attended A&E the previous day. In 2022/23, there was an increase of nearly nine per cent in the number of patients who received same day emergency care in our hospitals compared with the previous year.

Virtual wards

We have been increasing our use of virtual wards, which allow us to provide high quality care to suitable patients in their own home. As well as being better and more convenient for patients to be in their own, familiar environment, it allows us safely to look after more patients than we can on a physical ward.

As of March 2023, all four trusts across north west London were collaborating to support patients on virtual pathways. Since March 2022, we have worked together to support the care of 2,851 patients; 1,617 have been patients of our Trust. The Trust consistently exceeds our target to admit 62 patients to virtual pathways each week.

Mental health services

We have seen a 30 per cent increase in the amount of time patients with mental health needs are waiting in A&E. We are committed to improving care for this especially vulnerable group and appointed our first lead nurse for mental health last summer.

In collaboration with Central and North West London NHS Foundation Trust, we are creating an emergency centre for patients with mental health needs at St Mary's Hospital, away from our busy A&E department. Due to open in spring 2023, it will provide a calmer and safer environment for patients. Since late last year, we've also been able to refer suitable patients in our A&Es to a new mental health crisis assessment centre in North Kensington which is run by Central and North West London NHS Foundation Trust.

2. To progress plans to build a motivated, healthy and inclusive workforce for the long term

In the aftermath of the Covid-19 pandemic it became clearer than ever that we have to invest in our people in order to build the healthy, motivated workforce that is crucial to the delivery of 'better health, for life'.

Improvement Through People Management

In 2022/23, we invested more in our Improvement Through People Management programme, a one-day training programme supported by a dedicated online learning platform and two management pathways for both new and experienced managers. Additional resources for managers include sessions on inclusion, enabling good performance and giving quality feedback to help build a better culture through management. From April 2023, the programme will be a mandatory requirement for all managers to help embed a more consistent, sensitive approach to people management across the organisation.

Equality, diversity and inclusion

A number of initiatives around equality, diversity and inclusion launched in 2022/23 to help us ensure our organisation is welcoming for staff and patients of all backgrounds.

Our equality, diversity and inclusion team has been building on an inclusive recruitment programme developed in 2021/22. Initially implemented in autumn 2021, the aim of this programme is to increase diversity in leadership starting from band 7 roles.

Every member of staff recruiting to roles over band 7 is required to complete an inclusive recruitment training session, which helps managers understand the importance of running a fair and open selection process as well as the implications of conscious and unconscious bias. Interview panels are required to be diverse in terms of gender and ethnicity. Hiring managers must also complete a report for the chief executive that explains how they ensured inclusivity throughout the recruitment process.

Eighteen months from launch, the programme has helped improve diversity at a senior level at the Trust. As of March 2023, 54 per cent of appointments at a band 7 level or higher were from Black, Asian or minority ethnic backgrounds, compared to 44 per cent as of March 2022. We have seen modest improvement in diversity among senior management in the same period, with people from a Black, Asian or minority ethnic background representing 43 per cent of the senior management team as of February 2023, compared to 41 per cent in February 2022.

The programme was developed with input from our staff networks, who have continued to feedback and support improvements throughout this process. We report progress on the programme to our networks each month. While some staff have found some of the changes challenging at times, we believe that as we are able to iterate the programme and demonstrate improvements in diversity of management, staff will see the value of this endeavour. We will continue to review and improve on this process in the year to come and will undertake research on our approach alongside Imperial College London in 2023/24.

In addition, the equality, diversity and inclusion team launched three toolkits which provide staff with guidance on talking about race, being an ally and dealing with microaggressions. The team are also piloting a centralised reasonable adjustment fund to improve the way we support disabled staff to make adjustments or adaptions to the way they work to ensure they can perform their roles effectively. Items and adaptations include specialist workplace equipment, British Sign Language interpreters, specialist software and training, and assistive technology.

Colleagues are working together across the Trust to develop anti-discrimination and anti-racism statements that reflect and demonstrate our commitment to becoming a more inclusive organisation. We expect to publish both statements in 2023/24.

Staff networks continue to provide both a space for staff to connect with one another and a way for staff to work with senior leaders to make improvements at the organisation. In 2022/23, the Black, Asian and minority ethnic (BAME) networks for nurses and midwives, and multidisciplinary staff became the Trust's race equality networks, reflecting their focus on improving the working lives of people of all races. The LGBT+ network marked Pride in June 2022 and LGBT+ History month in February 2023 with events sharing staff stories. Black History Month celebrations organised by our race equality networks included listening sessions with executives, talks from academic Dr Barbara Banda and poet Zita Holbourne, and special menus at all of our hospital sites. I-CAN, the network for staff with disabilities, marked another successful year of the Calibre leadership programme for disabled staff, and the women's network marked Women's History Month in March 2023 with a series of events focused on networking and career development for female staff.

Practical support and wellbeing for staff

In 2022/23 we had a renewed focus on practical support and wellbeing for staff. Beginning in 2020, in response to feedback from staff during the first wave of the pandemic, the Trust began implementing longer term, more strategic changes to our staff spaces and onsite food and shops offer for staff and patients while progressing practical improvements.

In July 2022, the Trust officially opened two new lounges for staff in the restaurants at Charing Cross and Hammersmith hospitals. The openings mark a major milestone in the Trust's staff spaces improvement programme, supported by Imperial Health Charity and design company Taylor Howes. We are now progressing a project to refurbish the whole of the general shop, coffee shop and surrounding space in the Queen Elizabeth the Queen Mother building at St Mary's Hospital in order to provide a transformed food and rest area and a separate staff lounge. We expect works to begin in summer 2023.

The lounges are part of the wider staff spaces improvement programme which has so far, delivered 80-plus general improvement projects and three pilot 'rest nests' – interior-designed, fully refurbished breakrooms.

Recognising that staff faced a challenging winter in 2022/23, we pulled together a number of initiatives to support staff wellbeing. This included a booklet detailing the practical, financial, emotional and physical support available at the Trust, in addition to signposting to resources from external providers. The Trust continued the expansion of CONTACT, which offers free, confidential counselling and psychological support to staff. Throughout January and February 2023, the Trust offered all teams and departments working onsite a box of breakroom supplies as a token of appreciation for their continued dedication and

support. In addition, every member of staff received a £45 voucher as a festive gift ahead of the Christmas holidays.

As part of a package of support for staff health and safety, the Trust continued the annual autumn vaccination service, offering against flu and Covid-19. The service launched in September 2022 with a dedicated appointment for every member of staff. All staff were encouraged to attend their appointments for a confidential conversation with a vaccinator. Vaccinations were strongly encouraged but the team was sensitive to the concerns of staff who choose not to be vaccinated. As the campaign continued through the autumn and into winter, the team responded to staff feedback with articles and information sessions with leading experts, drop-in and overnight vaccination services to offer more flexibility, and roaming vaccinators to support staff who struggle to find time to leave their wards. As the campaign concluded in February 2023, the Trust had vaccinated just over 48 per cent of staff against flu and Covid-19, ranking fifth for acute trusts in London.

The Trust has taken several measures to help staff feel safe at work in the face of an increase in conflict on site. Measures include a security team operating on all sites around the clock, as well as body cameras available to staff who work in isolated areas or those prone to conflict. The Trust is also expanding staff training and resources to help avoid and de-escalate conflict.

Industrial action

Several periods of industrial action across the NHS – as well as in other sectors – put additional pressure on our services. However, we are absolutely committed to supporting the rights of staff to take industrial action and worked in partnership with our trade union representatives to ensure strikes could go ahead while prioritising providing safe care.

National staff survey results

The national 2022 staff survey results – with our highest ever response rate of 56 per cent – show continued progress, with increased scores for the themes, 'we are compassionate and inclusive', 'we are always learning' and 'we are a team'. We were third highest amongst NHS trusts in London for staff recommending their organisation as a place to work. Areas most in need of improvement are flexible working, equality, diversity and inclusion, and preventing and tackling conflict.

Looking ahead

Looking ahead to 2023/24, the Trust is embarking on a programme to transform staff engagement and overhaul staff recognition, with solutions co-designed with staff across all professions and at all levels. The programme aims to build on the successes seen in this year's national staff survey results, while responding to areas identified for improvement.

More information about our workforce can be found in the staff report section of this report as well as our Annual Workforce Equality, Diversity, and Inclusion report 2021/22 on our website. The report for 2022/23 will be published in autumn 2023.

3. Managing our aging estate and planning for major redevelopment

We have to make progress on our hospitals' redevelopment in the coming year, especially at St Mary's Hospital where our deteriorating infrastructure is having an increasingly big impact on our staff and patients. Our Trust has the highest backlog maintenance liability in the NHS and, with our own budget for next year including a very large efficiency savings target, we cannot afford to continue to waste money on failing buildings.

Our redevelopment plans are gaining momentum. Since we submitted a new strategic outline business case for the redevelopment of St Mary's Hospital in September 2021, we have continued to work hard to progress much needed plans for the redevelopment of all three of our main sites while managing ongoing maintenance issues caused by the old and poor condition of our estate.

For St Mary's this work has included working on phasing the scheme to speed up delivery, spread the costs and be ready to start building work in 2025. And we are continuing to explore options for maximising the benefits of this once-in-a-generation opportunity. We now need a clear and substantial funding allocation from the government's New Hospital Programme to move on to the next phase of planning.

For Charing Cross and Hammersmith hospitals we are planning significant refurbishment and some new buildings at both sites. We started work on first stage business cases for both sites and hope to submit them to the New Hospital Programme later this year.

Following the temporary closure of part of the Western Eye Hospital in early 2022 due to fire safety concerns, we were given the go ahead for a major £9m building project that will allow us to reopen the hospital fully in summer 2023, with additional operating capacity to help tackle the waiting list backlog created by the Covid-19 pandemic.

We temporarily relocated many services from the Western Eye to Charing Cross Hospital – including in a mobile operating theatre – and they will continue there until the works are completed. Longer term, the proposal has always been to move the Western Eye Hospital's services into a modern purpose-designed facility on another hospital site and to sell the Samaritan and Western Eye buildings together to maximise the income to be reinvested in the overall redevelopment programme.

Significant changes to the way we work in 2022/23

A. Strengthening our focus on the needs of our patients and wider users

This year we built on our aspiration to become more user-focused, and to strengthen our focus on the needs and views of our patients in everything we do.

In October, we established a new experience function which grouped together existing teams, including: complaints, PALS, patient feedback, front of house/main receptions, patient and public involvement, patient information, brand and marketing, digital communications and the digital workplace. The new function will lead, organise and join up all our efforts to gather, understand, connect and respond to the needs and views of our diverse 'users' – patients, staff, local communities and partners.

Part of this work includes the development of a clear shared vision of what being user-focused means for patients, local communities and staff. We also want to make sure we make best use of the huge amount of data and feedback we already collect to generate and connect insights to shape everything we do – from local, ward-based improvements to setting and informing our strategic change priorities. Finally, we see value in using this resource to help join up existing building blocks. For example, this work links with our emerging health inequalities programme, our equality, diversity and inclusion governance, and our safety incident management work – so that we can work more effectively, and in a user-focused way.

Though we are at the start of this journey, several projects are under way to help us make better use of insights. In the coming year, research and insights gathered from these projects will support us to co-design improved services that meet user needs.

Projects include:

- **helping wards use insights:** this project aims to help wards make better use of patient feedback, performance data and other insights to support continuous local improvement. The goal is to co-design a user insights package for wards, alongside staff, lay partners and our quality improvement team.
- **interpreting:** through community engagement we heard how non-English speaking communities had concerns about patient interpreting. In 2022 we carried out a detailed review of our interpreting service including interviews and focus groups with patients, communities, and staff. This first phase of the project has identified immediate and longer-term improvements which we will continue to co-design with our lay partners and communities in the year to come.
- **end-of-life care:** Imperial Health Charity has awarded the Trust a grant to undertake research with staff, patients, their family, friends and carers, and local communities to help us understand how we can improve end-of-life care. The work will help us to improve communication with patients and their loved ones, support us to develop personalised care to suit people from a range of cultures and backgrounds, support staff with additional training and help us to develop new ways of working.
- **outpatients:** we have commenced a piece of research to understand what users need from our outpatient services, including our digital and administrative services and our communications with patients. This research will inform transformation plans and help us design better outpatient experiences for patients and staff while empowering patients throughout the pathway.
- **wayfinding:** we continue to work on making our hospitals easier to navigate and we have been working to improve the environment by redecorating and decluttering many public areas across our hospitals. We have updated our AccessAble guides, which provide users with landmarks to look out for, where to find wheelchair accessible entrances and the quickest routes to our units. In 2023/24 we will continue to make improvements to help users navigate our services, including outpatients at Charing Cross Hospital where we plan to implement zoning and install digital signage. We will make improvements to our website and appointment letters to help patients better navigate our hospitals.
- **community engagement programme:** we have always strived to have two-way trusted relationships with our communities. The Covid-19 pandemic highlighted the value of these relationships as we worked to address vaccine hesitancy, concerns about end-of-life care and patient interpreting through online Q&As. These meetings further strengthen our relationships and we have worked with community groups on 'end-of-life' care and patient interpreting improvement projects. To continue to build this trust and collaboration, we now have a regular and growing calendar of events we attend in the community to listen to and act on issues that are important to our local people, such as improving maternity services and how to ensure equitable care.

B. Reduce health inequalities across our local communities

Throughout the year we have continued to make progress under the Trust-wide population health and equity framework which encompasses the work we do to improve the health and wellbeing of the populations around our hospitals, directed by our organisational vision of 'better health, for life'.

Developed with wide consultation from organisational and lay partners across our health and care system, the framework is intended to guide planning, prioritisation and evaluation of our work in this area, to help maximise our impact. The framework covers bringing a focus to equity, prevention and health improvement to our core business, through to our contribution as an 'anchor institution'.

Improving equity

Significant work has been spent in 2022/23 positioning a focus on improving equity as both a Trust priority and a domain of quality, including the first board level reporting on health inequalities to our quality committee and Trust board.

A mapping exercise to understand potential inequities in the patient journey with regard to access, outcomes and experience was completed and supported the identification of four initial priority areas which are being progressed into improvement work: outpatient attendance; elective waitlists and supporting patients to 'wait well'; patient experience and smoking cessation.

In outpatients for example, we completed analysis which showed patients from our most deprived communities or those from a minority ethnic background are more likely to not attend their first outpatient appointment at the Trust. This has led to a dedicated project working with colleagues from Imperial College London and behavioural insight experts to understand reasons behind this and design interventions to be specifically piloted with these patient populations. We will scale successful pilots across the Trust as part of the outpatient transformation programme.

This work has been underpinned by significant advances with regard to our data quality and completeness, working with the business intelligence analytics team to build equity data into our data warehouse and business rhythms, and adapt applications and dashboards to allow staff to interpret this data for their own specialty areas. These developments also allowed us to analyse our 2021/22 complaints by ethnicity and deprivation for the first time.

Supporting community health

For smoking cessation, a baseline review of existing Trust provision and best practice from across the sector was completed along with a set of recommendations to scale services for both patients and staff. These will be implemented in 2023/24 as part of the prevention agenda under the framework.

Through the Trust's strategic partnership with Chelsea Football Club Foundation, we launched a pilot 12-week healthy lifestyle programme for patients who have suffered transient ischaemic attacks (TIAs), or mini-strokes. The programme will be further scaled to other related specialties in 2023/24, where a focus on health improvement and prevention has the most potential to benefit patient health outcomes and their experience of our care.

We also initiated a community-focused big room for maternity services, where representatives from the community, Trust and integrated care board come together weekly to progress improvements. The big room is especially focused on breastfeeding and signposting to support for mental health challenges, which were issues identified by mothers and maternity champions in Westminster, and Kensington and Chelsea as areas of community need.

Joining up care

Under the integrated care pillar of the framework, we successfully won funding from the integrated care board to pilot a new model of working between primary and secondary care. The new model will benefit patients who face inequity of access and outcomes, by better identifying complex and high-risk patients; joint proactive management of their needs; and offering de-medicalised pathways with stronger connections to social and voluntary services.

We were also awarded funding from the integrated care board's health inequality transformation fund to work collaboratively between primary, secondary and social care, to establish a whole systems data-driven approach to improving equity and population health at primary care network level. The focus is on a translation of clinical insights on wider determinants of health, into actionable improvements for patients that can be measured, evidenced and scaled up.

We will use whole system activity data, linked to patient characteristics and clinical insights to inform integrated ways of working that benefit patients who face inequity of access and outcomes. We will achieve this through embedding a strengthened interface into the care model between primary and secondary care; joint proactive management of need and risks; offering de-medicalised pathways with stronger connections to social and voluntary services; and proactively identifying those patients not accessing healthcare and experiencing inequitable access and outcomes.

With regard to our role as an 'anchor institution' and place-based working we have scaled our activity with cross-sector partners to address the wider social determinants of health.

With funding support from Imperial Health Charity, this includes establishing a new community recruitment business partner role which will work with local authorities and others to create more opportunities for local residents in our hospitals.

Specific to Westminster, the Trust is also a partner under the #2035 collaborative, formed this year and aimed at reducing the life expectancy gaps between different wards in the borough. This will be achieved through bringing partners and community together to better listen and respond to community needs, and to work differently with one another to achieve change.

The efforts to progress the redevelopment of St Mary's Hospital under the national New Hospital Programme and the launch of the Paddington Life Sciences partnership this year, demonstrate a closer collaboration with local stakeholders to bring benefits to the population beyond delivery of healthcare. This includes new public spaces and employment opportunities which contribute positively to people's health, wealth and wellbeing.

The 'Compassionate Communities' programme was run in 2022 and funded 20 grassroots organisations around our hospitals to support them with Covid-19 recovery, in areas such as food security, mental health and building community connections. Round two of this funding scheme is currently being scoped for launch in summer 2023.

C. Join up care across providers, especially with the other three acute NHS trusts in north west London

The four acute NHS trusts in north west London came together as an acute provider collaborative from autumn 2022. The move builds on the close partnership working that offered so many advantages to patients during the Covid-19 pandemic.

The move strengthens collaborative decision-making and helps our organisations make the most effective use of our collective resources to provide better care, for more people, more fairly. This has proved particularly important as the whole NHS sought to tackle longer waiting times for planned care and increasing pressure on urgent and emergency services. During 2022/23, all four trusts were virtually able to eliminate waits of more than two years by sharing capacity and offering patients the chance to have surgery sooner at a neighbouring hospital.

Developing an elective orthopaedic centre

As we came out of the pandemic with long waiting lists and many other challenges, we wanted to draw on best practice and go further with our improvements. The North West London Acute Provider Collaborative held a public consultation on the proposal to bring together much of the routine, inpatient orthopaedic surgery – primarily hip and knee replacements – for the population of north west London in a purpose-designed centre of excellence, completely separated from emergency care.

Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency. We expect to see a reduction in surgical complications and length of stay, while enabling more patients to be treated at a lower cost per operation.

Almost 2,000 patients and local people took part in the 13-week public consultation – between October 2022 and January 2023 – on the proposal to develop a centre of excellence for inpatient orthopaedic surgery at Central Middlesex Hospital, Park Royal. The feedback received through the consultation was used to inform our decision-making and develop solutions around the key themes of travel and transport, the clinical and workforce models and health inequalities, in a decision-making business case.

In March 2023, the proposal was approved by the NHS North West London, our sector's integrated care board. The acute care collaborative will now work together to establish the new 'elective orthopaedic centre' at Central Middlesex Hospital. The hospital will benefit from a £9 million investment to create a dedicated 41-bed unit through a small expansion and some remodelling. The new elective orthopaedic centre, expected to open in 2023/24, will serve over 4,000 local patients each year.

End-to-end care for patients who have their operation at the new centre will continue to be the responsibility of the surgical team at their 'home orthopaedic hospital', with outpatient care provided locally or online. Patients will only need to travel to Central Middlesex for their operation. Their 'home orthopaedic hospital' surgeons will carry out the operation at the elective orthopaedic centre with the support of a permanent, specialist team. Door-to-door transport to and from the new centre will be provided for patients who are unable to travel independently or via an existing patient transport scheme, and who would otherwise encounter a long, complex or costly journey.

Care pathways for patients with complex health needs and day-case patients are unchanged and surgery will be provided, as now, at a range of north west London hospitals. These patients will also benefit from shorter waiting times, as moving low-complexity, inpatient surgery to the new centre will free up capacity at these other hospitals.

Increasing diagnostics capacity through community facilities

New NHS community diagnostic centres are a national initiative to build additional diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. This approach for checks, scans and tests will be more convenient for patients and help to improve outcomes for patients with cancer and other serious conditions.

Using national funding, the three new community diagnostic centres in north west London are designed to help combat health inequalities, improving healthcare for those who need it most. It is expected that an additional 300,000 diagnostic tests per year will be provided across the three new community diagnostic centres by 2024/25.

Working together with London North West University Healthcare NHS Trust, the community diagnostic centres will open on existing NHS sites located near to areas of significant deprivation:

- Ealing Hospital, opening winter 2023/24
- The Wembley Centre for Heath and Care, opening late autumn 2023
- The Willesden Centre for Health and Care, opening summer 2023.

Improving patient pathways

We are working more systematically to identify and prioritise improvements to specific care pathways. Last year, we improved the pathway for patients having thoracic surgery and we have been working up plans to expand diagnostic services for ophthalmology.

D. Use our financial and other resources more sustainably

We were able to break even as of the end of March 2022/23, however, generating recurrent cost efficiencies remains a significant challenge. The focus for 2023/24 will be finding additional, sustainable efficiencies and ensuring we are using all of our available resources effectively. In 2023/24 we will aim to deliver efficiencies of £53 million, equating to 3.6 per cent of turnover, which is in line with other trusts. The Trust's approach to delivering this level of improvement in productivity and efficiency is multi-faceted and includes bottom-up opportunities as identified in individual services; a series of pan-organisational reviews of cross-cutting themes including estates utilisation, theatre efficiencies, outpatient service model, digital services and other patient pathways.

Learning, improvement and innovation

In 2022/23 we took significant strides in our commitment to build learning, improvement and innovation into everything we do. This is particularly evident in our world-leading research, working in partnership with Imperial College London as part of Imperial College Academic Health Science Centre (AHSC) and through the National Institute for Health and Care Research (NIHR) Imperial Biomedical Research Centre (BRC).

NIHR Imperial BRC

The NIHR announced a five-year funding award for our BRC, which we run in partnership with Imperial College London. Our award of £95m covers five years from December 2022 and represents a £5.3m increase on the previous award. It will be used to translate scientific breakthroughs into new treatments, diagnostics and medical technologies, in order to improve patient care, locally and around the world. We will be focusing on 14 themes, responding to the most pressing local health needs, and linked by four common threads: early diagnosis, precision medicine, digital heath and convergence science. As well as allocating funds for research projects, the BRC also provides vital research infrastructure such as clinical trial capacity, state-of-the-art data handling and academic training.

Paddington Life Sciences

In September 2022, we set out our vision for a new life sciences cluster in Paddington. Paddington Life Sciences aims to maximise local and global benefits of NHS, research, industry and community partnerships centred around St Mary's Hospital. Earlier this year, we opened the first new initiative within the development – a dedicated digital collaboration space. The space houses the NIHR Imperial BRC digital health team who provide state-of-the-art management and analysis of healthcare data to help researchers and clinicians address important health issues, such as respiratory disease, infection, pregnancy and premature births, and cancer.

North West London Clinical Trials Alliance

We supported 1,009 clinical research studies this year, up from 898 in 2021/22. We are a proud partner of the North West London Clinical Trials Alliance, which was launched in 2021 with the aim of improving access to and the quality of clinical research in the region. The alliance continues to go from strength to strength, both in terms of the clinical research studies delivered and the growing number of partners. It was also shortlisted for the New Statesman's inaugural Positive Impact Awards in October.

Research highlights

We and our partners Imperial College London continued to produce world-leading research, harnessing the latest technologies such as machine learning to aid diagnosis.

Some highlights include launching a £2.9 million NIHR-funded national trial (REMAP-CAP) to find effective treatments for people hospitalised with flu over the next two years; two studies finding that the hormone kisspeptin could be used to treat women and men distressed by their low sexual desire; a study demonstrating that changing the order of treatments given to breast cancer patients could reduce side effects and improve outcomes; and a clinical research study showing that ENO Breathe, an online breathing and wellbeing programme developed by the English National Opera and respiratory clinicians at the Trust, helps improve quality of life and breathlessness for people recovering from Covid-19.

Humans of Health

The AHSC's online photography exhibition 'Humans of Health' series has been continuing to highlight staff and patients engaged in innovative healthcare research. It is also about to go on the road with physical exhibitions across the AHSC's partners' institutions and hospitals.

Highlights and special recognition

2022/23 was another bumper year for the Trust in terms of awards and recognition, with a wide range of staff and teams honoured for their expertise, innovation and commitment.

Dorcas Gwata, who works as a psychiatric liaison nurse, was named best nurse at The Sun's annual awards for her work helping vulnerable people and trying to address health inequalities. Another highlight was Naman Julka-Anderson being awarded UK radiographer of the year by The Society of Radiographers, for his involvement in the oncology podcast Rad Chat. Our radiographers were also awarded UK and London regional team of the year.

Collaboration is at the heart of everything we do and we were delighted our partnership work was recognised at the Health Service Journal's (HSJ) annual awards. We received two awards for our work with North West London integrated care systems (ICS), expanding cross-disciplinary end-to-end pathway redesign of heart failure care and integrating digital technologies to support patients with heart failure. The Trust was also awarded the Military and Civilian Health Partnership Award jointly with NHS England, for our work developing the Veterans Trauma Network.

We were shortlisted Trust of the Year at the HSJ awards and won in a similar category at NHS England's London Healthcare Support Worker Programme awards.

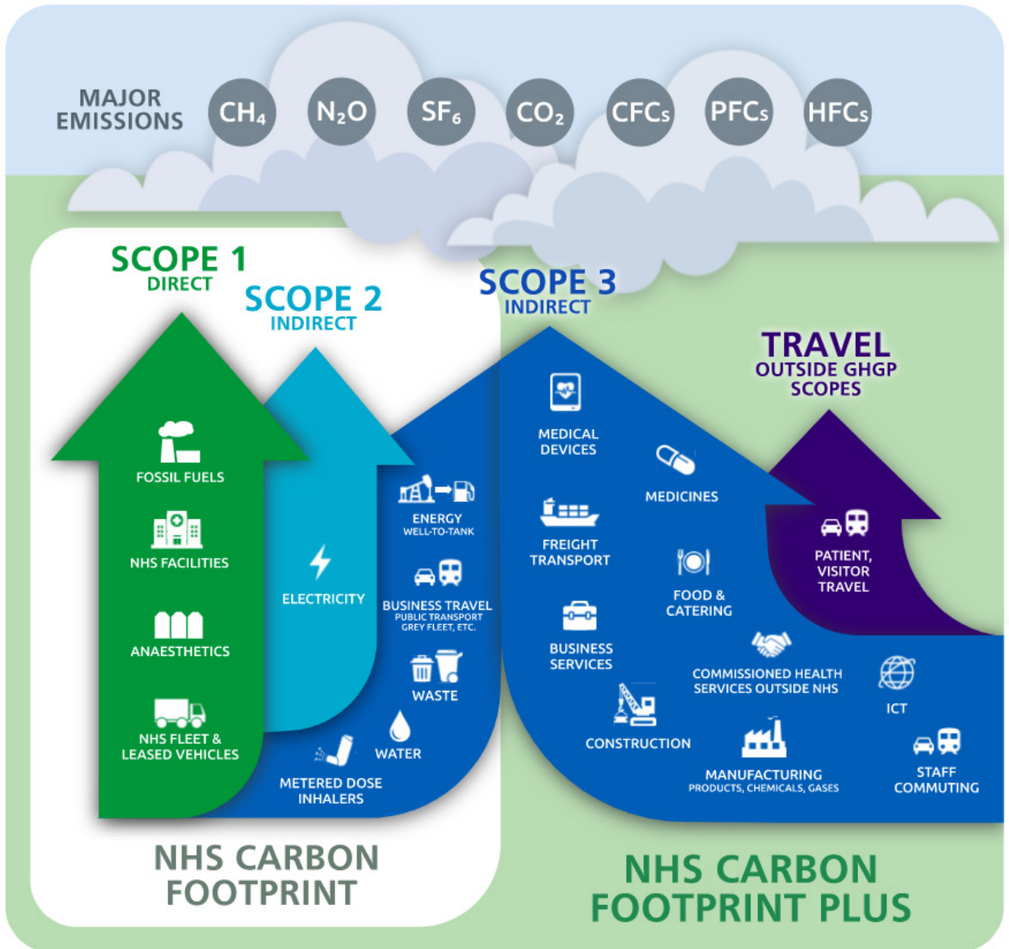
SUSTAINABILITY REPORT

Sustainability report

On 1 July 2022, the NHS became the first health system in the world to embed environmental requirements into legislation, through the Health and Care Act 2022. This commits us to rapidly reducing our carbon footprint with a goal of net zero by 2045.

Figure 1 shows the major NHS sources of greenhouse gas emissions. The NHS carbon footprint – which includes scope 1, 2 and certain scope 3 greenhouse gas emissions – is the carbon footprint that NHS organisations have the greatest direct control in reducing. The other scope 3 emissions include medicines, medical equipment, other supply chain and staff commuting, plus patient and visitor travel emissions. These are greenhouse gas emission sources that the NHS has limited direct control over reducing but can influence them through, for example, greener procurement, contract management and partnerships with suppliers. Combined, these represent the NHS carbon footprint plus.

Figure 1: Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS



Source: Greener NHS: Delivering a net zero National Health Service

Since launching our green plan in May 2021 we have been acting to deliver upon two core targets against our baseline carbon footprint in 2019/20:

- for emissions we control directly (the NHS carbon footprint), to reach net zero emissions by 2040, reducing emissions by at least 47 per cent by 2028-2032
- for emissions we can influence (the NHS carbon footprint plus), to reach net zero emissions by 2045, reducing emissions by at least 73 per cent by 2036-2038, based on 2019/20 emissions.

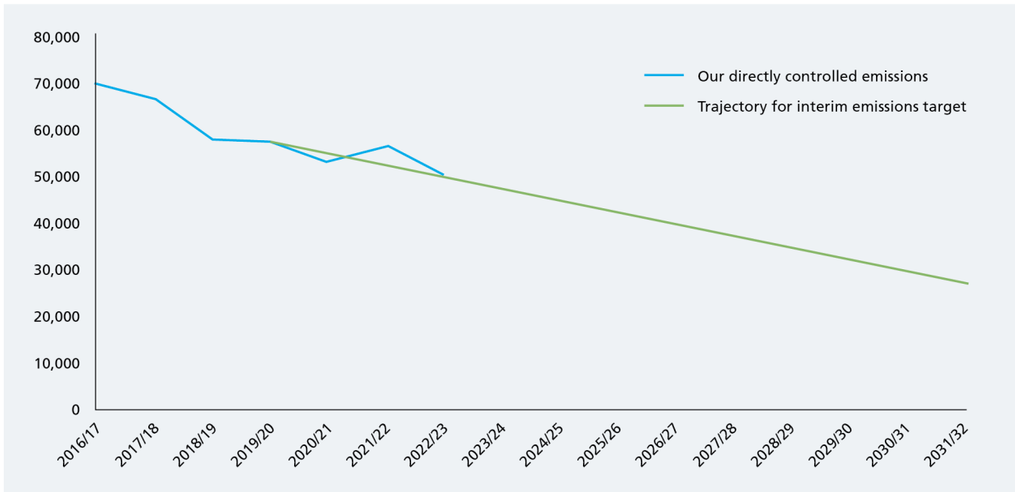
Our green plan is based on continuous learning and innovation and provides our people with a platform to contribute to reducing our impact on the environment and to deliver sustainable healthcare, helping to secure better health, for life, for generations to come. More information about our green plan is available on our website: https://www.imperial.nhs.uk/about-us/our-strategy/green-plan

Improving our understanding of our carbon footprint

Over the last year we have continued to improve the data used to estimate the carbon footprint that we can directly control. This improvement has more closely aligned our approach to that used by Greener NHS. The impact is that our estimated carbon footprint for each year has risen, although the headline trend remains unchanged.

In the three years since 2019/20 our directly controlled carbon footprint has fallen by 13 per cent from 57,622 to 50,327 tonnes of carbon dioxide equivalent. This reduction of 7,295 tonnes is the equivalent to driving a petrol car 900 times around the earth.

Figure 2: Our progress: estimated directly controlled carbon footprint including tenants



Source: Imperial College Healthcare analysis

Over this period, we have seen reductions in emissions across most of our directly controlled emission sources, with the exception of Entonox use (used to control pain, often during childbirth), waste disposal and buildings energy oil use. These three emissions sources accounted for 11 per cent of our directly controlled emissions in 2022/23.

Table 1: Drivers of progress in our directly controlled carbon footprint between 2019/20 and 2022/23 (including tenants)

NHS carbon footprint emissions source	Emission source as a per cent of total directly controlled carbon footprint in 2022/23	Percent change in emissions by emissions source between 2019/20 and 2022/23
Gas	**53%**	**-12%**
Electricity	**33%**	**-18%**
Oil	**1%**	**16%**
Waste disposal	**4%**	**4%**
Water and sewage	**0%**	**-55%**
Anaesthetic gases – Volatile agents	**1%**	**-66%**
Anaesthetic gases – Nitrous oxide	**2%**	**-30%**
Anaesthetic gases – Entonox	**5%**	**79%**
Inhalers (propellant only)	**0%**	**-8%**
Total directly controllable carbon footprint	**100%**	**-13%**

Source: Imperial College Healthcare analysis

Buildings energy (i.e., consumption of gas, oil and electricity) represent the largest component of our directly controlled carbon footprint as of 2022/23 – standing at 53 per cent, one per cent and 33 per cent respectively. However, we are now well placed to reduce our dependence on natural gas from 2023/24 onwards as we begin to reap the benefits of our public sector decarbonisation fund grant upgrades, which will result in significant reductions in our buildings' energy related carbon footprint as the national grid decarbonises.

Due to shortfalls in the methodologies currently available to calculate emissions over which we have influence, we are yet to measure our progress in this area. We wait for further development from Greener NHS (and others) on the best method to estimate our emissions outside our direct control that can accurately detect the impact of our actions.

Our people

A key strand of our green plan is ongoing communication, learning and engagement with our people. We aim to increase awareness of the importance and urgency of climate change; ensure our people have a voice; and provide the resources, tools and safe spaces to identify local opportunities for improvement and to act.

In the last year, we have:

- launched a short training module to educate staff about the relationship between health, healthcare and climate change and support them to take local action to reduce our carbon footprint
- introduced the green plan in our corporate welcome and some local induction programmes
- created a 'Greening Your Ward' crib sheet to help staff make practical improvements as part of our Trust-wide ward accreditation programme
- expanded the activities of our staff green network, including launching a newsletter and hosting events
- completed an independent audit of our sustainability data, which rated our reporting as, "significant assurance with minor improvement opportunities".

In the year to come, we aim to:

- increase uptake of our training module
- double our green network's membership from 250 to 500
- implement recommendations from the independent audit
- work with internal stakeholders to refresh our green plan for 2024/25 to 2027/28.

Our partnerships

We recognise that we cannot get to net zero alone, and our green plan places an emphasis on building partnerships with local authorities, academic institutions, charities, and wider industry. This will strengthen our collective capacity so we are well placed to collaborate in tackling complex environmental problems and can quickly identify new ideas and opportunity areas that will accelerate progress towards shared environmental and health goals.

In the last year, we worked with the 10 hospitals across the Shelford Group to accelerate progress in our plans to tackle nitrous oxide waste, a medical gas with a high global warming potential.

We have been working with Imperial Health Charity to identify green spaces that are in need of restoration across all our hospital sites. We want to build on the improvements made to the neonatal intensive care unit's garden terrace at St Mary's Hospital and the sanctuary garden at Charing Cross Hospital to improve more green spaces for staff and patients.

This year, we also signed up to Westminster City Council's first Sustainable City Charter to help shape plans to reduce the carbon footprint in our area and support others to act in a city-wide approach.

Our actions

Our green plan provides a platform for our people to contribute to reducing our impact on the environment and to deliver sustainable healthcare and is underpinned by 12 green goals. Our ultimate aim is to create a culture of improvement and innovation around environmental issues at our Trust so that our people feel empowered to act. Over the last year well over 50 green projects have launched or progressed in support of our green plan, from Trust-wide initiatives to local improvement projects.

This year, we have progressed the following initiatives around cleaner air and smarter travel:

- our staff car salary sacrifice scheme was overhauled to include only ultra-low emission and zero-emission cars, avoiding an estimated 106 tonnes of carbon dioxide from tailpipe emissions over the next decade
- we supported staff who cycle with cycle training events, additional funding to increase the capacity of bike stores and service sessions for over 800 cycles from Dr Bike, all of which helped us achieve 'Gold Cycle Friendly Employer Accreditation' from Cycling UK.

In 2023/24, we plan to trial a bike loan scheme for staff and conduct a trave survey so we can pinpoint additional ways to support greener and more active travel.

In early 2022, our information and communications technology team reduced energy consumption by introducing a new computer power management solution to automatically power down computers when not in use. We saw a return on investment within six

months, saving the Trust £440,000 and reducing our carbon footprint by 590 tonnes. Over the next year, we will expand this solution to more computers. We will also explore the potential of making our default search engine Ecosia, a web browser which invests advertising revenue in planting trees across the world and supporting climate action.

This year, a number of initiatives across the Trust targeted better waste management, including:

- a pilot scheme to collect and recycle metered-dose inhalers, in partnership with our waste management supplier
- an insulin pen recycling pilot on 8 North ward, launched by the pharmacy team at Charing Cross Hospital
- a waste audit in theatres at St Mary's Hospital, led by our orthopaedic team, which showed that across two theatres, improving waste segregation could result in an annual reduction of at least 1.5 tonnes of carbon associated with its disposal
- an audit of waste segregation in children's services, which identified a number of opportunities for improvement
- a pilot project on the Albert ward at St Mary's Hospital, supported by Imperial Health Charity and a commercial partner, which explored ways to efficiently collect single-use plastic face masks for recycling into new products such as operating theatre clogs and bed pans. The pilot will expand to other clinical areas in the year to come.

A number of initiatives focused specifically on reducing the use of plastics across our hospitals, including:

- an expanded trial of reusable surgical gowns in theatres
- a 14 per cent reduction in the use of plastic exercise bands led by the outpatient physiotherapy team at Charing Cross Hospital
- the move to reusable bags for pharmacy deliveries across the Trust.

Our imaging team are leading the way in sustainability research with a project in partnership with Imperial College London. The team have mapped out the carbon footprint of a single CT scan, from the moment a patient is referred to the time that the images are obtained. Taking into account the energy used by the machine, temperature control in the room and the journeys to and from hospital, they have calculated that a CT scan for one patient at Charing Cross Hospital has a carbon footprint of 3.57kg of carbon dioxide equivalent. Over the next year, the team will use this data to identify ways to reduce the environmental impact of imaging.

In the last year we have made significant progress with our green plan goal of sustainable use of medicines, equipment and anaesthetic gases. Our anaesthetic and theatre teams with the support of an Imperial Health Charity grant commenced a large-scale trial of volatile capture technology at all our sites, and with two different devices. This innovation captures much of the harmful volatile anaesthetic agents used when delivering care and in the longer-term there is the potential for the volatile agents to be reprocessed and recycled to be used again. In the year to come, the trial will evaluate the technical, clinical and cultural feasibility of putting this technology in place at all theatres, across all sites.

Alongside this our anaesthetic teams continue to make progress in reducing the use of desflurane, a volatile anaesthetic gas used for surgery, which has a global warming potential 2,500 times greater than carbon dioxide. In January 2023, desflurane made up 2.7 per cent of our volatile anaesthetics use, down from 10.3 per cent in April 2022. And last year, we began to decommission an entire nitrous oxide manifold, which is estimated to significantly lower our nitrous oxide waste at Charing Cross Hospital, leading to a reduction in our directly controlled carbon footprint of at least 460 tonnes per year.

Finally, our therapies team expanded the reuse and recycling scheme for walking aids, improving information for patients and adding more drop-off locations at Charing Cross Hospital to make it easier to return walking aids that are no longer needed. In the year to come, the scheme will further expand with additional drop-off locations at St Mary's Hospital.

We continue to build on our efforts to provide patient centred care, close to home where possible, with virtual outpatient appointments. Around 30 per cent of our outpatient care is carried out virtually, in line with national standards, which has helped avoid an estimated 20.7 tonnes of carbon emissions normally associated with patient travel. We have introduced a digital letter process which will reduce the paper and consumable cost of printing an estimated 700,000 appointment letters per year. Finally, we have introduced remote monitoring to reduce the number of patients attending hospital unnecessarily. We expect this to contribute significantly to our carbon reduction.

In the last year our estates and facilities team made progress against our goal to develop greener facilities. We successfully completed a range of retrofits and upgrades from a £27 million public sector decarbonisation fund (PSDF) grant at Charing Cross and Hammersmith hospitals. The air source heat pumps at Charing Cross Hospital will be switched on in early 2023/24 and will immediately reduce our dependency on natural gas at the hospital, and in the medium to long-term as the national grid decarbonises, it will lead to reductions in our carbon footprint. These upgrades have the potential to contribute to our greener facilities green plan goal and reduce our carbon footprint across both sites by 5,000 tonnes per year.

We are on track to complete further upgrades in 2023/24 from an additional £23 million PSDF grant at these two sites, including air source heat pumps at Hammersmith Hospital. Once completed, these upgrades will lead to a potential further reduction in our carbon footprint of a further 3,400 tonnes per year over the medium to long-term.

Professor Tim Orchard, Chief executive
29 June 2023

QUALITY ACCOUNT 2022/23

Overview

This quality account is an opportunity for us to review our progress against key quality and safety improvement measures in 2022/23. It has been another year influenced by the far-reaching effects of the pandemic, with large waiting lists for care and increased demand for our emergency departments, while still caring for those with Covid-19.

We have nonetheless made good progress in many improvement areas. An important one in patient safety where we have been working to implement the NHS Patient Safety Strategy and have begun transitioning to the Patient Safety Incident Response Framework. We remain well below the national average for incidents causing moderate or above harm despite an increase in our incident reporting rate, which positively reflects our work to embed values and behaviours that allow our staff to feel supported in openly reporting incidents.

Similarly, we have made strides forward in our work to become more 'user-focused' and incorporate the views, preferences and insights of our patients and families into our strategic goals and improvement priorities. This year we have recruited six patient safety partners from our local community to be a 'critical friend' on elements of our patient safety work as we develop plans and policies in this area.

As in previous years, we continue to have among the lowest mortality rates in the country. We also have some of the lowest rates for unplanned patient readmissions for both adults and children. We have maintained our focus on infection prevention and control measures, with a new package of education and support for staff. Disappointingly, despite these efforts, we have seen a slight increase in some hospital-acquired infections, but we are confident that we will see the full benefits of our new approach in the coming year.

Our priorities for 2023/24 largely mirror those of 2022/23 with ongoing efforts to reduce waits in planned care and ease pressure on our urgent and emergency care pathways. We remain committed to supporting our staff to feel valued, motivated and healthy, and to continue to press the case for redeveloping our aging hospital estates. We will also continue to progress our local safety improvement programme priorities to achieve long-term, sustainable changes over short-term fixes.

This activity will sit alongside our work with our new North West London Acute Provider Collaborative partner trusts: Chelsea and Westminster Hospital NHS Foundation Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust.

Collectively we have identified four areas for improvement based on our shared local challenges: quality; people; finance and operational performance; and infrastructure. With responsibility for leading the quality domain, Imperial College Healthcare drives collective priorities including: improving care for deteriorating patients and end of life care; standardising processes for clinical harm and mortality reviews; more effectively gathering and responding to the needs and preferences of our patients and local communities; and, co-designing improved ways of working on other clinical pathways to increase quality and reduce unwarranted variations. This will allow us to provide better care for more people, more fairly and we look forward to progressing these in the next year.

Thank you to everyone who has helped us put this quality account together including Healthwatch, our commissioners and our local authorities, and to our staff who are so committed to providing our patients with the highest quality of care.

Professor Tim Orchard
Chief executive

PART 1:
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

1.1 Priorities for improvement

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

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. This framework sets out how we embed improvement knowledge and skills across all levels of our organisation at scale and pace.

To date, there have been 5,589 attendances at improvement training and 1,290 (nine per cent) current members of staff are trained in improvement, of which 152 are trained as improvement coaches (one per cent of the organisation).

The Imperial Management and Improvement System (IMIS)

IMIS is the Trust's operational mechanism to help the organisation, our divisions, directorates, specialties, frontline and corporate teams deliver on their objectives. This in turn enables teams to incorporate learning, improvement and innovation into everything they do, building a culture of continuous improvement.

IMIS is now being deployed to directorates within the surgery, cancer and cardiovascular division. It aims to provide teams with a consistent and systematic approach to prioritising, monitoring and managing (i.e., improving and sustaining) strategic and operational change. Work is also progressing with select frontline teams to embed improvement within the ward routine via 'improvement huddles'. This allows any member of staff to raise improvement ideas or issues and proactively problem solve with their multidisciplinary team.

2023/24 improvement priorities

The priorities for the quality section of the annual report focus on the quality and safety improvement programme and are set out in the table below. The other strategic priorities are addressed and covered in our annual report.

We have made good progress with many of the safety improvement priorities we set ourselves for 2022/23, including the implementation of the NHS Patient Safety Strategy and in particular our work to begin transitioning to the Patient Safety Incident Response Framework (PSIRF), following its publication in September 2022.

We will continue to focus our efforts in 2023/24 on implementing all elements of the national strategy, whilst working on the priority improvements set out in the table below. These have been developed following review of quality insight data, including: incidents, complaints, patient feedback, claims and inquests, audit, mortality data including structured judgement reviews, outcomes from our ward accreditation programme, risks and emerging issues, as well as national, acute collaborative and local priorities and planned improvement work.

We are committed to focusing on these priorities, along with a wide range of other work aiming to improve the quality and safety of care provided to our patients, the experience they receive, and the environment and culture in which our staff work.

In addition to our local priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (Chelsea and Westminster Hospital NHS Foundation Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust) on a number of priority areas. Many of our local priorities are aligned with these collaborative workstreams, which are focused on streamlining and ensuring consistent processes and reporting across the four acute collaborative trusts in the following key areas:

- care of the deteriorating patient and end of life care (including treatment escalation);
- user insights and focus;
- mortality and clinical harm review outcomes;
- national patient safety strategy (with focus on PSIRF);
- maternity standards;
- GIRFT (Getting It Right First Time) and the clinical pathway redesign.

Focus area	Reduce harm to patients through our safety improvement programme
Rationale for selection	We have had a safety improvement programme in place since 2018. The programme is supported by the safety improvement team, with steering groups in place for individual workstreams and overall reporting to our executive management board quality group. Following review of our quality insights and data, and progress with our previous priorities, we have agreed nine priority improvement areas for the safety improvement programme in 2023/24. These have been identified as our key areas of risk internally. Some of these are not new priorities but will build on the work which we did throughout 2022/23, described in the next section along with plans for our ongoing improvement work. These are: • reduce infection transmission through improving basic standards of infection prevention and control practice with a focus on hand hygiene • improve the treatment of patients with sepsis, signs of deterioration with a focus on appropriate treatment escalation • reduce harm from inpatient falls through a focus on improving the completion of a high-quality falls multi-factorial risk assessment (MFRA) at the point of admission and the completion of post-fall assessments for people who have fallen • reduce the harm caused when undertaking invasive procedures by implementing the new National Safety Standards for Invasive Procedures (NatSSIPs2) • improve nutrition and hydration, in particular the identification and management of adult patients with dysphagia (swallowing problems) • improve the safety of blood transfusion • reduce harm in maternity care through a focus on fetal monitoring during labour and implementing a new process for the management of test results, including urine specimens. Our new safety priorities for 2023/24 are: **Reduce medication related harm with a focus on anticoagulants and insulin** Issues related to medications are one of our most frequently reported types of patient safety incidents, however the percentage of these causing moderate or above harm to patients remains low at 0.48 per cent (11/2274). Through regular review of our incident data we have identified two specific areas where we have an opportunity to improve patient safety: anticoagulant therapy and insulin. Our thrombosis and anticoagulation committee will lead on an action plan to improve how we manage anticoagulant therapy, especially for patients who may need to have their medication paused before a procedure and then re-started at an appropriate time afterwards. A newly established safe use of insulin task and finish group has developed an improvement plan which will support staff with the safe management of blood sugars. This will focus on the implementation of an intervention bundle, including education and training for staff and improvements to the dispensary process and the electronic process for ordering insulin. **Improve the experience of patients who are waiting for care through a focus on targeted harm review** Following the loss of elective care activity and reduced productivity as a result of Covid-19, in 2020 we introduced a process for clinical prioritisation and harm review of patients waiting for elective surgery. This process was designed to ensure that treatments are prioritised for the most urgent patients (those whose surgery is classified as P1 – emergency, or P2 – urgent and needs to occur in less than one month) and to identify any potential or actual harm which may have occurred as a result of delays. We have not found any significant harm through this process so far. An incident involving the death of a patient on the waiting list was investigated and confirmed as low harm as the patient had a number of reasons why they were not operated on within six months. We were however identifying a small number of cases of harm through our incident reporting process for patients who have had their diagnostics or treatment delayed. This would not have been picked up through our original clinical harm process because it did not include review of potential or actual harm to patients on a diagnostic or outpatient/non-admitted pathway. At the beginning of 2023, through our new clinical harm review assurance group, we developed some targeted clinical harm processes to ensure that we are reviewing those patients where harm is more likely to occur, some of which have now launched. These processes include audit, data monitoring using real-time dashboards, and harm review for the following: • patients who had long waits in our emergency departments • patients who experienced ambulance handover delays • patients who had delayed discharges after being deemed medically fit for discharge • patients who were 'boarded' (cared for temporarily in other areas when there are no suitable beds to admit them to) • patients who were diagnosed with sepsis but had a delay in their antibiotics being administered • patients who are on the waiting list for a diagnostic procedure • patients whose surgery has been classified as P3 (should occur within three months), or P4 (can occur within three to 12 months). In 2023/24 we will continue to implement these processes and use the outputs to drive improvements in patient experience and outcomes.

Key metrics	Each of our safety improvement priorities has its own set of defined metrics for improvement. The main metric is a reduction in the percentage of incidents causing harm to patients for each of these key areas of risk.
Focus area	**Implement the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE); including the launch of our new incident reporting/risk management system**
Rationale for selection	Throughout 2022/23 we have been working on our plans to implement key elements of the NHS patient safety strategy, including the patient safety syllabus and the framework for involving patients in patient safety. Progress so far and some of our ongoing plans are described in the next section. Our main focus has been on working towards the implementation of the new Patient Safety Incident Response Framework (PSIRF) which will replace the current serious incident framework as the way the NHS investigates and learns from patient safety incidents. The framework has four key aims: • compassionate engagement and involvement of those affected by patient safety incidents (patients, families and staff) • application of a range of system-based approaches to learning from patient safety incidents • considered and proportionate responses to patient safety incidents • supportive oversight focused on strengthening response system functioning and improvement Through our PSIRF task and finish group, we have been developing and delivering our implementation plan so that we will be ready to launch PSIRF by the national deadline of September 2023. We are also working collaboratively to implement the PSIRF standards across the North West London Acute Provider Collaborative in a consistent manner to support shared learning and improvement. During 2023/24 we will continue this work, using our patient safety insights, to develop our Trust's patient safety incident response plan and patient safety incident response policy, ahead of final transition in September 2023. Key next steps include the commissioning of training across the acute provider collaborative; agreement of our patient safety profile and patient safety incident response plan; agreement of our model to meet the required roles and how we will resource this, with plans to progress this through business planning; and development of our approach for engaging patients, families and carers in learning responses and improvement, with support from our patient safety partners. We will also continue work to transition to the new national way of reporting incidents (Learn from Patient Safety Events – LFPSE). We will work closely across the North West London Acute Provider Collaborative to align working practices and tender for a joint local risk management system for the four acute trusts in north west London. This will be designed to make it easier for staff to report incidents and for themes and trends to be identified to support improved learning.
Key metrics	• Percentage of staff who have completed PSIRF training. Other measurements related to PSIRF will be confirmed on completion of our patient safety incident response plan • Number of projects/programmes in which we involve our patient safety partners • Qualitative feedback from patient safety partners • Percentage of staff who have completed parts 1b and 2 of the patient safety syllabus (target is 90 per cent by October 2023).
Focus area	**Improve the treatment of patients with deterioration in their mental health**
Rationale for selection	The demand for mental health support for patients within the acute hospital healthcare setting has continued to rise and is projected to increase by up to a further 20 per cent over the coming years. Managing mental health presentations here in the Trust has become increasingly challenging, partly because we do not always have the right environment or enough staff with the right training to provide the required level of care. This impacts upon the patient and staff experience and creates a challenge in regard to how to best support the patient therapeutically whilst minimising potential risks to the patient and all others in that environment. We have invested significantly in the development of a new mental health nursing team to support patients on wards and also in our emergency departments, but concerns raised through serious incidents and a recent inquest highlighted the need to do more. In August 2022, we held a mental health summit that brought together key stakeholders within the Trust and from partner organisations, including local mental health trusts. The summit highlighted increasing demand, increasing cause of concern about quality of care for patients and concern from staff about the management of patients. Following the summit, we developed a comprehensive improvement plan. This is being led by a monthly mental health care improvement steering group, chaired by our chief nurse. Successful delivery of the actions will be our key focus in 2023/24. This will require a multi-provider approach with a number of work streams to consolidate existing pieces of work and develop new and innovative approaches to improving the care for people with mental health needs, as well as creating a safe working environment for staff.
Key metrics	• Reduction in agency and bank use for mental health nursing staff • Improvements in compliance with the use of the Mental Health Act • Reduction in serious incidents relating to mental health • Improved staff training levels and reported knowledge and awareness.
Focus area	**User insights and focus**
Rationale for selection	The Trust has set a strategic goal to become more 'user-focused' – to better understand the needs, views and preferences of our patients, staff, local communities and partners. We already gather a huge amount of information including operational information, feedback from surveys (including the friends and family test and national CQC surveys), complaints and compliments received from patients, research activities and community engagement. We want to use this information in better ways, including connecting insights and data to help inform our strategy and our improvement priorities. This will allow us to confidently shape and improve our services and care according to needs of the diverse population we serve. There are many benefits of becoming more 'user focused.' It will help us to design experiences for individuals within our clinical pathways – of which are safe, straightforward, easy to understand, comfortable, dignified, and efficient. We aim to improve clinical outcomes, reduce health inequalities, and become more operationally efficient. We have already begun some key user focused improvement projects, including: • development of a user insights package for wards, which can support continuous local improvement, and feed into other programmes of work, for example safety improvements • development of an action plan to improve our patient interpreting service so that it meets the needs of our patients and staff. This will also improve translation of patient information and written materials given to patients and support us to fully meet the requirements of the accessible information standard • launch of a project to better understand how we can improve end of life care. The work will help us to improve communication with patients and their loved ones, support us to develop personalised care to suit people from a range of cultures and backgrounds, support staff, particularly when they need training or lack confidence, and help us to develop new ways of working • undertaking user research to understand issues, needs and expectations of outpatient digital, communications and administration services • continuing to make improvements to help users navigate our services, including completing our wayfinding programme, working to improve the environment by redecorating and decluttering many public areas across our hospitals. In 2023/24 we will implement zoning and install digital signage at Charing Cross Hospital outpatients and we will also be making improvements to our website and appointment letters. We will also be working alongside the other three trusts in the North West London Acute Provider Collaborative to identify opportunities for shared learning and support, focusing on connecting insights from different sources to build a more accurate picture of key issues and potential improvements. In the coming year, research and insights gathered from these projects, will support us to co-design, alongside patients, improved services of which meet user needs.
Key metrics	To be confirmed – will include improved patient feedback and survey results.
Focus area	**Embed our ward accreditation programme as an enabler for Pathway To Excellence®**
Rationale for selection	Our ward accreditation programme+ (WAP+) aims to support our ambitions to create a positive practice environment and embed a culture of continuous improvement. The programme accredits wards in a variety of metrics across the six Pathway to Excellence® standards (leadership, shared decision making, safety, quality, professional development and wellbeing). In May 2022 we began roll-out of our new WAP+ methodology following a successful trial and have so far accredited 63 clinical areas, with local improvement work then implemented as a result of the findings. Next year, we will focus on embedding the programme, and ensuring that the WAP+ measures and outputs are aligned to, and support the delivery of, Pathway to Excellence®. This is an internationally recognised accreditation scheme which celebrates and recognises the essential contribution that nurses and midwives provide to high quality, evidence-based patient care. We are one of 14 NHS trusts selected to participate in it by the chief nursing officer for NHS England and have started the process initially for Charing Cross Hospital.
Key metrics	Improvements in ward-based quality standards

Progress against our 2022/23 improvement priorities

This section describes the progress we made with the quality and safety improvement priorities we agreed for 2022/23. These were chosen following a review of our quality insights, the NHS patient safety strategy, and in consultation with staff and our partners.

Improve: We will develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods

Focus area	What did we achieve?
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. This was one of our improvement priorities throughout the Covid-19 pandemic as this increased the risks associated with hand hygiene further but also increased the risk associated with the use of personal protective equipment (PPE). We continued this priority into 2022/23 as our incident and audit data showed that there was further work to be done to embed best practice. In summer 2022 we launched a new approach to infection prevention and control education, training and support, following review of our infection-related data and feedback from our staff, and a review of what similar organisations have in place. This new approach involved an improved online training package, which over 90 per cent of required staff (excluding doctors in training) had completed by the end of February 2023. Further work is under way to support improved compliance with all core skills training amongst our junior doctors. This is being enhanced by a rolling programme of structured education and training visits across the Trust by members of our infection prevention and control team with divisional colleagues through our 'Better Together Thursday' campaign. The first of these took place in September 2022, with positive feedback from staff involved, with the second due to take place in April 2023. The Change Lab team at Imperial College London have also been working with our infection control teams and frontline clinical staff on three wards at St Mary's Hospital to develop behavioural insights informed interventions designed to improve compliance, which are now being tested and will be rolled out Trust-wide if successful. With the government's move towards 'living with Covid-19' our successful 'PPE helper' support programme, which was implemented in response to the new PPE requirements introduced during the pandemic, was stood down this year. We now have in post three infection prevention and control support practitioners who will help lead PPE education on each of our three main sites. This will be enhanced by a new clinical practice educator who will start this year. Overall results in the Trust-wide annual infection prevention and control practice audit showed a small decrease in compliance compared to when it was last conducted, from 65 percent in October 2021 to 60 per cent in November 2022. The results have been shared with divisions and who are creating local action plans in response to areas of risk. Despite a huge amount of work, we have continued to see an increase in infection related incidents. This is partly related to Covid-19, with infection rates rising in line with community rates during the surges. We also exceeded our yearly thresholds for MRSA blood stream infections (though we are pleased that there was a reduction – five in 2022/23, compared to 11 in 2021/22), E. coli blood stream infections and Clostridium difficile cases, on a backdrop of a national increase. Our key improvement action is the continued roll-out of our education and support programme to improve basic standards of infection prevention and control practice, with a focus on hand hygiene. This will continue to be a safety improvement priority in 2023/24.

Focus area	What did we achieve?
Improve how we agree and document appropriate treatment escalation plans for our patients in an individualised, compassionate and inclusive manner	This priority was originally chosen in 2020 as we were seeing incidents where patients had not had an individualised discussion regarding the action that we think should be taken if their heart stops. Following a scoping exercise for this improvement priority in 2021, we identified that to improve the timeliness and quality of treatment escalation plans, we needed to make wider improvements to how we care for patients who are at the end of their life, and their families. This was also a key theme highlighted by our medical examiners and in our structured judgement reviews. Our key action in 2022/23 was the development and launch of a new online training module designed to help staff deal confidently with cardiopulmonary resuscitation (CPR) treatment and escalation decisions. By the end of March 2023, 80 per cent of eligible staff had completed this module (excluding doctors in training), with plans in place to reach our 90 per cent target before the end of quarter one 2023/24. Recognising that we needed to do more, at the end of 2022 we agreed the funding to establish an end-of-life education and training team. Recruitment to this team will be completed in 2023. Once in post they will support key improvements including: • improved symptom control and communication regarding end-of-life issues • improved holistic assessment and individualised planning for end of life to meet identified need in conjunction with patients and those important to them • increased discharge to patients' preferred place of death • improved knowledge and understanding of CPR and treatment escalation decisions • improved ability to support Trust-wide service improvement programmes, education and training delivery including culture change programme and communications skills. This improvement priority feeds into end-of-life care planning but also into the care of patients when they are deteriorating. Following review of key themes from incidents, we plan to expand the scope of this priority for 2023/24 to include improving the treatment of patients with sepsis and signs of deterioration with a focus on appropriate treatment escalation.
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, we identified this as a priority area in 2020/21 as we had issues remaining around ensuring consent forms are uploaded onto the electronic patient record. In addition, our process made it difficult to determine if informed consent has taken place. During 2022/23, our aim was to roll out our digital consent process to all elective specialties, which we have achieved. The process allows patients to review clear information on their treatment, ask questions directly of the clinical team, and electronically consent to their procedure. We have received positive feedback from both patients and staff as a key measure of improvement. As we have achieved the aim of this priority, we will be transitioning this to business as usual and will continue to monitor user insights and uptake through continued measurement and reporting.

Focus area	What did we achieve?
Reduce avoidable harm and improve performance and outcomes associated with invasive procedures	The aim of this priority is to improve performance and outcomes associated with invasive procedures with a focus on team performance and safety culture. It was originally chosen as a priority in response to a series of never events in 2019/20 related to invasive procedures which highlighted the need to improve our processes, safety and staff experience. This improvement priority is led by the invasive procedures group and includes work to improve compliance with our existing policies and procedures that are designed to reduce the risk of avoidable harm during invasive procedures. We made the following achievements in 2022/23: • developed and launched a Trust-wide checklist to improve the safety of central line insertions and a supporting e-learning module • completed a review of over 100 local safety standards for invasive procedures ('LocSSIPs'). The review identified key priority areas for audit. Audits completed so far have provided good levels of assurance that the LocSSIPs audited are being effectively used • rolled out the new national standard operating procedure (https://www.salg.ac.uk/salg-publications/stop-before-you-block/) to prevent wrong side blocks – prep, stop, block. A survey with anaesthetists following implementation provided good feedback on the new process and has been used to inform ongoing improvement. We are pleased that operations and procedure incidents causing moderate or above harm have further reduced to 0.9 per cent in 2022/23, compared to 1.5 per cent in 2021/22. However, we are still seeing incidents where failure to follow key safety checks is a factor. Reducing avoidable harm and improving outcomes associated with invasive procedures will therefore remain a priority for 2023/24. Our focus for the next year will be on implementing the new national safety standards for invasive procedures (NatSIPPs) 2, which was published in January 2023. The key aim is to standardise, harmonise and educate across organisations and procedural teams to enable safe, reliable and efficient care for every patient having an invasive procedure.
Reduce the number of patient falls and associated harm levels	This has been an improvement priority for two years following an increase in the number of falls reported on our incident reporting system as causing harm to patients. Trust-wide improvement work is led by our falls prevention and safe mobility steering group. Key achievements in 2022/23 include: • development of metrics and processes to improve oversight of safe mobility and falls prevention – this will now be used to develop a dashboard to target key areas for improvement • agreement to develop a shared falls prevention e-learning packages with the other acute trusts in the integrated care system (ICS) which will now be taken forward • implementation of a new adult basic admission assessment and falls workflow in the electronic patient record • implementation of a pilot of divisional sponsorship for improvement work to support spread and reduce variation • scoping of options to improve assurance of compliance with bed rails guidance. This will be part of our Trust priority audit plan in 2023/24. Despite this work, the percentage of patient falls reported on our incident reporting system as causing moderate or above harm increased to 2 per cent in 2022/23 from 1.5 per cent in 2021/22. Analysis of our falls incidents and investigations has identified a number of themes which we will continue to work to improve during 2023/24. These include work to improve consistent completion of falls multifactorial risk assessments and post-falls assessments.

Focus area	What did we achieve?
Improve the checking of blood components prior to transfusion	Patients can be seriously harmed if given the wrong type of blood during a transfusion. During 2021/22 we reported two 'never events' where patients were incorrectly administered incompatible blood, which could have been avoided if the right pre-administration checks had been carried out. Fortunately, neither patient came to harm because of the incident. This priority aimed to improve the checking of blood components at the bedside before transfusion. During 2022/23 we have achieved the following: • development of a new e-learning package on all aspects of blood transfusion with modules for specific roles. We achieved compliance of 76 per cent for doctors in training and 91 per cent for all other staff • delivery of face-to-face training in clinical areas on how to complete the pre-administration checks at the bedside, including the use of the electronic pre-administration checklist on Cerner. This included sharing learning from incidents to show why these checks are important and need to be done this way • introduction of digital handheld checking devices to assist with bedside checking in areas where the Cerner checklist cannot be used, such as in theatres where a different electronic system is used • design of a paper checklist which sits on the compatibility tag attached to each blood component. These will be introduced in April 2023 and will provide a checklist for use during information communication and technology down times and in areas that do not have access to the checklist in our electronic patient record. It also provides a visual reminder and learning aid for staff. We have not reported any never events related to blood transfusion since August 2021, however we do still see incidents. Improving the safety of blood transfusions will therefore continue as an improvement priority into 2023/24. In 2023, we will also participate in a national comparative audit on the process of administering blood, including bedside checking which will help identify further improvements.
Improve the identification and management of adult patients with dysphagia	Patient nutrition and hydration is a cornerstone of meeting patients' basic health and care needs. In 2019 a patient died in Sheffield Teaching Hospital Trust from an incident of dysphagia (the medical term for swallowing problems) resulting from the ingestion of the wrong consistency diet. This incident led to publication of the National Confidential Enquiry into Patient Outcome and Death, "Hard to Swallow?". Following review of an increase in incidents, including two serious incidents which occurred in 2021, we identified some gaps in our assurance around the recommendations of this inquiry and this was therefore confirmed as a safety improvement priority for 2022/23. Due to emerging safety risks in year, we have been unable to focus on making improvements in this area. For this reason, we will continue to ensure this is a priority for 2023/24 and have sourced additional speech and language resource within the safety improvement team to take forward this work. This will include the development of an education and training plan and improvements to our Trust-wide processes and systems, as well as locally led improvements at ward level. We will also look to scope other improvements in overall management of nutrition and hydration within the Trust based on our insights and learning.

Focus area	What did we achieve?
Improving fetal monitoring during labour	Cardiotocography (CTG) is the most widely used technique for assessing fetal wellbeing in labour and monitoring is performed during labour to identify if fetal hypoxia is developing (this occurs when the fetus is deprived of an adequate supply of oxygen and may occur for several reasons). In line with the saving babies' lives care bundle (2016, 2019), at least hourly, the CTG should be systematically reviewed by two qualified professionals – this is called 'fresh eyes'. This was identified as an improvement priority in mid-2022 following concerns raised due to learning from recent incidents, and the compliance with hourly fresh eyes reviews of CTGs on our labour wards. Safety improvement team resource was diverted to support our maternity services with this new priority. During the remainder of the financial year, the following was achieved: • a deep dive to understand the problem and to collect ideas for improvement. This included visits to the departments, conversations with many staff members in different roles and review of multiple data sources such as incidents • our helping our teams transform (HOTT) team was prioritised to support maternity staff through completion of a series of conversation cafes to gain further insight and learning • the addition of a co-sign function to the fresh eyes form on Cerner in October. This helped staff to document fresh eyes compliance more easily and accurately, as they no longer had to log on independently • fresh eyes compliance is being shared with staff on a monthly basis using an infographic poster, to help motivate them to improve and celebrate successes. This also includes key messages and highlights areas for further improvement • compliance with fresh eyes increased from 63 per cent in March 2022 to 91 per cent across both sites by March 2023. This safety improvement priority will continue into 2023/24, focusing on improving fetal monitoring, interpretation and escalation.
Improving follow up of abnormal urine results in maternity	The aim of this priority is to reduce variability and provide assurance that abnormal midstream specimen of urine (MSU) results in maternity across all teams are acted upon according to our agreed processes. This became a safety improvement priority in July 2022 because missed follow-up of results had been highlighted as a contributory factor in incidents. In addition, patient safety research nationally and internationally has identified poor test result management as a key priority area for improving all patient safety. Following scoping of current issues and processes, several local improvements have been made to reduce risk and improve efficiency, such as introduction of a communications leaflet in the antenatal clinic at St Mary's Hospital. The next step is to introduce an electronic system for checking and following up results which will reduce the potential for human error and create a single standard process across all areas. This safety improvement priority will therefore continue into 2023/24.

Insight: we will improve our understanding of safety

Focus area	What did we achieve
Improve patient safety incident reporting rates and implement Learn From Patient Safety Events (LFPSE)	Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. Consistent reporting across the organisation enables 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 are 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. Over the course of the year we have seen an overall improvement in our incident reporting rate, which is positive, particularly as our harm levels remain low (our rolling 12-month percentage of incidents causing moderate or above harm is 1.13 per cent, below the national average of 2.61 per cent). Our patient safety incident reporting rate per 1,000 bed days is consistently above national average and our annual rate is the highest it has been for over four years. This year we have been focused on preparing for the transition to LFPSE. This has included the mapping of our current incident form with the new LFPSE questions and stakeholder engagement to review user requirements for both reporting and learning from incidents. Other progress we have made includes: • emphasising the importance of reporting incidents alongside other key safety messages through our Trust-wide 'Set the Standard' communications campaign, which included improved guidance for staff on how to report incidents and what we do to investigate and learn from them • developing and launching a new dashboard of incident data. This has had positive feedback from clinical staff as it allows them to track and monitor their incidents in real-time, identify themes and implement actions quickly in response • implementing a newsletter for junior doctors which helps share learning and reflections, explain the process, and provide greater support for junior doctors involved in incidents. This was developed by our junior doctor safety improvement working group in response to feedback that junior doctors sometimes found the process around incident reporting and investigation stressful. As described in the above section, in 2023/24 we will implement LFPSE and re-tender for a new incident reporting system with the other North West London Acute Provider Collaborative trusts. As well as making it easier to report, and identify themes and learning from incidents, this will provide further opportunity to highlight the importance of reporting incidents through the communications and training we will need to develop to support the launch.
Improve our response to patient safety incidents and implement the patient safety incident response framework (PSIRF)	We are continually working to improve our approach to investigating patient safety incidents. We are pleased that in 2022/23 we have not had any serious incidents or internal 'level 1' investigations which went overdue, but we know we have more work to do to improve the timeliness and quality of our investigations. During 2022/23 we focused on embedding the use of 'after action review' as our primary method of investigation (this approach involves a rapid review of the incident, with all staff involved coming together to discuss the incident in a structured and facilitated manner. This helps support a systems approach to investigation and ensures staff are fully supported when they are involved in an incident, the learning is rapidly shared and any immediate action is taken to mitigate recurrence). Our main action was to develop our implementation plan for PSIRF, as described in the section above. Once in place, the new framework will help improve our approach to patient safety incident investigation, with a clear focus on improvement and ensuring those affected by the incident are fully involved in the process, something which we do not currently always get right.

Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety	
Focus area	**What did we achieve**
Implement the framework for involving patients in patient safety	We are passionate about ensuring we involve patients, families and carers within our patient safety programme, and have been working to deliver the requirements of the NHS England framework for involving patients in patient safety throughout the year. During 2022/23, we recruited six patient safety partners to become active partners in all elements of governance, monitoring and improvement related to patient safety. We completed a robust induction programme with our patient safety partners and are now working collaboratively to align our patient safety partners with our safety improvement priorities, including work to implement PSIRF. We will continue to work to progress delivery of the overall framework throughout all of our patient safety work in 2023/24.
Support our staff to complete the patient safety syllabus training modules	Training is a fundamental part of the national patient safety strategy. A new patient safety syllabus was published in 2021 which includes online training which is required for all staff across the NHS. Our aim during 2022/23 was to ensure that 90 per cent of our staff had completed level 1: essentials for patient safety by April 2023. We just missed this target, with compliance at 81.9 per cent at the end of March 2023. We have improvement plans in place to achieve our 90 per cent target by the end of quarter one 2023/24. During 2023/24 we will roll out level 1b training (for senior leaders) and level 2 (access to practice) in a consistent way across the North West London Acute Provider Collaborative with regular reporting of compliance. We will develop our implementation plans for levels 3 to 5 once these are available.
Develop the patient safety specialist model for the Trust	Patient safety specialists, defined as the lead patient safety experts in healthcare organisations, are key to local delivery of the national patient safety strategy. We now have two patient safety specialists at our trust. During 2022/23, they engaged in all national meetings and shared learning through our ongoing patient safety workstreams. However, given the scale of the work, and the size and complexity of our trust, we have agreed to increase the number we have and implement a mixed model of corporate oversight and management of the overall strategy with divisionally based specialists. Development of this model will be a continued focus for us in 2023/24.

Covid-19 quality improvement activities

For the third successive year we have had to reprioritise our efforts to caring for patients with Covid-19, while also dealing with the wider impact of the pandemic, including an increase in patients whose elective, planned care had been delayed, higher demand than usual in our emergency departments, and supporting the biggest vaccination programme in the history of the NHS. Throughout the year, we have continued to respond and adapt quickly to the changing impact of the pandemic. As we enter the fourth year of the pandemic, we will carry on reviewing the changes and additional services and processes that we have implemented to ensure that we provide high quality care to our patients and support to our staff.

Hospital-associated Covid-19 infection, transmission and deaths

During 2022/23, Covid-19 has continued to cause significant disruption to services as well as continuously posing a threat of transmission for our patients, visitors and colleagues across the Trust.

Although we have adopted strategies to live with Covid-19, balancing the risks of access to care versus the risks to individuals through infection, waves of Covid-19 continue to pose challenges, particularly with regard to patient flow.

In line with national guidance and by engaging collaboratively with infection prevention and control teams across the sector, we have adopted a pragmatic approach to Covid-19 testing to give consistency across clinical areas and to aid patient flow. We moved away from blanket screening to a more targeted approach for symptomatic patients. However, in high-risk areas where patients are at a greater risk of poorer outcomes from the virus, we have kept tailored approaches to ensure patient safety.

We have also had to manage other respiratory viruses such as influenza and RSV, placing greater pressure on finite resources. Our vaccination programme – discussed in further detail below – contributed to the successful navigation of an extremely difficult winter period. Moving forward, our focus will switch to preparation for coming waves and winters, drawing on the lessons learned from 2022/23.

We are continuing to operate a robust Covid-19 surveillance platform, with daily reports on hospital-onset Covid-19 infections (HOCI) shared with clinical and managerial staff, facilitating timely flagging of risks and providing valuable time to plan mitigation measures.

The surveillance platform uses the UK Health Security Agency (UKHSA) HOCI definitions of cases and reports new Covid-19 positive laboratory samples as:

- **hospital-onset indeterminate healthcare associated (HOIHA):** Positive test result three to seven days post admission
- **hospital-onset probable healthcare-associated (HOPHA):** Positive test result eight to 14 days post admission
- **hospital-onset definite healthcare-associated (HODHA):** Positive test result on or after 15 days post-admission.

We recorded 668 HOCIs in 2022/23, broken down as follows:

HOIHA (positive test result three to seven days post admission)	250
HOPHA (positive test result eight to 14 days post admission)	165
HODHA (positive test result on or after 15 days post-admission)	253

Sadly, of these 668 cases, 60 patients (nine per cent) died within 30 days of a positive sample following either an indeterminate, probable, or definite HOCI.

Our clinical incident management systems are used to investigate and learn from Covid-19 outbreaks and related incidents. All outbreaks trigger a 72-hour report and are reviewed weekly by a multidisciplinary panel to assess cases' suitability for investigation under the serious incident framework. Up until October 2022, all deaths following a HOCI were automatically referred for a structured judgement review, as per our learning from deaths process (see section 1.2 for more information).

The Covid-19 board assurance framework and associated action plan is regularly reviewed and presented to our executive and board quality committees. It is anticipated that the board assurance framework will continue into 2023/24 with a focus more generally on respiratory pathogens, rather than Covid-19 specifically.

Vaccination programme

Our vaccination programme has continued to provide staff, patients and eligible members of the local community with convenient access to seasonal Covid-19 and influenza boosters in 2022/23, as well as continuing to offer first and second doses.

We remain committed to improving uptake of vaccinations in our staff and patients. We have worked with clinical services to minimise referral processes and wait times, offering walk-in appointments for staff and patients who are in our hospitals for inpatient treatment or outpatient appointments. An initiative with maternity services staff has encouraged pregnant women already on-site for antenatal care appointments to attend vaccination centres with 'express lanes' set up to ensure minimal waiting times.

We have also improved access by operating a regular roaming vaccination service, with trained vaccinators visiting areas of the hospital to provide vaccinations in other clinical settings. Pop-up 'mini hubs' have been mobilised across our estate to further improve ease of access for eligible groups.

The vaccination programme has continued to make appointments available to the local community via the national booking system. Over 5,700 appointments were booked in 2022/23, taking the total number of appointments booked via the national system to over 28,000 since the service began in November 2021.

Through our commitment to the north west London vaccination effort, the St Mary's vaccination centre became the only vaccination site in the region to offer the Nuvaxovid (Novavax) vaccine in the autumn 2022 campaign. This vaccine was the only suitable alternative for people who had previously experienced a severe allergic reaction to mRNA vaccines or their ingredients. A referral process was established with GPs in the region so that their suitable patients could receive their seasonal vaccinations.

We have continued to adapt our vaccination programme in response to changing national requirements and by using our expertise and resources in new and innovative ways to meet the needs of the population.

As well as clinical vaccination services, the vaccination programme has provided an overseas vaccination validation service for people who have had one or more Covid-19 vaccinations outside of England. The service supported over 3,400 people to have their vaccination records added to personal health records in England, including GP records and the NHS app.

In the autumn 2022 campaign, we had the second highest staff uptake of Covid-19 vaccinations of all acute trusts in London. Staff uptake of influenza vaccinations was just above regional and sector averages.

The government recently accepted the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) that Covid-19 booster vaccinations for health and social care workers become a seasonal offer like flu vaccinations. This is a significant change from the previous recommendation to make boosters available all year round.

We therefore paused vaccination services at the end of the autumn 2022 campaign and will shift to offering seasonal campaigns, in line with NHS England guidance. This marks the first time we have closed our vaccination centres since they became operational on 20 December 2020. During this time, we have administered over 99,000 Covid-19 vaccinations.

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.

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. The lessons learned from operating the service since December 2020 will be incorporated into future campaigns.

1.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2022/23. 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 2022/23, the Trust provided services to combat Covid-19 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 2022/23 represents 96 per cent of the total income generated from the provision of Trust services in 2022/23. The income generated by patient care associated with these services in 2022/23 represents 84 per cent of the total income generated from the provision of services by the Trust for 2022/23.

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.

During 2022/2023, 59 national clinical audits covered relevant health services that the Trust provides. During this period, the Trust participated in 97 per cent of national clinical audits and 100 per cent of national confidential enquiries which we were eligible to participate in.

There were two clinical audit programmes in which the Trust did not participate. The first was the Society for Acute Medicine's benchmarking audit. The second audit was muscle invasive bladder cancer audit, which is part of the British Association of Urological Surgeons (BAUS) audit programme (BAUS Urology). The divisions review other relevant metrics to provide assurance through divisional governance processes.

The national clinical audits and national confidential enquiries that we were eligible to participate in are included in a table in Annex 3. The number of cases submitted are presented as a percentage where available. Please note that percentages will be accurate up to March 2023 where host organisations were contacted, but some data collection was still ongoing.

National clinical audit

The Trust reviewed the reports of 49 national clinical audits and confidential enquires in 2022/23. These clinical audits, linked to 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 Hip Fracture Database (NHFD) Report

The NHFD report was rated as significant risk due to the low percentage of patients with a hip fracture who were admitted to an orthopaedic ward within four hours (1.6 per cent).

There is a decline in performance across other hospitals too (the average for participating trusts in England was 19.4 per cent in 2021 compared to 34.9 per cent in 2020). A ring-fenced fractured neck of femur admission bed has now been commissioned which should improve performance.

National Audit of Inpatient Falls (NAIF)

The NAIF report was rated as acceptable risk/reasonable assurance with some previously known areas for improvement. We are performing above national average for many of the audit standards, including carrying out a prompt medical assessment after a fall (80 per cent vs 60 per cent nationally) and completing a high-quality multifactorial risk assessment (80 per cent vs 30 per cent nationally), although we know we have further room to improve. Actions are being taken forward as part of the safe mobility and falls prevention steering group workplan.

NCEPOD Hard to Swallow?

This study was focused on management of dysphagia (swallowing problems) for patients with Parkinson's disease, however the themes were similar to those identified previously as part of a Trust-wide review of dysphagia management. A local action plan is in place for the services specifically involved in this audit, however wider Trust-wide improvement is required; this will remain a safety improvement priority in 2023/24.

National Audit of Care at the End of Life (NACEL)

NACEL evaluates the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in hospitals in England and Wales.

Results for our Trust suggest strong organisational leadership and governance. The possibility that a patient may die within the next few hours/days was recognised in 97.5 per cent of relevant patients. The audit shows that we routinely discuss CPR and treatment escalation decisions and recognition of dying, but only 59 per cent of patients have an agreed individualised care plan. This falls below the national average. The audit also showed that we do not always discuss nutrition and hydration and potential side effects from anticipatory medications at the end of life. We need to improve our holistic assessment of patients' symptoms in the last hours and days of life, in documenting the benefit of starting, continuing or stopping certain interventions, and in recording preferred place of death.

This remains a safety improvement priority for the Trust.

MBRRACE – UK Perinatal Mortality Surveillance

The perinatal mortality surveillance covers perinatal deaths from 22+0 weeks gestational age (including late fetal losses, stillbirths, and neonatal deaths) of babies born between 1 January and 31 December 2020. The audit showed that our stabilised and adjusted mortality rates were similar to, or lower than, those seen across comparable trusts and health boards in the comparator group with a Level 3 neonatal intensive care unit. Overall, the crude mortality rates for babies born within the Trust shows there has been a reduction in neonatal death rates year-on-year. Three areas for improvement have been identified, with actions underway: timeliness of reporting, completeness of information submitted and recording of ethnicity for all perinatal losses.

National Comparative Audit of Blood Transfusion

The objective of the national audit programme is to provide evidence blood is being ordered and used appropriately, administered safely, and to highlight where practice is deviating from guidelines to the possible detriment of patient care. The national comparative audit based on NICE standards and our performance was rated as acceptable risk/reasonable assurance. The action plan included identification of a location in Hammersmith Hospital for administration of intravenous iron, implementation of a single unit policy across the Trust; and the addition of consent for transfusions to our digital consent platform.

Local clinical audit

As well as participating in national clinical audits, we have a Trust priority audit programme in place designed to support our existing priorities, including our safety improvement programme. Select examples are included in the table below.

Audit title	Audit findings
Consultant ward round audits	The corporate audit team undertook a seven-day services audit related to consultant ward/board rounds and the documentation of these across a number of areas. The audits assessed whether there was documented evidence of a ward round taking place daily, whether a consultant was present at each of these ward rounds and whether any emergency inpatient admission was seen by a consultant within 14 hours. The following clinical areas were audited this year: • cardiology wards at Hammersmith Hospital – substantial assurance • paediatric wards at St Mary's Hospital – reasonable assurance. The next audit will take place in the emergency department, focusing on patient time spent in the department and referral times to other specialties.
LocSSIPs	A rolling audit programme is in place to ensure we are regularly reviewing how effectively our teams are using our local safety standards for invasive procedures (LocSSIPs). The following LocSSIPs were audited in 2023/24: • endoscopy procedure checklist (acceptable risk/reasonable assurance) • cardiac catheter lab safety checklist (low risk/satisfactory assurance) • umbilical venous catheter (UVC) insertion, umbilical arterial catheter insertion (UAC), central line/peripherally inserted central catheter (PICC) line (low risk/satisfactory assurance) • flexible cystoscopy (low risk/satisfactory assurance). Recommendations for improvement include education on the importance of doing verbal checks, highlighting previous near miss cases and ensuring adequate staffing.
MRSA screening and suppression therapy	During 2021/22, we saw an increase in the number of healthcare-associated MRSA blood stream infections. As part of the post investigation reviews of these cases, MRSA screening and suppression therapy were highlighted as areas that need assurance. An audit was therefore completed which identified areas for improvement. These were implemented as part of an overarching improvement plan in response to the increase.

In addition to the Trust-wide audit work described above, specialties within directorates conduct local audit activities which provide information on how their services are performing. Throughout 2022/23 there were 230 local audits registered in the Trust. These reports, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Maternity services

As with many maternity units in the country, during 2022/23 we experienced significant midwifery and nursing staffing shortages. Our maternity services have been focused on continuing to deliver personalised and safe maternity and neonatal care, and to ensure

that the people who use our services are listened to, understood and responded to with respect, compassion and kindness. Our data shows that we have managed to achieve this for most of our patients.

We identified some key areas for improvement including around our approach to fetal monitoring and follow up of abnormal urine results; these are being carried on as safety improvement programme priorities into 2023/24 so that the work can be completed and embedded.

We have also been focused on implementing the requirements from three key national programmes/reports, which are summarised below.

Ockenden independent maternity review at Shrewsbury and Telford Hospital NHS Trust – final report published in March 2022

Since the interim Ockenden report was published in 2020, all maternity services in the country have been working to achieve compliance against a number of immediate and essential actions. This culminated in an externally led assurance visit in September 2022 to review progress and provide additional support where required. Our report from this visit was generally positive and recognised the 'clear and insightful view of both successes and issues' faced and the plan in place to build on well-established achievements. We have since been confirmed as compliant with five out of the seven immediate and essential actions. Actions plans are in place to achieve the remaining recommendations from the review, with regular reporting through our internal governance processes.

'Reading the Signals' – The report of the independent investigation into maternity and neonatal services in East Kent – published in October 2022

The findings of this report were similar to the Ockenden review, highlighting failings in governance and leadership, failure to listen to staff and to patients and families when concerns are raised, issues around culture and teamworking, as well as care and service delivery issues. While the recommendations from the report were for national bodies rather than NHS trusts, we reviewed our systems and processes through the lens of the findings to see if there were any further improvements we needed to implement. We were assured that we have mechanisms and actions in place to monitor safe performance, standards of clinical behaviour, and improve team working and the organisational behaviour. Support is also provided via the North West London local maternity and neonatal system which provides surveillance and assurance of maternity services across the sector.

Maternity Incentive Scheme (year four)

The maternity incentive scheme (MIS) aims to support maternity services to deliver safer care through recovery of an incentive element built into the clinical negligence scheme for trusts' contributions, where trusts can evidence compliance with all ten safety actions. Following completion of a comprehensive action plan in February 2023, we reported compliance with all aspects of scheme. The focus will now be on embedding the progress made to ensure the improvements are sustained.

In March 2023, our maternity units at Queen Charlotte's & Chelsea Hospital, St Mary's Hospital, and our private maternity unit, Lindo Wing, were inspected by the CQC as part of their national maternity inspection programme. Once we have the results of the inspection we will implement any additional improvements required.

A single maternity improvement plan is currently being produced by NHS England and key stakeholders. This will bring the recommendations and improvement actions from the final Ockenden report, East Kent report and maternity incentive scheme year five together. Once this is received, we will develop a full improvement plan which combines all our current work and any further actions we need to take. Where this will add value, we will do this collectively with the other trusts in the North West London Acute Provider Collaborative quality committee through the maternity standards quality priority workstream.

Our participation in clinical research

In collaboration with Imperial College London – and with many other partners in industry, charity and government (local and national) – the Imperial Academic Health Science Centre (AHSC) partnership drives our biomedical and clinical research strategy, coordinates our efforts and aligns priorities across north west London. It ensures we remain at the forefront of new scientific discovery and aids in translating cutting-edge research for the benefit of our patients and the wider population.

Much of our innovative research is enabled through 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 Research Centre (PSRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). The Imperial CRF has recently been awarded funding (£11.3m) for a further five years from 2022 onwards, as has our ECMC (£1.2m) and PSRC (£2.6m).

One of the greatest successes in the past year has been the renewal of our BRC programme – the NIHR Imperial BRC received the largest amount of funding (£95.3m) in the recent competition. The BRC focuses on experimental medicine – early phase discovery science trialled in the clinic for the first time – and is structured around four main strategic areas:

- early diagnosis (developing new tests and improving current testing to speed up diagnosis and allow earlier treatment)
- precision medicine (tailoring treatment to a patient's specific needs to improve outcomes)
- digital health (using computer technology to provide clinicians with more accurate information for better treatment and allow patients to manage their health)
- convergence science (bringing different scientific fields together to provide new perspectives and solve complex health research challenges).

BRC highlights from the past year include new insights into our understanding of how Covid-19 vaccines perform in patients with serious conditions who need to take immunosuppressing drugs, development of a digital platform to enable us to routinely collect data within the home to analyse the well-being of patients living with dementia, the first effective drugs for patients with previously untreatable complement-mediated kidney disease, and the successful completion of the first ever 'human challenge' trials of the Covid-19 virus in healthy volunteers.

We continue to invest in the analysis of large, interlinked datasets, and to develop new artificial intelligence tools to assist in clinical decision-making.

We also have a strong focus on those sectors of our population who are underrepresented or underserved in terms of their involvement and inclusion in clinical research, with a view to addressing the wide variations in health across our local and national populations. We aim to widen access and increase opportunities for participation in clinical research

to better reflect our patient demographics. This is essential to developing and rolling out health technologies which are effective for all.

We continue to work in close partnership with Imperial Health Charity to complement the research we undertake, particularly around clinical academic training and development of nurses, midwives, dietitians, physiotherapists and other allied health professionals.

The total number of patients receiving NHS services provided or sub-contracted by the Trust in 2022/23 that were recruited to participate in research approved by a research ethics committee was 14,504. 14,738 patients were recruited into 420 NIHR portfolio studies in 2022/23 – this includes 470 patients recruited into 90 studies sponsored by commercial clinical research and development organisations.

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. Following the suspension of the CQUIN programme due to the Covid-19 pandemic, the programme was reinstated in April 2022. However, as opposed to previous years, the Trust's income was not conditional on the achievement of the targets. For the financial year 2022/23 it was agreed that in order to re-establish the programme we would report performance data for only 13 CQUIN schemes, and there was no focused improvement work related to those schemes.

Submissions have been made for the first three quarters of 2022/23, and we are on track for our quarter four end of year submission in May 2023. Our CQUIN goals for 2023/24 have not yet been agreed, however it is possible we will focus on five schemes, and a proportion of our income in 2023/24 will be conditional on achieving quarterly targets for these schemes.

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the CQC for all of its sites; we were compliant with the requirements of our CQC registration during 2022/23 and our current registration status is 'registered without conditions'. Additionally, the Trust was not subject to any enforcement action this year. Our overall CQC rating remains 'requires improvement'.

The CQC did not return to routine activity (including inspections) during 2022/23 as it had planned for a variety of reasons, including the impact of its own internal restructure and work to develop new methodologies on its resources. They continue to carry out urgent and focused inspections for serious concerns; we were not subject to a focused inspection this year. We were included in a national maternity inspection programme which ran from August 2022 through March 2023; the Trust's maternity inspection took place in March 2023. The final report and any updated ratings are expected to be published in quarter one of 2023/24.

We participated in routine engagement meetings with the CQC this year, responded to routine incident requests (as part of the CQC's learning from deaths mandate), and responded to general enquiries from the CQC (complaints or concerns about the Trust are raised either directly by the CQC in response to their intelligence or by others such as patients, families, member of the public, etc.).

We did not participate in any special reviews or investigations by the CQC this year, nor were we captured in any reports published this year following special reviews or investigations undertaken in a previous year.

The CQC requires all trusts to participate in the NHS England patient survey programme. The outcomes of the following surveys were published this year:

- 2021 adult inpatient survey, published September 2022
- 2021 national cancer patient experience survey, published July 2022
- 2022 maternity survey, published January 2023.

We performed favourably in all surveys, both compared to previous performance and in relation to other trusts. No serious concerns were raised in any survey published this year; where improvements were needed, they were managed in line with normal Trust processes. During 2022/23, the Trust participated in the 2022 national cancer patient experience survey, 2022 adult inpatient survey, 2022 urgent and emergency care survey, and 2023 maternity survey, with outcomes expected to be published during 2023/24.

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

We submitted records during 2022/23 to the commissioning data sets (CDS) dashboard (formerly 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 December 2022), which included the patient's valid NHS number, was:

- 98.1 per cent for admitted patient care
- 99.2 per cent for outpatient care
- 94.7 per cent for accident and emergency care.

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

- 100 per cent for admitted patient care
- 100 per cent for outpatient care
- 99 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 Social Care 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 2022/23.

Data quality

In 2022/23, the Trust's elective care data quality framework transitioned to business as usual and was also renamed as the waiting list and waiting times data quality framework to ensure that emergency care will be represented in the plan for 2023/24. Progress and metrics related to data quality is reported to the Trust executive on a bi-monthly basis. This provides a comprehensive overview of data quality across the organisation as well as detailed updates on performance across the current data quality metrics and outcomes of internal audits on waiting lists.

A weekly waiting list decision support panel continued to support rapid review of operational process changes, alongside impact analysis and mitigations, for data quality and reporting. Significant work has been completed to monitor, track and report data quality as well as mitigate patient risks throughout the Covid-19 recovery period.

A large-scale review of our waiting list and waiting times data quality commenced during 2022/23 to assess; the outputs of this will inform the plan for data quality improvement in 2023/24.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures, and compliance with which is regularly reported internally to our quality committee and then to the North West London Acute Provider Collaborative board-in-common. All patient deaths which occur in the Trust are scrutinised by the medical examiner. Through this process, which involves 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 when the criteria are met.

Structured judgement review 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, dependent on any issues identified, may be subject to more in-depth investigation via our serious incident framework to identify further areas for learning and implement actions to improve. In addition to this, a regular death review panel is in place to consider any complex cases and triangulate all associated investigations.

We no longer rate deaths on whether they might have been 'avoidable', but instead on the quality of care (graded from excellent to very poor), with a final decision then being made on whether the death was more likely than not to have occurred due to problems in care.

Prior to October 2022, all deaths of patients who died in our Trust after a hospital-onset Covid-19 infection (HOCI) went through an enhanced mortality review process. In October 2022, our executive approved a proposal to stop automatically undertaking structured judgment reviews (SJR) for patients who die with a HOCI. This was not a national requirement but was an important part of our scrutiny whilst we learnt about the evolving pandemic. Through this process we incorporated learning into our policies and guidelines but we have not found any significant lapses in care and we weren't gaining any new learning. We have now reverted to the standard mortality review process where the medical examiner would trigger a structured judgement review if concerns are raised.

Patient deaths: April 2022 – March 2023

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	490	448	486	511	1,935
Number of deaths referred for SJR – based on date of death	61	107	27	49	244

Deaths which occurred in 2022/23

Of the 1,935 deaths that occurred during 2022/23, all deaths were subject to medical examiner review, and 224 were referred for structured judgement review. Of the 260 deaths which have had these reviews completed (the number also includes some structured judgement reviews completed that were allocated in 2021/22 but completed in 2022/23), there were 18 for which some issues were identified in the overall care delivered. The key themes from these were around improving end of life care and recognising and responding to the deteriorating patient. This is one of our safety improvement programme priorities for 2023/24. There was also learning related to communication with the patient's family, in particular around how we approached the concerns they raised as part of the investigation process, which is being fed into our plans for developing our approach and process for engaging patients, families and carers in learning responses and improvement as part of PSIRF.

Of these 18, the death review panel has reviewed 11 cases so far and has confirmed poor care in eight. The panel concluded that in three cases, the poor care had more likely than not contributed to the deaths. There are two cases for which further investigation is required before a final decision can be made. During 2022/23, the panel also reviewed three cases that were completed in 2021/22; poor care was confirmed in three of these and for two it was felt that the poor care contributed to the death.

A separate process is in place nationally for all stillbirths, late fetal losses and neonatal deaths called the perinatal mortality review tool (PMRT). This consists of designated review meetings where each aspect of care is scored and action plans to address any issues are approved. These are recorded on the national PMRT database and the generated reports are collated and analysed nationally and within the Trust for trends and themes to facilitate learning.

Of the six PMRT reviews completed in 2022/23, there were no cases where care or service delivery issues were identified which may have changed the outcome. We have a backlog of PMRT cases from previous years caused by pausing of the review process in pandemic surges. A recovery plan is in progress with escalation processes in place. This will be completed by December 2023. Additional resource has been allocated to support this important work.

We have started work to review the maternity and neonatal death process, including the PMRT process, and align it with our overall mortality review governance and reporting to improve visibility of outcomes and actions. The amended process should be implemented before the end of quarter one 2023/24.

The outcomes of structured judgement reviews and perinatal mortality reviews are shared with the relevant clinical teams and across the Trust through divisional quality and safety committees. A bi-monthly newsletter is now also being produced. Individual action plans are developed in response to each case. Cases are also shared with the safety improvement programme workstream leads to ensure the improvement work covers the findings of the reviews.

In April 2023, we expanded our medical examiner service to include deaths which occur in the community within the London Borough of Hammersmith & Fulham and the City of Westminster, which will improve how we learn from deaths across the local healthcare system.

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 classify four as key standards. Through our rolling audit programme we continue to be able to report good levels of assurance against the four priority standards, and full or partial compliance with all other standards. The four key standards are: early consultant review, access to diagnostic services, access to interventions and ongoing review which are described below.

Standard two – early consultant review: Our policies, procedures and staffing models comply with this standard. Previous audit identified areas of improvement which included the quality of documentation and the structured use of consultant-led board rounds. Since then we have worked hard across the trust to improve the quality and multidisciplinary participation of board rounds and have created new standards for these so that everyone, including our patients, gets the best of out of them. Our audit programme will review compliance against these standards in 2023/24.

Standard five – access to diagnostic services: The trust can report compliance against this standard for the provision of ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Our imaging and diagnostic services remain under considerable pressure due to large patient waiting lists which has been mitigated with the use of improved technology and new ways of working, including remote reporting and outsourcing routine reporting.

Standard six – access to interventions: We can still report full compliance with this standard. Twenty-four-hour access is maintained by rostered consultant-led teams and rotas.

Standard eight – ongoing review: We can report partial compliance with this standard. Twice daily consultant review occurs for high dependency/critical care patients as evidenced by regular audits. Most areas are compliant with the requirement for consultant review once every 24 hours. Where a consultant review does not occur every 24 hours, this can be mitigated as outlined in standard eight, by the use of clear patient pathway derogation to other senior decision-maker doctor. The use of comprehensive multidisciplinary consultant-led board rounds can also be utilised to highlight patient's needing daily review or where this can be delegated to another appropriate senior decision-maker. Our audit programme will review compliance against these standards in 2023/24.

Additional standards: 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.

Rota gaps

We have 802 doctors in training working at the Trust, with 46 gaps on the rota. Twenty-eight of these gaps have been filled by locally employed doctors. We have 18 unfilled posts, 10 of which are being recruited to. 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 difficult to recruit specialties and the use of locums, where necessary.

1.3 Reporting against core indicators

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

Mortality

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR hospital standardised mortality ratio (HSMR) and summary hospital-level mortality indicator (SHMI), 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 21/22*			Trust performance				
	Mean	Lowest	Highest	2022/23	2021/22	2020/21	2019/2020	OBJ
SHMI	100	62.26	124.7	75.02	72.73	77.02	70.24	OBJ
Banding**	2	3	1	3	3	3	3	OBJ
% deaths with palliative care coding	40.00%	12.00%	65.00%	62.00%	61.00%	56.00%	58.10%	OBJ

*National and Trust position currently rolling 12 months from November 2021 to October 2022
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital

HSMR

	Trust performance			
	2022/23*	2021/22	2020/21	2019/20
HSMR	77.9	68.03	75.9	67.6
National performance	3rd lowest HSMR of all acute non-specialist providers	6th Lowest HSMR of all acute non-specialist providers	3rd lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers

*National and Trust data currently only available to December 2022
Source: Telstra Health

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

- it is drawn from nationally reported data
- our palliative care coding rates are high, and we are confident that they are accurate with a clinical coding review process in place
- we have reported a lower-than-expected SHMI ratio for the last five years
- we have the third lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (up to October 2022)
- we have the third lowest HSMR of all acute non-specialist providers across the last available year of data (up to December 2022)
- mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our structured judgement reviews we can provide assurance that we are providing safe care for the majority of our patients. Where care issues are found we have a robust process for referral for more in-depth review.

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
- continuing to work with the other trusts in the North West London Acute Provider Collaborative to improve our learning from deaths processes collectively
- completing a review of the processes and function of the specialist mortality and morbidity meetings across the Trust, including the data being used, and implement improvements in response.

Patient reported outcome measures (PROMs)

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

An external agency is responsible for sending patients the second questionnaire (part B) after 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 following 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 NHS England.

	National performance*			Trust performance			
	Mean	Best	Worst	2020/21*	2019/20	2018/19	2017/18
Hip replacement surgery (EQ-5D)	0.465	0.841	-0.135	0.535	0.468	0.480	0.464
Knee replacement surgery (EQ-5D)	0.315	0.923	-0.165	0.316	0.425	0.310	0.298

Source: NHS Digital
*2020/21 data is latest full year of data available.

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:

- a dedicated nurse leads the process to ensure quality data input and triggers the patient reported outcome measures pathway
- monthly reports are reviewed so we can monitor performance and introduce improvements where necessary.

28-day readmissions

	National mean*	2022/23*	2021/22	2020/21	2019/20
28-day readmission rate (Patients aged 0-15)	9.79%	4.77%	5.35%	4.80%	4.78%
28-day readmission rate (Patients aged 16+)	8.50%	6.10%	6.32%	6.18%	7.45%

*National data only available up to September 2022

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

- continuing to work 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. Our performance, compared to our peers and our previous performance, is listed in the table below and shows we are above the average compared to other acute trusts. We are also above the acute trust average for staff who would recommend their organisation as a place to work.

We also scored well for staff saying care of patients is their organisation's top priority, up from 80 per cent in 2021 to 82 per cent in 2022, compared with a drop in the average for all acute trusts (from 76 per cent to 74 per cent).

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2022	2021	2020
Percentage of staff who would recommend the Trust to friends and family needing care	62%	86%	39%	73%	74.3%	79%

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2022	2021	2020
Percentage of staff who would recommend the Trust as a place to work	57%	75%	41%	66%	64.5%	71.4%

Another key measure in the NHS Staff Survey is the overall measure of engagement and morale. Overall engagement measures motivation, involvement and advocacy. In 2022, our overall score for engagement remained 7.0 and is above the average for acute trusts. The same trend is seen in the overall score for morale, where we are above the average for acute trusts.

These results show that we are making progress in a number of areas, despite the continuing and incredibly challenging demands on our staff.

We saw increased scores for the themes, 'we are compassionate and inclusive', 'we are always learning' and 'we are a team', and we achieved above average scores, compared with other acute trusts, in five out of nine categories, up from three out of nine categories in 2021. We are particularly encouraged by the increased scores for questions that relate directly to initiatives we have put in place over the past few years. This includes increased scores for questions about team working, line management and compassionate leadership that show the impact of our "improvement through people management programme", and values and behaviours work providing a range of training and support for our people managers across the Trust.

Our equality diversity and inclusion programme has also been a significant priority in 2022/23. This included:

- the launch of the Calibre leadership programme designed for staff with disabilities
- an inclusive recruitment approach for senior roles to improve representation of Black, Asian and minority ethnic (BAME) staff
- the introduction of 19 BAME ambassadors to provide a safe and supportive space for BAME staff to raise concerns
- a bespoke team-based race equity training for managers
- the relaunch of our equality impact assessment process which helps us to consider the impact of our policies on all groups of people.

We have also focused on improving our health and wellbeing programme, which this year included a winter wellbeing plan including breakroom supplies, Christmas vouchers for staff, completion of the further 'rest nest' and staff room renovations, a programme to support staff with financial wellbeing support and guidance, a programme to improve the support for staff who experience violence and aggression, and the training of 88 of wellbeing champions.

Areas where scores were lower in the staff survey and require further action include flexible working, retention, and in tackling violence and aggression, harassment and bullying or discrimination. The only people promise theme we fell just below the acute average in is "we work flexibly", where we scored 5.9 which is the same score as in 2021, but lower than the acute average of 6. For the "thinking about leaving" subtheme under "morale", we scored 5.7 compared to the 5.9 acute average. We were also below the acute average for the subtheme "diversity and equality" at 7.7 compared to the 8.1 average. All these areas have been incorporated into our 2023/24 people priorities and improvements will be driven through this work programme.

Patient feedback and experience

One of our quality priorities for 2023/24 is to become more user focused. Please read the improvement priorities section of this report for information. Patient feedback is a core component within this objective. Below we describe in more detail some of the work we already doing, as well as our plans for the next financial year.

Patient recommendation to friends and family

From 2015, the Trust has used the national friends and family test (FFT) question as a tool to collect patient feedback across all of our clinical areas, including accident and emergency (A&E), inpatients, maternity and outpatients. The question is added into our feedback surveys. You can see a list of the surveys we use on the Trust website: https://www.imperial.nhs.uk/about-us/how-we-are-doing/patient-experience

Prior to 2020, the FFT asked patients, their families and/or carers whether they would recommend our services to friends and family if they required similar treatment. In 2020 revisions were made to the survey, following an extensive review by NHS England, this included a change to the question itself. We now ask: 'Overall how was your experience of our services?' Those who respond can choose from the following options: very good, good, neither good or poor, poor, very poor or don't know.

We publish monthly FFT results on the Trust website (https://www.imperial.nhs.uk/about-us/how-we-are-doing/patient-experience#Results) and on the NHS England website (https://www.england.nhs.uk/fft/). You can also view our average performance scores for 2022/23 A&E and inpatient services below. The rating is based on the percentage of people who describe the service as very good or good.

FFT feedback is processed using a digital system which enables us to view and review the insights collected and to identify trends and improvements. This information is shared with services, clinics and wards.

Through engagement with teams, we are exploring means to improve the reporting of this information, including how we can combine with other insights and data we collect – to make it more useful, and to help quickly translate feedback into quality improvement projects within each ward, clinic and area.

During the next year we also plan to review feedback trends based on protected characteristics including ethnicity, sex, religion, gender identity, age, sexual orientation, religion and disability status. This will help us to see if we can improve experiences for specific groups of patients, and the information can also be used to support our health inequalities programme.

We use various methods to collect feedback – including text message, tablets on our wards and paper forms so that we avoid digitally excluding anyone visiting our hospitals. We are currently in the process of designing and testing new and potentially more inclusive methods of promoting our feedback surveys.

A&E friends and family test

Participation rate

The average participation rate over the past year has been 7.3 per cent. This was a very similar response rate to 2021/22.

	National performance 2022/23			Trust performance					
	Mean	Best	Worst	2022/23	2021/22**	2020/21*	2019/20	2018/19	2017/18
Score	76%	85%	16%	82%	84%	N/A	93%	94%	94%

*Reporting was suspended for most of 2020/21 due to the Covid-19 pandemic
**The 'FFT' question was changed in 2020/21 so our data for this year is not comparable to previous performance

We believe our performance reflects that:

- at a time of extreme pressure and competing demands due to the continuing impact of Covid-19, extended winter pressures and strike action, we have tried to maintain a high standard of care.

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

- introducing patient liaison volunteers into the emergency department to support patients in accessing drinks and snacks in the department
- continually trying to improve communication with patients. We have:
  - produced a leaflet which can be given to patients during the busiest times, and which explains how we are ensuring the safety of all patients and what patients can expect
  - provided useful information on our plasma screens in the department including videos which cover topics such: what to do if your condition worsens, how we manage our waiting lists and priortise care, explanation for why there might be delays, and what patients can do to support staff
  - improved signage throughout the department – including information on facilities such as wifi, refreshments, and accessing translation services. Signage also explains the pathway to patients and the different stages of care they are likely to experience.

Within our surveys we collect free text comments to help us gather more information from patients, their families, friends and carers, and so that they can describe their personal experiences. Questions include: 'Where are we doing well?' and 'Where could we do better?' The digital system enables us to review the sentiment of each comment, identifying if it is positive, negative or neutral. Over the last year we have received 55 per cent more positive comments than negative.

Inpatient friends and family test

Participation rate

The average participation rate over the past year has been 32.25 per cent. This was a very similar response rate to 2021/22.

	National performance 2022/23			Trust performance			
	Mean	Best	Worst	2022/23	2021/22	2020/21*	2019/20
Score	94%	98%	91%	96%	95%	N/A	97%

*Reporting was suspended for most of 2020/21 due to the Covid-19 pandemic
**The 'FFT' question was changed in 2020/21 so our data for this year is not comparable to previous performance

We believe our performance reflects that:

- we have maintained high standards of care for our patients despite the pressures of the last year, as evidenced by the overall rating of care
- our staff deliver consistently good care. This is a positive reflection of strong local leadership and support.

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

- continuing to work to be more user focused, with patient feedback central to our plans. See 'our improvement priorities' section for more information.

Responsiveness to inpatients' personal needs

We take part in the national survey patient experience programme that is coordinated by the Care Quality Commission (CQC). The results from these surveys are published on the CQC website (https://www.cqc.org.uk/). The surveys are conducted on a one-to-two-year cycle, and include: maternity survey, emergency survey, inpatient survey, children's and young people survey and national cancer survey.

The table below shows our performance with a key selection of questions from the national inpatient survey which show our responsiveness to inpatients' personal needs, compared to peers as well as our previous performance.

	National performance 2022/23			Trust performance			
	Mean	Best	Worst	2021/22	2020/21	2019/20*	2018/19
Score	72.6	87	63	73	70.8	N/A	65.2

*There was no national inpatient survey published in 2019/20
**The most recent data is from the national survey which was published in September 2022 for data from 2021

Our performance reflects that:

- this data is drawn from the nationally reported results of the national inpatient survey, which was published in September 2022 for data collected from patients who were in hospital in November 2022. You can view the full report on our website
- the score is based on the average of the following questions within the CQC inpatient survey:

- to what extent did staff looking after you involve you in decisions about your care and treatment?
- did you feel able to talk to members of hospital staff about your worries and fears?
- were you given enough privacy when being examined or treated?
- thinking about any medicine you were to take at home, were you given any of the following?
- did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- we are performing above the national mean and our performance has improved compared to previous years.

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

- continuing to work to be more user focused, with patient feedback central to our plans. See 'our improvement priorities' section for more information.

Venous thromboembolism

Venous thromboembolism (VTE) includes deep vein thrombosis (DVT) and pulmonary embolism (PE) both of which are blood clots within a vein obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission and applying preventative measures such as early mobilisation, chemoprophylaxis with anticoagulants and mechanical devices such as compression stockings.

We have continued to exceed the national guidance for VTE risk assessment of over 95 per cent of all in patients.

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20
Percentage of patients risk assessed for VTE	95.47%	100%	71.83%	96.5%	96.4%	96.6%	95.9%

Source: Trust data – suspended reporting to NHS England
*National performance data is currently suspended – figures reflect performance from 2019/20 national data.
**2022/23 includes provisional Q1-Q4 figures based on Trust data.

Our performance reflects that:

- we have monitored VTE risk assessments monthly throughout the year and have exceeded the national target of 95 per cent for all inpatients.

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

- working to improve data accuracy affected by issues such as change of ward use and by working with the areas that are below target to support staff to complete the assessment
- initiating audits to ensure compliance with the NICE quality statements and guidance relevant for VTE.

Clostridium difficile

Trust performance

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20***
Rate of Clostridium difficile per 100,000 bed days	29.7	0	115.1	27.7	25.3	16.5	28.6
Number of cases				90	71	59	101

*National performance figures are based on UK Health Security Agency (UKHSA) epidemiological data for the period April through February financial year 2022/23. The complete financial year 2022/23 data will be available in May 2023.
** Based on April through March financial year 2022/23 cases.
***Change to Public Health England *C.diff* definitions

Our performance reflects that:

- our submissions to UKHSA's data collection system are carried out monthly and signed off by the chief executive's office
- incidence and rates of *C.difficile* infection are routinely monitored at bi-weekly meetings with our clinical divisions and reported monthly to the Trust-wide *C.difficile* infection forum
- the infection prevention and control team provide assurance via quarterly reports to quality committee that infection rates are monitored, interpreted and strategies are developed and implemented to drive improvement
- In 2022/23, we reported 90 cases of *C.difficile* attributed to the Trust. This is above the allocated threshold of 67 cases. Despite the increase in cases, we have had no lapses in care so far this financial year; an improvement for the Trust when compared with the two lapses in care reported in 2021/22.

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 and personal protective equipment (PPE) use to reduce the incidence and transmission of infection.

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	2022/23**	2021/22	2020/21***	2019/20
Patient safety incident reporting rate per 1,000 bed days	54.9	205.5	23.7	56.8	56.6	52.1	Apr-Sep 19: 50.7 Oct 19 – March 20: 50.4

*National performance data is as of 2021/22.
**2022/23 Trust data is provisional (April 2022-March 2023).
***From 2020/21 onwards data has been reported nationally on an annual basis, rather than every six months.

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 annually (previously every six months)
- we monitor our incident reporting rates internally on a monthly basis.

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 through the implementation of the Patient Safety Incident Response Framework (PSIRF) and LFPSE, 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 incidents or never events then undergo an investigation which involves root cause analysis (a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened).

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20***
Percentage of severe/ major harm incidents (# of incidents)	0.26%	0.00%	1.10%	0.12% (24)	0.10% (19)	0.12% (18)	Apr-Sep 19: 0.03% (2) Oct19-Mar20: 0.04% (3)
Percentage of extreme harm/ death incidents (# of incidents)	0.14%	0.00%	0.90%	0.04% (9)	0.03% (6)	0.06% (9)	Apr-Sep 19: 0.06% (5) Oct 19 – Mar 20: 0.06% (5)

*National performance data is as of 2021/22.
**2022/23 data is provisional (April 2022-March 2023).
***From 2020/21 onwards data has been reported nationally on an annual basis, rather than every six months.

We believe our performance reflects that:

- we utilise nationally reported and verified data from the NRLS
- we continue to work to improve our incident reporting process and increase the numbers of incidents reported with positive results as described above. This enables us to identify with more accuracy actual or potential harm and investigate appropriately
- between April 2021 and March 2022 (most recent national data available), we reported 0.10 per cent severe/major harm incidents (19 incidents) compared to a national average of 0.3 per cent, and 0.03 per cent extreme/death incidents (six incidents) compared to a national average of 0.1 per cent
- between April 2022 and March 2023, based on our provisional internal data, we reported 0.12 per cent severe/major harm incidents (24 incidents) and 0.05 per cent extreme/death incidents (nine incidents). Eleven of these remain under investigation so the final harm level may change.

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 2023/24 improvement priorities’ section for more detail.

Part 2:
OTHER INFORMATION AND ANNEXES

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

Our performance with NHS England's single oversight framework indicators

NHS England 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 ongoing effects 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 have been 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%	63.1%	65.4%	62.5%	61.8%	60.4%
Diagnostics	**Maximum six week wait for diagnostic procedures**	1%	9.2%	11.5%	12.1%	6.5%	6.6%
Cancer access initial treatments	**Two-week wait**	93%	86%	77.5%	86.4%	92.5%	87.0%
Cancer access initial treatments	**Breast symptom two week wait**	93%	74%	32.6%	92.2%	88.1%	84.0%
Cancer access initial treatments	**% cancer patients treated within 62 days of urgent GP referral**	94%	61%	57.0%	50.0%	68.1%	69.0%
Cancer access initial treatments	**% patients treated within 62 days from screening referral**	85%	44%	36.6%	45.0%	37.3%	56.0%
Cancer access initial treatments	**% patients treated within 62 days (upgrade standard)**	90%	85%	87.3%	81.1%	88.3%	85.0%
Cancer access initial treatments	**% patients treated within 31 days of decision to treat**	96%	94%	94.9%	91.1%	94.8%	95.0%
Cancer access subsequent treatments	**Surgical treatments within 31 days**	94%	92%	93.0%	89.9%	87.0%	99.0%
Cancer access subsequent treatments	**Chemotherapy treatments within 31 days**	98%	99%	99.5%	99.1%	100.0%	97.0%
Cancer access subsequent treatments	**Radiotherapy treatments within 31 days**	94%	92%	94.5%	84.9%	97.1%	85.0%
Infection control	***C. difficile* acquisitions**	77	90	26	26	20	18

In May 2019, we 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. We will commence formal external reporting of A&E four-hour performance from early April 2023 (for March 2023 data).

ANNEX 1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

North West London Integrated Care Board (ICB)

Thank you for sharing your annual Quality Account 2022/23 with the North West London Integrated Care Board for comment on the 5th May 2023. We have reviewed the stated areas of focus for 2022/23 and note;

- Improve: We will develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods. We note the Trust's progress against the areas of focus.
- Insight: we will improve our understanding of safety. We acknowledge the overall improvement in incident reporting rates with resultant harm levels remaining low. In relation to investigations, we support work the to improve the timeliness of investigation and the embedding of the use of 'after action review' methodology.
- Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety. We note your success at recruiting Trust Patient Safety Partners, in addition, the launch of and uptake of staff completing Patient Safety Syllabus training, we will be interested to see how these will have a positive impact on your patient safety culture and work.

The ICB notes the continued impact of Covid-19 on the Trust and its services and acknowledge the work the Trust has implemented to mitigate risk to your patients as a result.

In terms of Trust participation in national audits and confidential enquiries, we note the Trust has identified a number of learning points. We will be interested to see how your implementation of the learning points will show improvements in the care of patients associated to these audit conditions and subsequently the Trust performance next year. In addition to the national audits, we also acknowledge the extensive local audit programme and the recommendations from these to improve the care to your patients.

We support your commitment to the Commissioning for quality and innovation (CQUIN) in 2023/24 as part of the NHS contract. The ICB Quality Team look forward to working with you regarding the schemes and the Trust's achievement against these through the year.

We recognise that maternity services as a whole have been under immense scrutiny and we are aware of the Trusts input into the Local (North West London) Maternity and Neonatal System where maternity standards and compliance are monitored and reviewed. In March 2023 the CQC undertook a review of maternity services as part of their national maternity inspection programme and we anticipate the outcome of this. We understand the CQC has not undertaken any other inspections and the Trust's rating remains unchanged.

We note the work the Trust has undertaken in relation to Learning from Deaths and the changes to how deaths are graded. We also note and agree with the change in how patients who died after a hospital-onset Covid-19 infection are reviewed so they are now reviewed in line with Trust's standard mortality review process. We acknowledge the different, national, process for review of maternity and neonatal deaths and note the Trust process for sharing the learning from these.

The ICB acknowledge and agree with the data statements and reporting against the core indicators within the report.

On behalf of NWL ICB, we can confirm that to the best of our knowledge, the information contained in the report is accurate. The ICB supports the on-going quality priorities for 2023/24 and looks forward to working closely with Imperial in exploring further quality improvement initiatives to build on the provision of safe and effective services for our patients.

I would like to take this opportunity to thank Imperial for its continued focus on quality.

London Borough of Hounslow's Health and Adult Care Scrutiny Panel

On behalf of the London Borough of Hounslow's Health and Adult Care Scrutiny Panel, please find our response statement for inclusion in the Imperial College Healthcare NHS Trust Quality Account 2022-23 report.

Statement

The London Borough of Hounslow's Health and Adults Care Scrutiny Panel (the 'Panel') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust (the 'Trust') Quality Account 2022-23 report. This report provides an update on progress made and identifies future priorities. The Panel would like to thank the Trust and its staff for continuing to provide services, and for preparing the Quality Account for comment.

2022-23 Quality Account

Improvement priorities

Thank you for sharing your improvement priorities, for this and next year. We note the work done on the 2022/23 improvement priorities, and we are pleased to see the Trust continues to improve patient safety, services for staff and patients, alongside the continued clinical research activities.

The Panel commends the Trust and its staff for its commitment to delivering a high standard of care for patients. We are pleased to see the positive steps taken towards ensuring continued compliance and to improving quality of care.

Progress against 2022/23 goals:

1. Improve hand hygiene practice, and the safe use of PPE in our clinical areas
    - We note a new approach to infection prevention and control education, training, and support. However, the decrease in infection control compliance from 65% to 60% raises concerns about maintaining infection prevention within the Trust.
    - We would like to stress the importance of infection prevention and control practice being a priority and hope to see an improvement in compliance rates.
2. Improve how we agree and document appropriate treatment escalation plans for our patients in an individualised, compassionate and inclusive manner
    - We note the implementation of an online training module designed to help staff with cardiopulmonary resuscitation (CPR) treatment. We are pleased to see the Trust continues to improve patient safety through building a strong safety culture, alongside staff education and training.
    - We hope the Trust will continue progress in due course so the 90% target can be met for the next year.
3. Improve how we document that our patients have provided informed consent prior to relevant procedures

- We commend the success of the digital consent process and are pleased with the positive feedback received from both patients and staff.

4. Reduce avoidable harm and improve performance and outcomes associated with invasive procedures

- We note the achievements of the invasive procedures group, however we stress the importance of reducing operation and procedure incidents to ensure patient safety and care.

5. Reduce the number of patient falls and associated harm levels

- We note the work on falls prevention, but also note that the Trust has observed an increase in patient falls. This raises concerns about patient safety, and we ask for improvements in the fall prevention strategy and implementation.

6. Improve the checking of blood components prior to transfusion

- The Panel notes the implementation of digital training and rigorous pre-administration checklists and ask that this continues to be a priority.
- The Panel is pleased to see the Trust has not experienced a never event related to blood transfusion since August 2021.

7. Improve the identification and management of adult patients with dysphagia

- We note the organisation faced challenges in addressing this priority and stress the importance of continued work to address the importance of patient safety.
- The Panel asks clear targets and milestones should be set to track progress and successful implementation of training and improvements.

8. Improving fetal monitoring during labour

- We commend the Trust's 93% compliance with "fresh eyes" and are pleased to see a commitment to providing high-quality care to patients.

9. Improving follow up of abnormal urine results in maternity

- The Panel notes the progress the Trust has made to ensure patient safety and that the Trust will make efforts to implement a standardised safety protocol.
- We note that this is an area of improvement, and we ask the Trust reports the outcome of implementing the electronic system.

Statements of assurance from the board

- We are pleased to see an increase in the participation of national audits, and the number of local clinical audits.
- We note that the Trust's CQC rating is 'Requires improvement' which is of concern and ask that this continues to be a priority.
- The Panel notes the work on data quality and look forward to the plan for data quality improvement.

Reporting against core indicators

- The Panel notes the low mortality ratios across the Trust. We note the collaboration with North West London Acute Provider Collaborative to share knowledge and data to make evidence-based improvements.

- We commend the Trust for prioritising patient care and note the percentage of staff stating that the care of patients is the top priority increased to 82%, in comparison to other acute trusts who observed a decrease.
- The Panel notes the commitment towards monitoring progress and reporting equality diversity and inclusion.

On behalf of the Panel, I thank the Trust for sharing the Quality Account for comment. We hope to continue this positive engagement going forward.

Health and Social Care Select Committee at the London Borough of Hillingdon

The Health and Social Care Select Committee welcomes the opportunity to comment on the Trust's 2022/2023 Quality Report.

Members note that the following priorities have been set for 2023/2024:

1. Reduce harm to patients through our safety improvement programme;

2. Implement the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE); including the launch of our new incident reporting / risk management system;

3. Improve the treatment of patients with deterioration in their mental health;

4. User insights and focus; and

5. Embed our ward accreditation programme as an enabler for Pathway to Excellence.

Good progress appears to have been made by the Trust in relation to its 2022/2023 quality priorities.

Members are pleased to note the activity undertaken in relation to Covid-19 vaccinations and positive improvements put in place to address the disruption caused by hospital-associated infection. They are also impressed by the Trust's awareness that there is still room for improvement. The Trust's commitment to improving the uptake of vaccinations in staff and patients, and initiatives such as the roaming vaccination service, have resulted in more than 99k Covid-19 vaccinations being administered. This performance should be commended.

In terms of the staff survey results, it is noted that the percentage of staff who would recommend the Trust to friends and family needing care has been going down over the last three years but is still ahead of the national average (62%) at 73%. Performance against the percentage of staff who would recommend the Trust as a place to work was also good, achieving 66% compared to the national average of 57%. It is pleasing that this performance has been achieved during particularly challenging times and the Committee looks forward to hearing about the priority people programmes that are put in place to further improve the performance.

The Trust's performance in relation to participation in the A&E friends and family test has reduced year on year since 2017/2018. Although this seems to have been a national trend, the Trust's performance in 2023/23 (82%) is still above the national average of 76% and compares favourably to the best national performance of 85%.

Looking forward, there are areas where the Trust continues to express a commitment to make improvements, and the Committee notes that there are a number of areas where further improvements are still required. Members look forward to being provided with more detail, on the progress of the implementation of priorities, but more importantly on the achievement of objectives outlined in the Quality Report and improved outcomes over the course of 2023/2024.

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

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

NHS England 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 beginning in 2019/20 and have continued this year.

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 2022 to May 2023
  2. papers relating to quality reported to the board over the period April 2022 to May 2023
  3. feedback from clinical commissioning groups
  4. the annual governance statement May 2023
  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 2022
  8. the head of internal audit's annual opinion of the Trust's control environment May 2023
  9. mortality rates provided by external agencies (NHS Digital and Telstra Health).
- 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 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 June 2023, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the board

Matthew Swindells, Chair
29 June 2023

Professor Tim Orchard, Chief executive
29 June 2023

ANNEX 3:
PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES 2022/23

Details of the eligible audits applicable to Imperial College Healthcare NHS Trust and compliance of the mandatory audit programme during 2022-2023 are listed in the table below:

Name of Project	Host Organisation	Did we participate?	Stage / submission details
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Breast and Cosmetic Implant Registry	NHS Digital	Yes	5 cases
Case Mix Programme	Intensive Care National Audit and Research Centre	Yes	Ongoing
Elective Surgery: National PROMs Programme	NHS Digital	Yes	100%
Emergency Medicine QIPs – 551 cases in total			
a. Pain in children	Royal College of Emergency Medicine (RCEM)	Yes	49 cases
b. Infection Control	Royal College of Emergency Medicine (RCEM)	Yes	330 cases
c. Consultant sign-off	Royal College of Emergency Medicine (RCEM)	Yes	172 cases
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]	Royal College of Paediatrics and Child Health	Yes	100%
Falls and Fragility Fracture Audit Programme			
a. Fracture Liaison Service Database	Royal College of Physicians	Yes	Ongoing
b. National Audit of Inpatient Falls	Royal College of Physicians	Yes	Ongoing
c. National Hip Fracture Database	Royal College of Physicians	Yes	Ongoing
Gastro-intestinal Cancer Audit Programme			
a. National Bowel Cancer Audit	NHS Digital	Yes	184 cases
b. National Oesophago-gastric Cancer	NHS Digital	Yes	155 cases
Inflammatory Bowel Disease Audit	IBD Registry	Yes	Ongoing
Muscle Invasive Bladder Cancer Audit	The British Association of Urological Surgeons	No	
National Adult Diabetes Audit			
a. National Diabetes Core Audit	NHS Digital	Yes	Ongoing
b. National Diabetes Foot Care Audit	NHS Digital	Yes	Ongoing

c. National Diabetes Inpatient Safety Audit	NHS Digital	Yes	Ongoing
d. National Pregnancy in Diabetes Audit	NHS Digital	Yes	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme			
a. Adult Asthma Secondary Care	Royal College of Physicians	Yes	Ongoing
b. Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	Yes	Ongoing
c. Paediatric Asthma Secondary Care	Royal College of Physicians	Yes	117 Cases
d. Pulmonary Rehabilitation Organisational and Clinical Audit	Royal College of Physicians	Yes	Ongoing
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	Yes	Ongoing
National Audit of Cardiac Rehabilitation	University of York	Yes	Ongoing
National Audit of Care at the End of Life	NHS Benchmarking Network	Yes	Ongoing
National Audit of Dementia	Royal College of Psychiatrists	Yes	Ongoing
National Audit of Pulmonary Hypertension	NHS Digital	Yes	Ongoing
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	Yes	Ongoing
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre	Yes	Ongoing
National Cardiac Audit Programme			
a. Myocardial Ischaemia National Audit Project	Barts Health NHS Trust	Yes	Ongoing
b. National Adult Cardiac Surgery Audit	Barts Health NHS Trust	Yes	1,522 cases
c. National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	Yes	Ongoing
d. National Audit of Percutaneous Coronary Interventions	Barts Health NHS Trust	Yes	Ongoing
e. National Heart Failure Audit	Barts Health NHS Trust	Yes	Ongoing
National Child Mortality Database	University of Bristol	Yes	Ongoing
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	NHS England and NHS Improvement	Yes	Ongoing
National Early Inflammatory Arthritis Audit	British Society of Rheumatology	Yes	Ongoing
National Emergency Laparotomy Audit	Royal College of Anaesthetists	Yes	120 cases
National Joint Registry	Healthcare Quality Improvement Partnership	Yes	Ongoing
National Lung Cancer Audit	Royal College of Surgeons	Yes	Ongoing
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	Yes	Ongoing
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	Yes	Ongoing
National Ophthalmology Database Audit	The Royal College of Ophthalmologists	Yes	Ongoing
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	Yes	140 cases
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE- UK collaborative	Yes	Ongoing
National Prostate Cancer Audit	Royal College of Surgeons (RCS)	Yes	Ongoing
National Vascular Registry	Royal College of Surgeons (RCS)	Yes	Ongoing
Neurosurgical National Audit Programme	Society of British Neurosurgeons	Yes	100%
Paediatric Intensive Care Audit[1]	University of Leeds / University of Leicester	Yes	Ongoing
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	Yes	27 cases
Renal Audits			
a. National Acute Kidney Injury Audit	UK Kidney Association	Yes	Ongoing
b. UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	Ongoing
Respiratory Audits			
a. Adult Respiratory Support Audit	British Thoracic Society	Yes	Ongoing
b. Smoking Cessation Audit – Maternity and Mental Health Services	British Thoracic Society	N/A	On hold nationally
Sentinel Stroke National Audit Programme	King's College London (KCL)	Yes	Ongoing
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	No	Trust is using other ways to measure the service
Trauma Audit and Research Network	Trauma Audit and Research Network	Yes	Ongoing
UK Parkinson's Audit	Parkinson's UK	Yes	100%

ACCOUNTABILITY REPORT

Corporate governance report

Directors' report

The Trust board and its committees

The Trust board is accountable, through the chair, to NHS England 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 2023 consisted of the chair, vice chair, six non-executive directors, chief executive, medical director, chief nurse, chief financial officer and chief operating officer, as outlined below. In addition, we have one associate (non-voting) non-executive director who provides additional expertise to the board.

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

Governance arrangements in the North West London Acute Provider Collaborative

The North West London Acute Provider Collaborative (the 'Collaborative') came into being on 1 September 2022, following approval of the trust boards of the four acute trusts: Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust, also from Chelsea & Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust Council of Governors, London Region and National NHS England. The four acute trusts remain as statutory bodies who also continue to work with other partners in the North West London Integrated Care System to deliver health to the population of north west London.

The governance arrangements have been developed based on core principles of corporate governance in a collaborative system. This includes adhering to the principle of subsidiarity while ensuring collaborative decision-making and holding each other to account. And ensuring the continuation of public accountability and stakeholder involvement and engagement at trust level as well as at the level of the collaborative.

Collaborative governance arrangements were established, including key elements:

- Trust-level committees providing local oversight across quality, workforce, redevelopment of the Trust estate and finance and performance as well as the statutory committees; audit and risk committee, and nominations and remuneration committee
- collaborative committees covering the domains of quality, infrastructure and digital, finance and operational performance, and people
- a model of shared non-executive directors across trusts
- lead chief executives for strategic priorities across the Collaborative.

The board in common is comprised of the four trust boards, meeting as individual trust boards but following a common agenda and shared reporting across the four trusts. Decisions at the board in common are made by each individual trust board. The board in common meets in public, normally four times per year, and is comprised of all voting members of the four trust boards. Among other duties, the board in common is responsible for setting the strategy for the collaborative. To ensure agility in decision making and to maintain oversight, the board in common delegates some specific

responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, which meets in the months when the board in common is not meeting. These responsibilities include the approval of business cases, where there is an urgent need for a decision that can't wait until the next board in common meeting. The meetings of the board in common cabinet are reported to the board in common.

Each statutory entity has a responsibility to maintain its own system of internal control, including a robust risk management framework. The audit and risk committees remain independent in each trust. They retain responsibility for ensuring that a system of internal control is maintained across the Trust, to ensure that risks are being identified and managed, and appropriate assurance mechanisms are in place. The audit and risk committees provide a summary of committee matters directly to the board in common. However, we anticipate developing governance arrangements further around risk and assurance in the next financial year. This is to enable the Collaborative to identify common risk areas where collaborative action can most effectively add value in the management of risks being 'owned' by trusts.

Each trust has retained its board committee structure. Committees review the key risks aligned with their functional domain and receive assurance regarding the management of those risks, via regular reports or risk and assurance deep dives where appropriate. Trust committee chairs report the outcome of their committees, including matters for escalation, including risks, to the respective collaborative committee.

Collaborative committees have oversight of each trusts' management of trust-level risks. The chairs of the collaborative committees receive summary reports from each chair of the trusts' associated board committees (except the independent audit and risk committees) in which they identify key risks (including any emerging risks or concerns), and any risks being escalated for consideration at Collaborative level. The collaborative committees report the outcomes of their committees to the board in common. The collaborative committees are therefore largely advisory and oversight in nature, with the exception of the collaborative finance and performance committee, which has delegated authority to approve business cases below the threshold requiring trust board approval (£5m).

The board in common receives summary reports from the collaborative committees and trust audit and risk committees, as well as more detailed reports where required. From these, each board takes assurance that there are effective systems in place to ensure risks are being identified and managed at the appropriate level.

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 in common; and for the chair in common usually via a process managed by NHS England.

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 as part of the committee annual report, and to the Trust board, and the findings used to inform the development plans for each committee.

In developing this collaborative governance model, we took into account current best practice in corporate governance as it was at the time. We also consulted with NHS England national and regional teams, and the Care Quality Commission. We plan to evaluate the collaborative governance model in quarters two/three of 2023/24, using internal audit as well as completing the recently published NHS England provider collaborative maturity matrix. In addition, at Trust level, we will complete a self-assessment against the recently revised NHS Providers Code of Governance, introduced on 1 April 2023.

Trust level governance

The Trust governance operates in the context of the collaborative governance arrangements outlined above.

The Trust board at 31 March 2023 was as follows:

Matthew Swindells	Chair in common
Bob Alexander	Vice chair
Professor Andrew Bush	Non-executive director
Peter Goldsbrough	Non-executive director
Nick Gash	Non-executive director
Sim Scavazza	Non-executive director
Linda Burke	Non-executive director
David Moss	Non-executive director
Aman Dalvi	Non-executive director (designate)
Janet Rubin	Non-executive director (designate)
Nick Ross	Non-executive director (associate)
Professor Tim Orchard	Chief executive
Professor Julian Redhead	Medical director
Professor Janice Sigsworth	Chief nurse
Jasbir Kaur (Jazz) Thind	Chief financial officer
Claire Hook	Chief operating officer

Associate non-executive directors are not voting members of the Trust board, and therefore do not attend the board in common meetings but provide specialist skills and experience to the Trust in a non-executive capacity and attend Trust committees.

Designate non-executive directors are voting non-executive directors of one of the other trusts in the Collaborative and are members of trust committees in the Trust. They cannot be appointed as members of the Trust board due to limitations on the number of non-executive directors as specified in the trust Establishment Order and legislation.

Attendance at Trust board meetings: 1 April 2022 – 31 March 2023

The Trust board met four times in regular session; two of these were as the board in common as part of the new governance structure in place within the North West London Acute Provider Collaborative. Attendance at the Trust board and attendance at the board committees is described below:

Trust board member	Attendance (actual/possible)
Non-executive directors	
Matthew Swindells, chair in common	4/4
Bob Alexander, vice chair	4/4
Professor Andrew Bush, non-executive director	1/4
Peter Goldsbrough, non-executive director	4/4
Dr Andreas Raffel, non-executive director (until July 2022)	2/2
Kay Boycott, non-executive director (until July 2022)	2/2
Sim Scavazza, non-executive director	2/4
Linda Burke, non-executive director (from September 2022)	2/2
David Moss, non-executive director (from September 2022)	2/2
Executive directors	
Professor Tim Orchard, chief executive officer	4/4
Professor Julian Redhead, as medical director	4/4
Jazz Thind, chief financial officer	3/4
Professor Janice Sigsworth, chief nurse	3/4
Claire Hook, chief operating officer	4/4

At Trust level, the board has six committees which meet regularly and are chaired by a non-executive director. 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. A summary of these Trust level committees, their purpose and membership are detailed below.

Trust audit, risk and governance committee

The terms of reference of the audit, risk and governance committee are available upon request.

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; the work of the internal and external auditors; 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. For this part of the meeting, membership is non-executive only.

In its broader, non-mandatory role, the committee oversee and seeks assurance that risk management and corporate governance arrangements are in place and working effectively.

It also 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. For this part of the meeting, the medical director, chief financial officer and director of nursing are also members.

The committee met six times in regular session during the reporting period and held three additional meetings to review the annual accounts and related issues only.

Audit, risk and governance committee member	Attendance (actual/possible)
Kay Boycott, non-executive director (committee chair from 1 April 2021-31 July 2022)	5/5
Nick Gash (committee chair from November 2022)	3/3
Professor Andrew Bush, non-executive director	3/6
Dr Andreas Raffel, non-executive director (until 31 July 2022)	3/3
Sim Scavazza, non-executive director	4/6
Jazz Thind, chief financial officer	9/9
Professor Julian Redhead, medical director	9/9
Professor Janice Sigsworth, director of nursing	9/9
David Moss, non-executive director (from October 2022)	3/3
Linda Burke, non-executive director (from October 2022)	3/3
Bob Alexander, vice chair (Chaired committee in September 2022)	1/1

The chief executive and chair are also regular attendees.

Deloitte LLP acted as the Trust's external auditors in 2022/23, having been appointed in April 2017 for an initial three-year period that was extended. KMPG acted as the Trust's internal auditors, having been appointed for an initial period of three years from April 2022.

Reflection of the business conducted in 2022/23

Outlined below is a summary of the key business conducted by the committee during 2022/23, in accordance with its terms of reference and includes the audit, risk and governance committee business items discussed at the March 2023 e-governance committee.

- the committee reviewed and approved the annual internal and external audit plans, and has considered the findings and recommendations arising from internal audit reports on:
  - risk management
  - data quality: discharges
  - sustainability reporting (green plan)
  - cyber security
  - capital projects (prioritisation)
  - benefits realisation (digital)
  - research governance
  - patient experience (complaints)
- the committee reviewed progress in implementation of previously accepted audit recommendations by management

- the committee received regular updates on counter fraud activities at the Trust, including initiatives to raise awareness and ongoing cases under investigation
- the committee, through delegated authority from the board, reviewed and approved the Trust annual report and accounts
- 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, 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 that had been identified as part of the board effectiveness survey; and to implement a revised assurance framework that would be based around a series of risk and assurance 'deep dive' reviews of existing and emerging risks as well as the development of assurance frameworks for areas of strategic risk
- the committee regularly reviewed the corporate risk register, 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 reviewed the Trust's risk appetite and agreed the development of a revised approach to risk appetite, linking it with the review of performance data and key risks at board committee level
- the committee received a risk and assurance 'deep dive' into information and communications technology disaster recovery and regularly received the Trust cyber security dashboard
- other key items of discussion included the annual emergency preparedness, resilience and response report; the annual fire safety report; the Western Eye Hospital fire improvement notice and actions, approach to the 2022/23 annual report and accounts; and accounting treatments
- the committee received regular reports on losses and compensation payments, and the use of tender waivers
- the committee discussed and approved the Trust's standing orders, scheme of delegation, matters reserved for the board and standing financial instructions
- the committee received an update on procurement of external audit, internal audit and counter fraud services procurement
- the committee also reviewed its terms of reference and discussed its annual review of effectiveness self-assessment.

Trust 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. 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 five times during the reporting period:

Quality committee member	Attendance (actual/possible)
Professor Andrew Bush, non-executive director (committee chair)	5/5
Peter Goldsbrough, non-executive director (committee chair from November 2022)	1/1
Kay Boycott, non-executive director (member until June 2022)	0/1
Sim Scavazza, non-executive director (member until September 2022)	2/2
Aman Dalvi, non-executive director (member from September 2022)	2/2
Professor Tim Orchard, chief executive officer	5/5
Professor Janice Sigsworth, chief nurse	5/5
Professor Julian Redhead, medical director	5/5

The chief operating officer also attends on a regular basis.

Outlined below is a summary of the key business conducted by the Trust quality committee during 2022/23, in accordance with its terms of reference:

- the committee discussed the risk and assurance deep dives into: provision of care to emergency department patients with mental health challenges; introduction into the ambulance handovers across the Trust; mortality rate review; maternity including Ockenden recommendations and care of patients with mental health challenges
- the committee received and noted the report received for the national audit of care at end-of-life 2021
- the committee received the annual complaints report for 2021/22
- the committee regularly received an update on Covid-19 including an update on vaccinations as well as the quarterly and annual infection prevention and control (IPC) report and the IPC board assurance framework for Covid-19. A focus on antimicrobial stewardship and treatment of both Covid-19 and other infections was maintained during the pandemic and continues to be maintained
- the committee were regularly updated on the Trust's flu vaccination programme
- the committee reviewed the draft quality account for 2021/22
- the committee received the key divisional risks within a written summary has been included in the quality function report
- the committee regularly received the maternity oversight assurance report which includes the clinical negligence scheme for trusts (CNST) maternity incentive scheme (MIS) and midwifery safe staffing report. The CNST MIS supports the delivery of safer maternity care and contributes towards meeting seven immediate and essential actions recommended from the Ockenden report

- on a quarterly basis the committee received the learning from deaths report; pressure damage report and safeguarding reports
- the committee regularly received a report or an oral update on regulatory compliance
- the committee regularly received the quality function assurance report which included: quality metrics / data insights, incident reporting, overdue investigations, overall rating of care, mortality rates, never events, clinical harm, duty of candour, structured judgement review completion, sepsis antibiotics, MRSA blood stream infections, aseptic non-touch technique competency assessment, cleanliness score, national clinical audit, clinical guidelines, inquests and claims, patient experience metric, mortuary security review, safeguarding quarterly review, divisional risks and quality risks, issues and areas of limited assurance
- on an annual basis the committee received the safeguarding report and cost improvement programme quality impact assessment
- other reports received by the committee were: transformation update, ward accreditation programme, and annual reports from the mental health and capacity governance group, paediatric discharges and violence and aggression.

Trust 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 to monitor progress, add support and understand risks and opportunities in these areas which are important in achieving our strategic goals.

The committee met six times in during the reporting period:

Finance, investment and operations committee member	Attendance (actual/possible)
Dr Andreas Raffel, non-executive director	1/1 (chair of the committee until July 2022)
Peter Goldsbrough, non-executive director	1/1 (member of committee until July 2022)
Bob Alexander, vice chair (committee chair)	5/5 (became chair of the committee in July 2022)
Janet Rubin, non-executive director	3/3 (joined the committee in September 2022)
Aman Dalvi, non-executive director	3/3 (joined the committee in September 2022)
Professor Tim Orchard, chief executive officer	5/6
Jazz Thind, chief financial officer	6/6
Claire Hook, chief operating officer	3/3 (became a member of the committee in November 2022)

The chair in common also attends on a regular basis.

Outlined below is a summary of the key business conducted by the committee during 2022/23, in accordance with its terms of reference:

- 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 high-level financial plan being developed for the acute provider collaborative; this continued to be refined as new guidance is made available
- the committee received an update on business planning for 2023/24 which included lessons learned from the business planning process in 2022/23
- 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
- the committee received assurance on the progress of the transformation plan which focused on larger-scale and longer-term change programmes to deliver our strategic goals, including financial sustainability
- the committee reviewed the financial aspects of the strategic outline case of the strategic imaging asset management programme
- other key reports the committee received included the winter plan for 2022/23, updates on the sector consolidation of payroll services, review of performance and strategy of Imperial Private Healthcare and review of the financial position of North West London Pathology. Risk and assurance deep dives of directorates and business planning for 2023/24 were also commenced
- the committee reviewed its terms of reference as part of the establishment of the acute provider collaborative and discussed its annual review of effectiveness self-assessment.

Trust 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 five times during the reporting period:

Redevelopment committee member	Board committee attendance (actual/possible)
Bob Alexander, acting Trust chair (April 2022 to June 2022, vice chair (July 2022 to present)	5/5
Peter Goldsbrough, non-executive director	5/5
Nick Ross, non-executive director	5/5
Sim Scavazza, non-executive director	3/5
Professor Tim Orchard, chief executive officer	4/5
Jazz Thind, chief financial officer	3/5
Matthew Tulley, director of redevelopment	5/5

The medical director and chief nurse are regular attendees.

Outlined below is a summary of the key business conducted by the committee during 2022/23, in accordance with its terms of reference:

- over 2022/23, the committee received the programme director's report on key activities which included updates on the St Mary's Hospital strategic outline case and programme business case, redevelopment and master planning for St Mary's, Charing Cross and Hammersmith hospitals, communications, stakeholder engagement and life sciences
- other reports and oral updates received by the committee were: contingency and estate management update; contingency planning; Samaritan Hospital and Western Eye

Hospital estate issues and refurbishment funding; design and planning contracts; land and property commercial advice; town planning support for St Mary's Hospital and communication support for the planning application for St Mary's Hospital

- in May 2022, the committee reviewed its terms of reference, discussed the committee's annual report and review of effectiveness self-assessment for 2021/22. A further update to the terms of reference was approved by the committee, following the introduction of the North West London Acute Provider Collaborative, in September 2022
- at the May 2022 meeting, the committee also received a deep dive on the development of the Trust's strategy and commercial partnerships in life sciences. This included the opportunity to strengthen links in both the Hammersmith and Paddington areas to help achieve the Trust's life sciences ambitions, the establishment of the Paddington Life Sciences Partners group and plans for the launch of the Paddington Life Sciences website and opening of the Digital Collaboration Space in Paddington
- an update on life sciences was brought to the committee in September 2022 and February 2023. The Trust continued to develop plans across each of its three major sites to ensure research, innovation and educational activities are central to the redevelopment plans
- the committee received an update on the Trust's green plan in May and December 2022. This included an update on the public sector decarbonisation fund grant and retrofits; computer power management system programme; and decommissioning of the nitrous oxide manifold at Charing Cross Hospital (moving to canisters) to reduce carbon emissions
- an update on the public sector decarbonisation programme of works was presented to the committee in July 2022
- other reports and oral updates received by the committee were: contingency and estate management update; contingency planning; Samaritan Hospital and Western Eye Hospital estate issues and refurbishment funding; design and planning contracts; the Trust's green plan; life sciences; public sector decarbonisation programme; land and property commercial advice, town planning support for St Mary's Hospital and communication support for the planning application for St Mary's Hospital; estates strategy 2022-2030
- the committee received a paper in July 2022 which highlighted the review of governance arrangements in light of the North West London Acute Provider Collaborative. Changes included the introduction of the redevelopment executive programme board, chaired by the chief executive, which would meet every six weeks. The frequency of the redevelopment committee was reduced to quarterly at appropriate times in the reporting cycle and otherwise as required
- the estate strategy for 2022-2030 was presented and ratified by the committee in December 2022.

Trust 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 (committee chair until November 2022)	3/3
Bob Alexander, vice chair (committee chair from November 2022)	4/4
Nick Ross, associate non-executive director	4/4
Sim Scavazza, non-executive director (from November 2022)	1/2

Outlined below is a summary of the key business conducted by the committee during 2022/23, in accordance with its terms of reference:

- the committee discussed the draft annual process and timetable for executive appraisal, pay, talent management and succession. The committee received an updated on the business case for chief executive pay; executive and very senior managers pay framework; very senior managers' annual uplift; and continuity and succession planning
- the committee also reviewed its terms of reference and discussed its annual report and review of effectiveness self-assessment for 2021/22.

Trust people committee

The committee monitors, reviews and provides assurance to the board on the cultural and organisational development of the Trust. This includes the organisation's understanding of strategic workforce needs, key human resources controls, recruitment and retention, performance management, and the achievement of key deliverables in relation to the equality, diversity and inclusion plan. It identifies the strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the locality, and assurance in relation to strategic issues relating to ethics and duty of care in the conduct of Trust affairs (including whistleblowing) and to the Trust's equality duty.

The committee met five times during the reporting period:

People committee member	Attendance (actual/possible)
Sim Scavazza, non-executive director (committee chair)	5/5
Kay Boycott, non-executive director (member until July 2022)	0/2
Dr Ben Maruthappu, associate non-executive director (member until July 2022)	1/2
Rev. Beverley Ejimofo, associate non-executive director (from 1 October 2021-July 2022, previously observer)	1/5
Professor Tim Orchard, chief executive officer	4/5
Professor Julian Redhead, medical director	3/5
Professor Janice Sigsworth, chief nurse	5/5
Kevin Croft, chief people officer	5/5
Bob Alexander, vice chair	1/1
Linda Burke, non-executive director (from September 2022)	3/3
David Moss, non-executive director (from September 2022)	2/3
Mr Raymond Anakwe, medical director (from July 2022)	3/4

Outlined below is a summary of the key business conducted by the committee during 2022/23, in accordance with its terms of reference:

- the committee regularly received an update on the people strategy and priority objectives. The priority objectives were reviewed individually during the year
- the committee received regular workforce performance reports
- the committee regularly received the health and safety report which relates to the occupational health and safety arrangements including the Trust's statutory duty to investigate certain Covid-19 incidents. It also monitors the performance of the occupational health service and included the development of the health and safety governance framework
- the committee received and discussed the annual national staff survey results and action plan; the annual responsible officer's report; workforce equality, diversity and inclusion annual report.
- the committee invited and received staff stories as part of the equality, inclusion and diversity updates; over the past year staff stories were given by members of staff in hotel services, a junior doctor, clinical nurse specialist and midwife
- the committee regularly reviewed the risk register for people and organisational development
- the people assurance report provided updates on the annual assurance report for GMC National Training Survey and the winter preparedness guidance for nursing and midwifery staffing report as well as the national staff survey, nursing and midwifery establishment. Improvement activity updates included inclusive recruitment, pathway to excellence, NHS People Promise, performance and development review 2022/2023 and management and leadership apprenticeships 2022/23
- the committee regularly received updates on the Freedom to Speak Up service and updates from the race equality network.

Collaborative committees with decision-making

As outlined in the summary of the collaborative governance arrangements, in addition to the Trust committees detailed above, there are some collaborative meetings that have decision-making authority delegated by the Trust board, via the board in common.

Board in common cabinet

The board in common delegates some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, which meets in the months when the board in common is not meeting. These responsibilities include the approval of business cases, where there is an urgent need for a decision that can't wait until the next board in common meeting.

Collaborative finance and performance committee

The collaborative finance and performance committee meets quarterly and is comprised of a vice chair, who chairs the meeting, the non-executive director chair of each of the four trusts' finance and performance committees, the chief executive lead for collaborative finance and performance, the chief financial officers from each of the four trusts and the chief operating officers from each of the four trusts. The committee has a responsibility to review financial and operational performance at collaborative level, to identify collaborative level projects or actions that would assist in managing trust level risks in finance or operational performance, and to consider collaborative business cases – those cases that affect more than one trust in the collaborative. The committee will approve collaborative business cases between £1m and £5m and recommend collaborative business cases to the board in common for approval where the value is above £5m.

Compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

The Trust did not make any political donations during 2022/23.

The Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier. Details of our performance against the code are contained in the annual accounts.

Well-led framework

It is of paramount importance to ensure that the Trust is well-led so that the services are safe and patient centred. In November 2019, we welcomed the Care Quality Commission (CQC) to inspect our services, which included a well-led inspection and a use of resources inspection by NHS Improvement. The Trust achieved an improved rating of 'good' for well-led and use of resources rating.

The organisation has recently undertaken self-assessments against the current CQC well-led framework, both at a Trust level and collaboratively. Representatives from the CQC join the quarterly system oversight meetings with the Trust and north west London sector colleagues. An overview of the arrangements in place to govern service quality are included in the annual governance statement and will be included in the quality report. The arrangements include a clear 'ward to board' assurance framework, which includes quality, workforce, performance and finance.

The quality committee seeks assurance on systems, processes and outcomes relating to quality (safety, clinical effectiveness and patient experience) on behalf of the Trust board. External peers are also invited to participate in ward accreditations and 'peer reviews' of services. The Trust leadership team have regular meetings with our CQC relationship manager and are in frequent contact to respond to any queries.

Directors' assurance

The directors have been responsible for preparing this annual report and the associated financial accounts and also the quality account. The directors 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.

To the best of the directors' knowledge, there are no known material inconsistencies between:

- the annual governance statement
- the corporate governance statement and annual report
- CQC insight reports and any consequent action plans.

Disclosure of information to Trust auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Income disclosures

The Trust has met the requirement of Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that its income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provisions of goods and services from other purposes. The impact of other income which the Trust has received has been invested in the provision of goods and services for the purposes of the health service in England.

Professor Tim Orchard, Chief executive
29 June 2023

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 judgments 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

Professor Tim Orchard, Chief executive
29 June 2023

Jazz Thind, Chief financial officer
29 June 2023

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

The chief executive of NHS England has designated that the chief executive should be the accountable officer of the Trust. The relevant responsibilities of accountable officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Professor Tim Orchard, Chief executive
29 June 2023

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 2022/23 follows the format required by NHS England.

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. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks 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 the Trust for the year ended 31 March 2023 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 the 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.

The Trust board, operating as board in common, takes collective responsibility for setting out the strategic direction of the Trust, including setting the risk appetite.

The Trust board, operating as board in common, is accountable for upholding high standards of governance and probity. The chair 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 and directorate level management and quality groups, as well as specialist committees (for example health and safety and infection prevention and control), where quality, safety and performance reports are reviewed and issues or risks 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
- risk management policy which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk
- risk registers which document risks at each level of the Trust, including actions to control, mitigate or resolve
- board assurance framework process, in the form of risk and assurance deep dives at board committees and assurance frameworks for key areas.

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

The effectiveness of the risk management framework is monitored by the executive management board monthly. The audit, risk and governance committee oversee risk management at the Trust, including the risk and assurance deep dives process.

The Trust risk appetite is agreed by the board, taking into account current risk exposure, strategic objectives and risk capacity. The appetite is then cascaded to the whole organisation.

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 staff identify and mitigate risk appropriately; scoring risks using a standardised matrix, which includes likelihood and consequence. If risks cannot be satisfactorily resolved or managed, they are considered for escalation on to the divisional registers. In turn these risks are reviewed for escalation onto the corporate risk register as appropriate, if they have a significant impact on the whole organisation, or 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.

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

The board assurance framework, in the form of the corporate risk register, risk and assurance deep dives, and assurance frameworks for key areas of risk, provides a high-level assurance process. This 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 audit, risk and governance committee oversee and monitor the performance of the risk management framework, informed by internal auditors undertaking reviews and providing assurance to the committee on the systems of control operating within the Trust.

Compliance with the NHS provider licence is routinely monitored through the NHS Oversight Framework but, on an annual basis, the licence requires the Trust to self-certify as to whether the organisation has effective systems, governance arrangement, and the resources required to ensure compliance. The 2022/23 self-certification processes concluded that the organisation had taken the necessary precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. Risks to our continued compliance with the licence provisions were considered as part of this review, including the principal organisational risks held on the corporate risk register.

The Trust's principal risks are included in the corporate risk register and managed by the executive management board. Principal risks are defined as those risks where the overall rating (likelihood x impact) is 16 or over.

The principal risks are summarised below and in the following pages, with further detail included within the performance report.

Risk	Rating (Current)	Controls in Place
Risk to patient experience and care due to delay for mental health patients in the emergency department	20	• reporting of all 12-hour trolley wait breaches as serious incidents (SI) • reporting of 12-hour stays in the department for mental health patients separated from physical health reporting agreeing and piloting a new escalation framework with commissioners • meetings with the mental health trusts to raise concerns and share data • escalation to the A&E delivery board • escalation of delays in real time to both the relevant mental health trust and commissioners • security presence in the emergency department at St Mary's Hospital increased • the establishment of a dedicated consultant lead for mental health in both emergency departments • agreement for joined up working on urgent and emergency care standards for mental health patients to see how to report the data in a useful way for the system.

Potential for cyber security incidents leading to compromised confidentiality/integrity/ availability of data. Risk to Data: A cyber security incident can result in data being stolen, destroyed, altered or ransomed	20	Technical Controls: • access to social networking, webmail, tor browsers and other high risk sites are all blocked • firewalls are maintained and a documented change control process to block threats • Trust managed servers and desktops are installed with antivirus software and are patched • secure web gateway is in place to detect and prevent any malicious network activity from coming into or leaving the network • a backup and restore system that, to date, has been able to restore files compromised by ransomware with minimal data loss • monthly cyber security dashboard reviewed at the data security and protection committee (DSPC) to track threat activity and effectiveness of response • a cyber incident response plan and an ICT disaster recovery plan is in place • working in accordance with the data security and protection committee toolkit requirements, such as performing an annual penetration test on the Trust critical assets • multiple security solutions have been procured and are being implemented.
Potential failure to gain funding and approvals from key stakeholders for the redevelopment programme	16	Engagement: • regular meetings with NHS England for early identification of potential issues/changes in requirements • reports to Trust board and executive management board • regular meetings with council planners and Greater London Authority (GLA) • active management of backlog maintenance • active ways of engaging clinicians through models of care work • active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation • active internal communications plan, including CEO open sessions • internal and external resources and expertise in place.
Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	16	• Trust-wide action plan in place in response to never events • monthly invasive procedure group in place, with representation from all divisions • policies and guidelines to support safe invasive procedures in place • invasive procedure e-learning module part of core clinical skills training • action plan specific to theatres and anaesthetics implemented • Trust clinical lead for procedural safety in post
Failure to manage non elective flow	16	• use of Cephid rapid swabs • contacting Nudge team as soon as issue arises • pathways reviewed several times to ensure only those who need it will receive a rapid swab • constant review of numbers with view to opening CDU beds when able to • care journey and capacity collaborative (CJCC meetings) • full capacity protocol • improving care journey and capacity collaborative • Urgent and emergency performance and accountability framework • A&E operational group established to identify areas of focus for -improvement, refocused with support from transformation team • roll out of long stay review meetings across all sites to expedite decision making.
Failure to address the underlying deficit resulting in failure to achieve financial sustainability	20	• monthly financial reporting, cash and performance reviews reported to executive management board, bi-monthly to finance, investment & operations committee, Acute Provider Collaborative finance and performance committee and board in common • monthly executive led performance and accountability review meetings established in May 2023 with divisions to track activity, financial, quality and workforce metrics/ targets/plan (including a focus on run-rate control and implementation of enhanced measures as required to support those not achieving plan 'financial recovery framework') • oversight by the ICS via system oversight meeting (SOM) • engagement with collaborative finance and performance committee and ICS financial recovery board (FRB) reviewing actions to achieve an underlying surplus across the acute collaborative • CEO and CFO engagement with NHS Provider Network, University Hospitals Association, Shelford etc., to lobby on system issues/pressures • implementation of longer term productivity and efficiency programme supporting identification and delivery of rolling efficiency plans

Risk of potential harm to patients due to cancellation or deferral of planned investigations and/or treatments as a result of extended waiting lists and/or reduced operational capacity. This is an enduring risk related to the impact of the Covid-19 pandemic	16	• most cancellations / deferral have been vetted by a clinician • a more robust process for cancelling/ deferring appointments has been introduced • surgical clinical harm review process in place and is being expanded to additional high-risk treatment and diagnostic groups • patient prioritisation framework in place for all adult and paediatric patients • pathways for recovery and restoration of services have been signed off in clinical review groups (CRG) • regular review of PTL (patient treatment list) • local oversight of the clinical harm review process (and prioritisation as the key outcome) by directorate general managers and clinical directors and regular reporting to division and to executive management board (quality) • optimisation of IS solutions where possible • insourcing as a bridge for additional capacity • strengthened governance process via CRG and EMBQ and reporting mechanisms, with direct connection with the clinical harm review team and clinical teams, including feedback to clinical teams.
Poor data quality across people, process, systems and reporting	20	• a number of mitigations are in place such as key data quality indicators, audits and logic within reporting to help identify risk cohorts • when high risk data quality issues are identified whole data set audits take place rather than sample only to ensure patients safety • where patient safety concerns are identified, these are escalated to the medical director's office via the clinical harm assurance Group and Datix are raised where appropriate. • large scale validation is carried out as part of business as usual across a number of waiting list on a monthly basis and robust quality assurance process with senior sign off is in place to support national submissions such as referral to treatment (RTT) and diagnostics (DM01). • currently a large scale project is underway to support diagnostics pathways. However, this provides only limited mitigation as the generation rate of data quality issues has grown significantly and is widespread for relatively small teams to keep up with.

The following has been identified as the significant risk facing the Trust through 2022/2023 and as it enters 2023/24:

Estates and redevelopment

The Trust's capital plan for 2023/24 is once again extremely challenging due to the level of backlog maintenance, information communications and technology infrastructure, and medical equipment replacements required to mitigate Trust level risks. This is in addition to divisional capital projects which are essential for the development and improvement of our services, which reflect into quality and safety of clinical services.

The Trust has the largest backlog maintenance liabilities of all NHS or foundation trusts, principally due to the age of its estates. Estates return information collection (ERIC) data published in 2016 showed the Trust had nearly 25 per cent of all NHS risk adjusted backlog maintenance costs, with a fully built-up backlog liability of £1.3 billion. The Trust is part way through a board-approved plan to spend a minimum of £131 million over eight years on the highest priority backlog items. The amount in the 2023/24 plan is consistent with this approach.

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 2023/24 plan represents the most urgent replacements. The statement from the CQC supports the need for redevelopment as the current estate provides a poor patient experience as overall the patient environment is poor, outdated and inflexible.

Clinical adjacencies are poor and inefficient. The St Mary's Hospital campus comprises a number of unconnected buildings intersected by public roads resulting in complex and inefficient logistics for both materials and equipment. There are multiple entrances, making wayfinding a major challenge for patients, staff and visitors. Failure of the estate and its infrastructure can lead to unplanned closures of beds and other facilities at short notice.

The Queen Elizabeth the Queen Mother building at St Mary's Hospital hosts one of London's major trauma centres, which is significantly undersized and overall, the utilisation of the Trust's clinical services is consistently above recommended levels leading to difficulties with patient flow and crowding.

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 capital programme is £48 million and deals with regulatory and safety issues, which includes business as usual:

- backlog maintenance
- information and communications technology
- equipment
- minor works.

The £24 million strategic investment pot is dependent on the Trust receiving transformation funding from NHS England for the Western Eye Hospital, cardiology and redevelopment which will the allow the Trust to prioritise this to achieve the most beneficial outcome/ impact.

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, NHS England 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 ongoing and in the autumn of 2019 the Trust was included in the Department of Health and Social Care's health infrastructure plan. The Trust submitted a strategic outline case to Department of Health and Social Care in August 2020. The health infrastructure plan has been succeeded by the 40 New Hospital Programme, which was announced in autumn 2020. St Mary's, Charing Cross and Hammersmith hospitals were part of this announcement. The New Hospital Programme 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 Hospital site."

The redevelopment plans for the new hospitals have continue to progress in year. Working with the central New Hospital Programme (NHP) the Trust has contributed to the production of the NHP programme business case which was approved in early 2023. The NHP funding announcement in May 2023 confirmed that all our schemes are supported within NHP funding plans. Funding will now be provided to continue development of business cases.

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.

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 2022/23.

Due to ongoing operational pressures in provider organisations across England and the impact of its own internal transformation activities, the CQC suspended most of its routine activities during 2022/23. Monthly engagement meetings continued to be carried out, along with requests for incident reports as part of the CQC's mandate for learning from deaths, of which three requests were made to the Trust (August 2022, December 2022 and February 2023). Although the CQC will always carry out urgent inspections where it has serious concerns, no urgent inspections took place at the Trust during 2022/23.

The Trust participated in one special review carried out by the CQC during 2022/23, which was a national maternity inspection programme that involved inspection of the safe and well-led domains for all maternity services that were last inspected prior to April 2021. The inspection of the Trust's maternity services at St Mary's Hospital, including the private maternity service delivered in The Lindo Wing and Queen Charlotte's & Chelsea Hospital, took place on 8 and 9 March 2023. The Trust anticipates that it will receive its draft inspection findings in summer 2023, after which the Trust will check the draft report for factual accuracy. The report, including re-assessed ratings for the safe and well-led domains, is anticipated to be finalised in summer 2023.

All trusts are captured in CQC patient surveys, these outcomes were published this year from surveys that ran in 2022/23 as set out below; we performed favourably in all surveys both compared to previous performance and in relation to other trusts. No serious concerns were raised in any survey published this year; where improvements were needed, they were managed in line with normal Trust processes.

- 2021 adult inpatient survey, published September 2022
- 2021 national cancer patient experience survey, published July 2022
- 2022 maternity survey, published January 2023.

During 2022/23, the Trust participated in the 2022 national cancer patient experience survey, 2022 adult inpatient survey, 2022 urgent and emergency care survey, and 2023 maternity survey with outcomes expected to be published during 2023/24.

Our workforce

The Trust People Strategy 2019-23 sets out a clear vision for our workforce. Each year, the Trust draws on this strategy and with national, regional and local drivers.

The national NHS People Plan and NHS People Promise, launched in 2020/21 sets an ambitious challenge to all NHS organisations; the NHS needs "more people, working differently, in a compassionate and inclusive culture". In 2023/24, it has been agreed we

align our Trust people priority framework to the national approach, which is also being adopted by the acute provider collaborative, where the people priorities are based around the four pillars in the national people plan. Progress against our strategy is monitored on a monthly basis by the people executive management board (EMB) and summarised for the people committee and people committee in common.

To ensure rigour around monitoring and early escalation of concerns, a similar approach adopted in 2022/23 will be replicated in 2023/24. Monthly reports to the people EMB are completed, providing an update on progress of the people priorities, performance against key milestones and associated metrics, updates on future activities and links to corporate and local risks. This report will also be summarised for EMB, people committee and people committee in common.

Integrated performance management

In 2020, the Trust introduced the new Imperial management and improvement system (IMIS) to help deliver organisational goals and objectives. This includes the performance routines within the organisation, use of integrated performance scorecards and our approach to using improvement methods towards achieving our goals.

The integrated performance 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 are balanced and contain a suite of metrics covering quality, safety, workforce, operational response and recovery and finance.

The scorecards differentiate between 'driver metrics', prioritised areas for improvement and 'watch metrics', where performance is at an acceptable level, but visibility is important. Business rules accompany the scorecard which provide guidance on appropriate response during performance meetings e.g. sharing successes, giving structured verbal updates or presentation of a countermeasure summary with trend analysis and improvement actions.

Performance data is discussed routinely through the meetings of the Trust board, board committees, executive management board, executive subgroups, divisional performance and accountability review meetings and directorate performance meetings. This framework allows detailed reviews and assurances to be given where potential issues are identified, with instigation of quality improvement plans and escalations.

External oversight

All trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence. The single oversight framework remains the external mechanism for NHS England 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 Integrated Care Board (ICB) with support from the NHS England 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 is set out in the NHS oversight framework.

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 finance and performance reports monthly to the executive management board and bi-monthly to the finance, investment and operations committee and 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. More information about our committees, their structure and responsibilities is included in the Corporate Governance section.

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 chief nurse 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.

As discussed above in the risk section of the report, we have identified one of our principal risks is the failure to address our underlying deficit.

The Trust auditors have reported this as a 'significant weakness' in the Trust's arrangements to secure financial sustainability. This relates to the lower than required level of cost improvements being identified and developed at the time of submitting the 2023/24 plan. Recommendations for improvement have been made and the Trust is accelerating its efforts to take these forward including the identification and realisation of specific opportunities to deliver its plan, and planning for future periods, with project planning for their delivery further ahead of the start of the period.

Data security and protection shared service

The new data protection office shared service was implemented in April 2023. The new shared service consists of the following four services:

- Imperial College Healthcare NHS Trust data protection officer services
- NHS North West London Integrated Care Board (ICB) – corporate data protection officer services
- NHS North West London ICB – GP data protection officer services
- NHS North West London Integrated Care System – data protection officer services.

The new service has been created following a transfer of the NHS North West London ICB data protection officers into the Trust to form a data protection office shared services team.

Data protection framework

The Trust has a published data protection framework designed to deliver compliance with the General Data Protection Regulation (UK-GDPR), Data Protection Act 2018 and the NHS digital data security and protection toolkit.

Data security and protection committee

The data security and protection committee is responsible for oversight of Trust data protection and security policies and monitoring the mitigation plans identified in the information and communications technology risks.

Chief information officer / senior information risk officer

The chief information officer acts as the senior information risk officer, a role designed to take ownership as an advocate for information risk on the Trust board, with overall accountability for data protection and cyber security. A senior information risk officer's action plan has been generated to manage and mitigate information threats and risks.

Chief clinical information officer / Caldicott Guardian

The chief clinical information officer / 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.

Data protection officer

The data protection officer is a role assigned in compliance with, and duties outlined in, the Data Protection Act 2018. These include to inform and advise the organisation and its employees about their obligations to comply with the UK-GDPR and other data protection laws; to monitor compliance with the UK-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 Information Commissioner's Office and for individuals (patients/staff) whose data is processed.

Data security and protection toolkit

The NHS digital data security and protection toolkit is an online self-assessment tool that enables organisations to measure and publish performance against the national data guardian's ten data security standards. It consists of three leadership obligations, 10 data security standards, 33 mandatory (and five non-mandatory) assertions and requires 110 mandatory evidence items. Mandatory standards may be either "met" or "not met" in a data security and protection toolkit return.

Following the Covid-19 pandemic, the submission period for the data security and protection toolkit for 2022/23 now runs from 1 July 2022 to 30 June 2023.

An audit of the 2022/23 data security and protection toolkit return was completed in May 2023. The data protection office shared service has in place data security and protection toolkit planners, action plans and metrics to ensure a successful submission of the toolkit in June 2023 accompanied by a "standards met" "low risk" audit opinion.

The previous Trust data security and protection toolkit return (2021/22) achieved a "standards met" for all evidence requirements, ensuring a satisfactory return. This was subject to an independent audit provisioned by NHS Digital and operated by KPMG, which returned an overall rating of high assurance / substantial confidence.

Data security and protection training

One mandatory evidence data security and protection toolkit requirement is for 95 per cent of staff to complete annual mandatory data security and protection training. This target was achieved in June 2022 for the purposes of the 2021/22 data security and protection toolkit return. There is a plan in place to achieve the annual mandatory training target for the 2022/23 data security and protection toolkit return by 30 June 2023.

Data security and protection incidents July 2022 to March 2023

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 incident reporting tool will automatically notify the Information Commissioners Office and Department of Health and Social Care. Due to the pre-set reporting interval of the toolkit 1 July 2022 through 30 June 2023 – there are only partial in-year metrics available.

Table 1: Incidents reported 1 July 2022 – 31 March 2023

Grade of incident	Number
Incident reported to the ICO and Department of Health*	2
Trust-level incident	29
Incidents under investigation yet to be classified	11
Total *+	42

*No incidents were reported to the ICO between 1 April and 1 July 2022.

***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.

Analysis of types of incidents (not mutually exclusive)

The following are categories of incidents. This analysis provides a high-level overview of the areas of work creating greatest concern. These figures have been used to support prioritisation of formal process reviews in order to identify service improvements and risk mitigations that may be implemented.

Category of incident	Number
Loss / theft	14
Email	10
Abuse of authorised access	5
Incorrect upload	3
Paperwork	1
Subject access request	1

Incidents reported to Information Commissioners Office and Department of Health and Social Care (Total = 2)

Incident	Summary of Incident	Incident Details	Action taken by ICO
1	Email containing demographic and special category health information sent by Trust employee to incorrect address.	A Trust employee sent an email containing demographic information and special-category health information of a sensitive nature to the wrong email address. The unintended recipient confirmed they had read the email but it had been deleted.	The ICO decided not to take action. The data subject subsequently complained about the length of time it took for them to be informed. An apology was provided, which they felt was insufficient. They stated that they intend to escalate this to the ICO. The case remains open.
2	Fertility clinic letter sent with address only leading to incorrect person opening letter	A letter from our fertility clinic containing details of the referrals process, was sent to a patient's address with no named recipient. This led to the letter being opened by people who had not been informed about the referral. The patient was unhappy others now knew they were using fertility services. The service uses pre-printed information sheets which are sent out patients. The names and addresses of patients are then handwritten on the envelope. In this case, a bank staff employee omitted to include the name.	The ICO decided not to take action and the DPO has recorded the case as closed.

In August and September 2022, the Trust was impacted by a national cyber security incident affecting a significant supplier of information communication and technology systems to the NHS. While the Trust was unable to access its financial systems for around six weeks, the Trust's financial system was not compromised; there was no direct financial loss related to this incident; and both payroll and banking facilities remained unaffected by the system issues.

Data quality and governance

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct and up to date. For 2022/23 as a whole, the Trust achieved the benchmark for the Data Quality Maturity Index, a national measure of data quality that monitors coverage, consistency, completeness and validity across a number of datasets, and is published by NHS England. However, we recognise that the pandemic, our growing waiting list for planned care, and some of our wider operational challenges have had an impact on our waiting list data quality and we continue to prioritise improvement in this area. Progress is managed through our waiting list data quality and reporting framework, which is led by our chief operating officer and reports regularly to the executive management board. An important component of this is a quality assurance and sample audit process to inform training, learning and development. The performance support team carries out routine audits of referral to treatment (RTT), emergency care metrics, diagnostics (DM01) and cancer waiting time data.

At an executive management board meeting in June 2022, it was acknowledged that, whilst significant work had been completed to monitor, track and report data quality as well as mitigate risk, a sustainable improvement in real time data quality has not yet been delivered. As a result, the performance support team were tasked with carrying out a Trust-wide review into data quality for waiting list, waiting times and performance. The high-level output of this review was presented to the executives in January 2023 and, following further detailed planning, a large-scale data quality improvement programme is now in development, with a primary focus on outpatients. The long-term desired goal is to improve data quality at source, to reduce layering of errors within patients' pathways by improving data capture ensuring it is accurate, complete and timely.

Register of 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/how-we-are-run/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 2114 staff, 65 per cent, had been returned at the end of March 2023.

The Trust has published on its website an up-to-date register of interests, 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.

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 also set out in the accounts.

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. Further information can be found in our *Annual Workforce Equality, Diversity, and Inclusion report 2021/22*. The report for 2022/23 will be published in autumn 2023.

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 reporting requirements will be complied with.

Emergency preparedness, resilience and response

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS emergency preparedness, resilience and response (EPRR) framework 2022. The Trust participates in the annual EPRR assurance process carried out by NHS England; the Trust continues to be rated as having 'fully compliant' assurance, and an annual work plan is in place to ensure maintaining the achieved level of compliance.

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.

The quality report has been prepared in accordance with 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 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 quality committee held in May, and at our audit, risk and governance committee held in June, where the authority of signing the final quality accounts document was delegated to the chief executive and chair.

Chief executive's review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review 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 sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal audits carried out have provided a range of levels of assurance, including two reports rated as 'amber-red' relating to data quality and patient experience (complaints). For all audits completed, management have accepted, and taken action to address, recommendations made. Management improvement plans for all audits with 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 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
- the board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed. Internal audit has rated the framework as providing 'Significant assurance with minor improvements' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control'
- the audit, risk and governance committee oversee 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 Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively
- 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.

No significant control issues have been identified in 2022/23. We recognise the risk to the Trust securing financial sustainability, due to the lower than required level of cost improvements being identified and developed at the time of submitting the 2023/24 plan (see the review of economy, efficiency and effective use of resources). We have accelerated our efforts to take these forward, including the identification and realisation of specific opportunities to deliver its plan, and planning for future periods, with project planning for their delivery further ahead of the start of the period.

Professor Tim Orchard, Chief executive
29 June 2023

REMUNERATION AND STAFF REPORT

Remuneration report

The remuneration and staff report sets out the organisation's remuneration framework for directors and senior managers and the amounts awarded to them including performance-based remuneration where applicable.

The senior managers to be included in the remuneration report comprise those executive and non-executive directors holding voting rights for board and board sub-committee meetings. 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 typically take effect from 1 April and salary levels for those executive directors who are voting members of the board are disclosed in the following pages.

The Trust has taken advantage of flexibilities offered in the agenda for change to offer spot salaries to 24 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 England 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)

The Trust is required to disclose the relationship between the remuneration of its highest-paid director against the 25th percentile, median and 75th percentile of remuneration of its workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

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 banded remuneration (shown as the mid-point of the applicable £5k band) of the highest paid director changed between financial years as shown in the table below:

Highest paid director *	2022/23	Change from prior year (%)	2021/22 (restated)
Total remuneration (£)	£295k – £300k	1.7%	£290k – £295k
Salary component of total remuneration (£)	£285k – £290k	1.8%	£280k – £285k
Performance pay and bonuses component of total information	£5k – 10k	0.0%	£5k – £10k

*The highest paid director remuneration has been restated in line with the restatement outlined in the executive directors' remuneration disclosure for 2021/22 elsewhere in the Remuneration and staff report.

It should be noted that whilst this disclosure is required to show pay with reference to the mid-point of the applicable £5k band, the actual increase in salary may be more or less than the increase shown, depending on whether the movement drives a change from one £5k band to another.

The following tables compare the banded remuneration of the highest paid director. 2021/22 figures have been restated to ensure consistency following amendments made to the calculation methodology during 2022/23. The impact of the restatement is to reduce the pay ratios disclosed for 2021/22.

2022/23	25th percentile	Median	75th percentile
Total remuneration (£)	33,884	45,091	57,915
Salary component of total remuneration (£)	33,884	45,091	57,915
Pay ratio information	8.78	6.60	5.14

2021/22 (restated)	25th percentile	Median	75th percentile
Total remuneration (£)	29,858	41,388	53,602
Salary component of total remuneration (£)	29,858	41,388	53,602
Pay ratio information	9.80	7.07	5.46

2021/22 (original)	25th percentile	Median	75th percentile
Total remuneration (£)	26,385	39,859	49,218
Salary component of total remuneration (£)	26,385	39,859	49,218
Pay ratio information	11.09	7.34	5.94

The year-on-year percentage change in ratio is driven by the impact of the 2022/23 pay award, which was proportionally higher for those on lower grades. Rates for temporary bank staff were also realigned to Agenda for Change rates in 2022/23 which led to higher proportional increases. The figures can also change year-on-year depending on the composition of the workforce by band.

The highest paid director did receive an increase in remuneration that was consistent with other staff groups.

In both 2022/23 and 2021/22 no employees received remuneration in excess of the highest paid director. Remuneration ranged from £15k–£20k to £295k–£300k in 2022/23 (2021/22 restated: £15k–£20k to £290k–£295k; 2021/22 original: £20k–£25k to £290k–£295k).

The average salary component percentage change from 2021/22 to 2022/23 is an increase of 8 per cent.

The calculation uses standardised reports from the Electronic Staff Record (ESR) system based on the Month 12 position. Calculations are then undertaken to reflect an annualised salary for those whose working pattern is less than full time, or who were in post for less than the whole year.

The calculation also includes assumptions for agency and other temporary employees but excludes consultancy services. Only the remuneration paid to the employee are included. Agency fees are excluded from the calculation but are not always known so are assumed to be 20 per cent of total cost.

Remuneration tables

Salary and pension disclosure tables are below; information subject to audit.

Changes to board arrangements in 2022/23

Coinciding with the creation of integrated care boards during 2022/23, a number of changes took place in the Trust's governance arrangements, including the establishment of a board in common to oversee the North West London Acute Provider Collaborative.

The Collaborative is an arrangement for common governance processes across the four acute providers in the North West London Integrated Care System (Imperial College Healthcare NHS Trust, Chelsea & Westminster NHS Foundation Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust). The board in common is led by a joint chair who acts as chair for all four trusts, with each trust also having a vice-chair. The board in common comprises executive and non-executive directors from each trust.

Board in common meetings act as the board meetings for each trust within the collaborative but voting on individual trust items is restricted to board members from the relevant trust. More information on the new arrangements is provided in the corporate governance section of this annual report.

As part of the collaborative arrangements, all non-executive directors are now required to serve on the boards of at least two of the acute providers in the collaborative. As noted above, the chair is a member of all four boards.

The remuneration report includes all voting directors of the Trust; the chair, non-executive directors and executive directors. Non-executive directors and the chair are paid a combined fee for all their board positions with the acute collaborative providers. The remuneration shown in this report reflects the proportion of their total remuneration relevant to their role with the Trust. Remuneration related to their roles with other members of the Collaborative is included in the annual reports of the relevant organisations.

As part of these changes, a number of the Trust's non-executive directors stood down from the board. The below tables list all those directors who served during the financial year.

Non-executive directors' remuneration 2022/23

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	**Salary[12]**	**Expense payments (taxable)**	**Performance pay and bonuses**	**Long term performance pay and bonuses**	**All pension related benefits[16]**	**Total remuneration**
	bands of £5,000)	**(total to nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
Name and title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Matthew Swindells, joint chair[1]	20 – 25	-	-	-	-	20 – 25
Bob Alexander, vice chair / non-executive director[2]	15 – 20	-	-	-	-	15 – 20
Professor Andrew Bush, non-executive director[3]	10 – 15	-	-	-	-	10 – 15
Peter Goldsbrough, non-executive director[4]	10 – 15	-	-	-	-	10 – 15
Sim Scavazza, non-executive director[5]	10 – 15	-	-	-	-	10 – 15
Nick Gash, non-executive director[6]	0 – 5	-	-	-	-	0 – 5
Linda Burke non-executive director[7]	5 – 10					5 – 10
David Moss, non-executive director[8]	5 – 10					5 – 10
Andreas Raffel, non-executive director[9]	5 – 10	-	-	-	-	5 – 10
Kay Boycott, non-executive director[10]	5 – 10	-	-	-	-	5 – 10
Nick Ross, non-executive director[11]	5 – 10	-	-	-	-	5 – 10

Executive directors' remuneration 2022/23

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	**Salary**	**Expense payments (taxable)**	**Performance pay and bonuses**	**Long term performance pay and bonuses**	**All pension related benefits[16]**	**Total remuneration**
	(bands of £5,000)	**(total to nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
Name and title	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Professor Tim Orchard, chief executive officer[13]	285 – 290	-	5 – 10	-	75 – 77.5	370 – 375
Professor Julian Redhead, medical director[14]	260 – 265	-	-	-	50 – 52.5	315 – 320
Professor Janice Sigsworth, director of nursing[15]	170 – 175	-	-	-	-	170 – 175
Jazz Thind, chief financial officer	175 – 180	-	-	-	32.5 – 35	210 – 215
Claire Hook, chief operating officer	165 – 170	-	-	-	57.5 – 60	225 – 230

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Pension benefits	**Real increase in pension at pension age**	**Real increase in lump sum at pension age**	**Total accrued pension at pension age at 31 March 2023**	**Lump sum at pension age relating to accrued pension at 31 March 2023**	**Cash equivalent transfer value at 1 April 2022**	**Real increase in cash equivalent transfer value[17]**	**Cash equivalent transfer value at 1 April 2022[17]**	**Employer's contribution to stakeholder pension**
	(bands of £2,500)	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**(nearest £1k)**	**(nearest £1k)**	**(nearest £1k)**	**(nearest £1k)**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Professor Tim Orchard, chief executive officer[13]	5 – 7.5	0.0 – 2.5	125 – 130	170 – 175	1,897	84	2,080	-
Professor Julian Redhead, medical director[14]	2.5 – 5	-	85 – 90	185 – 190	1,567	51	1,702	-
Professor Janice Sigsworth, director of nursing[15]	-	-	-	-	-	-	-	-
Jazz Thind, chief financial officer	0.0 – 2.5	-	75 – 80	95 – 100	1,154	44	1,246	-
Claire Hook, chief operating officer	2.5 – 5	0 – 2.5	50 – 55	85 – 90	648	39	730	-

Notes:

1. Matthew Swindells joined the board as joint chair of the North West London Acute Provider Collaborative on 1 April 2022.
2. Bob Alexander assumed the role of vice-chair of Imperial College Healthcare NHS Trust from 1 September 2022. He is also a non-executive director of London North West University Healthcare NHS Trust.
3. Professor Andrew Bush became a non-executive director of Chelsea & Westminster NHS Foundation Trust from 1 September 2022.
4. Peter Goldsborough became a non-executive director of Chelsea & Westminster NHS Foundation Trust from 1 September 2022.
5. Sim Scavazza became a non-executive director of London North West University Healthcare NHS Trust from 1 September 2022.
6. Nick Gash joined the board from 14 October 2022. He is also a non-executive director of The Hillingdon Hospitals NHS Foundation Trust.
7. Linda Burke joined the board from 1 September 2022. She is also a non-executive director of The Hillingdon Hospitals NHS Foundation Trust.
8. David Moss joined the board from 1 September 2022. He is also a non-executive director of London North West University Healthcare NHS Trust.
9. Andreas Raffel left the board on 30 September 2022.
10. Kay Boycott left the board on 31 August 2022.
11. Nick Ross served as a non-executive director to 31 August 2022. He continues to serve as a non-voting associate non-executive director. Remuneration shown relates to his role as a voting non-executive director.
12. All remuneration shown relates to the individuals' roles with Imperial College Healthcare NHS Trust. Remuneration for roles in other North West London providers are shown in the remuneration reports of the respective organisations.
13. Professor Tim Orchard – the amount of £45–50k of salary relates to payment for his clinical role.
14. Professor Julian Redhead – the amount of £55–60k of salary relates to payment for his clinical role.
15. Professor Janice Sigsworth chose not to be covered by the pension arrangements during the reporting year (2022/23).
16. 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 in pension is the nominal value adjusted for the impact of inflation and any increase or decrease due to a transfer of pension rights to or from other schemes. 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.
17. The movement in column (f) illustrates the real gain in value in the cash equivalent transfer value in the year and excludes gains resulting from inflation, employee contributions or transfers of benefits. For this reason, column (g) is not intended to be the sum of columns (e) and (f).

The table on the previous page reflects the proportion of the remuneration of non-executive directors that relates to their role with Imperial College Healthcare NHS Trust. As noted above, non-executive directors are now paid a combined fee to sit on the boards of at least two providers within the North West London Acute Provider Collaborative. This annual fee is £18k per annum, or £23k for those with vice-chair responsibilities. The Chair is paid a combined fee of £85k per annum. Actual remuneration for the year as shown in the table above may vary as these arrangements came into effect during the year.

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

In common with other members of staff, executive directors are able to sell annual leave in line with Trust policy. In 2022/23, three directors exercised this option: Prof. Tim Orchard and Jazz Thind sold leave in the value of £0–5k and Prof. Julian Redhead sold leave to the value of £0–5k.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

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

Remuneration report 2021/22 – restated

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	**Salary**	**Expense payments (taxable)**	**Performance pay and bonuses**	**Long term performance pay and bonuses**	**All pension related benefits[5]**	**Total remuneration**
	(bands of £5,000)	**(total to nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
Name and title	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Non-executive directors[7]						
Bob Alexander, acting chair / non-executive director[1]	55 – 60	-	-	-	-	55 – 60
Professor Andrew Bush, non-executive director	10 – 15	-	-	-	-	10 – 15
Peter Goldsbrough, non-executive director	10 – 15	-	-	-	-	10 – 15
Andreas Raffel, non-executive director	10 – 15	-	-	-	-	10 – 15
Sim Scavazza, non-executive director	10 – 15	-	-	-	-	10 – 15
Nick Ross, non-executive director	10 – 15	-	-	-	-	10 – 15
Kay Boycott, non-executive director	10 – 15	-	-	-	-	10 – 15
Executive directors						
Professor Tim Orchard, chief executive officer[2]	280 – 285	-	5 – 10	-	192.5 – 195.0	480 – 485
Professor Julian Redhead, medical director[3]	255 – 260	-	-	-	85.0 – 87.5	340 – 345
Professor Janice Sigsworth, director of nursing	185 – 190	-	-	-	17.5 – 20.0	200 – 205
Jazz Thind, chief financial officer	175 – 180	-	-	-	287.5 – 290.0	465 – 470
Claire Hook, chief operating officer[4]	160 – 165	-	-	-	107.5 – 110.0	270 – 275

Pension benefits	**(a) Real increase in pension at pension age**	**(b) Real increase in lump sum at pension age**	**(c) Total accrued pension at pension age at 31 March 2023**	**(d) Lump sum at pension age relating to accrued pension at 31 March 2023**	**(e) Cash equivalent transfer value at 1 April 2022**	**(f) Real increase in cash equivalent transfer value[6]**	**(g) Cash equivalent transfer value at 1 April 2022[6]**	**(h) Employer's contribution to stakeholder pension**
	(bands of £2,500)	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**(nearest £1k)**	**(nearest £1k)**	**(nearest £1k)**	**(nearest £1k)**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Professor Tim Orchard, chief executive officer[2]	10.0 – 12.5	10.0 – 12.5	115 – 120	165 – 170	1,685	167	1,897	-
Professor Julian Redhead, medical director[3]	5.0 – 7.5	2.5 – 5.0	75 – 80	180 – 185	1,435	90	1,567	-
Professor Janice Sigsworth, director of nursing	0.0 – 2.5	5.0 – 7.5	95 – 100	290 – 295	2,277	74	2,386	-
Jazz Thind, chief financial officer	12.5 – 15.0	17.5 – 20.0	70 – 75	95 – 100	900	228	1,154	-
Claire Hook, chief operating officer[4]	5.0 – 7.5	5.0 – 7.5	45 – 50	80 – 85	567	78	648	-

1. Bob Alexander joined the board on 1 October 2020 and became acting chair of the board from 1 April 2021.
2. Professor Tim Orchard: £45 – 50k of his salary relates to payment for his clinical role. The figures for Professor Orchard are restated to more accurately reflect the elements of pay related to performance and to his clinical role, though the overall value remains unchanged. The revised figures with originals shown in brackets are: Total Remuneration: £480-485k (no change); Salary £280-285k (was £270-275k), Performance pay & bonus £5-10k (was £15-20k) and element of pay related to clinical role £45-50k (was £35-40k).
3. Prof Julian Redhead: £55-60k of his salary relates to payment for his clinical role.
4. Claire Hook was appointed to the board as chief operating officer on 1 July 2021, having previously occupied other senior roles within the Trust.
5. 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. This is 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.
6. The movement in column (f) illustrates the real gain in value in the cash equivalent transfer value in the year and excludes gains resulting from inflation, employee contributions or transfers of benefits. For this reason, column (g) is not intended to be the sum of columns (e) and (f).
7. This note has been restated This note has been restated to disclose only those directors with voting rights on the board. The Trust's view is that board members with voting rights comprise the key senior managers to be disclosed.

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

In common with other members of staff, executive directors are able to sell annual leave in line with Trust policy. In 2021/22, one director exercised this option: Prof. Tim Orchard sold leave in the value of £5–10k.

Staff report

The headcount data is as of 31 March 2023 and is for clinical and corporate divisions and research and development (including hosted and contracted services).

Workforce composition by staff group

At the end of 2022/23 the Trust employed 15,213 staff. Approximately 64 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in the table below.

Trust staff group	Headcount 2022/23	Headcount 2021/22
Admin and clerical	2,108	2,040
Allied health professional (qualified)	777	762
Allied health professional (support)	123	126
Ancillary	1,090	993
Doctor (career grade)	48	37
Doctor (consultant)	1,294	1,284
Doctor (Trust and training grade)	1,913	1,812
Nursing and midwifery (qualified)	4,325	4,140
Nursing and midwifery (support)	1,260	1,157
Pharmacist	159	153
Physician associate	9	6
Scientific and technical (qualified)	888	851
Scientific and technical (support)	437	416
Senior manager	782	754
Trust total	**15,213**	**14,531**

Staff turnover

Staff turnover for 2022/23 was 12.2 per cent which was the same level as in 2021/22.

Workforce composition by sex

Sixty-nine 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 2022/23 women accounted for 60 per cent of senior managers, 33 per cent of executive directors and 38 per cent of board directors. There are five directors who are defined both as executive team members and as board directors.

Gender – all	Headcount 2022/23	Headcount 2021/22
Female	10,502	10,037
Male	4,711	4,494
Trust total	**15,213**	**14,531**
Gender – senior managers	**Headcount 2022/23**	**Headcount 2021/22**
Female	454	424
Male	328	321
Trust total	**752**	**745**

Gender – board of directors	Headcount 2022/23	Headcount 2021/22
Female	6	6
Male	11	10
Trust total	**17**	**16**
Gender – executive team	**Headcount 2022/23**	**Headcount 2021/22**
Female	7	7
Male	13	12
Trust total	**20**	**19**

Workforce composition by age and ethnicity

Age group	Headcount 2022/23	Headcount 2021/22
16-19 years	7	12
20-29 years	2,557	2,713
30-39 years	4,882	4,398
40-49 years	3,229	3,290
50-59 years	3,079	2,896
60 years and over	1,459	1,222
Trust total	**15,213**	**14,531**

Ethnic origin	Headcount 2022/23	Headcount 2021/22
White – British	3,203	3,366
White – Irish	361	385
White – Any other White background	1,763	1,755
Mixed – White and Black Caribbean	96	117
Mixed – White and Black African	98	95
Mixed – White and Asian	137	137
Mixed – Any other mixed background	241	240
Asian or Asian British – Indian	1,585	1,234
Asian or Asian British – Pakistani	328	325
Asian or Asian British – Bangladeshi	206	195
Asian or Asian British – Any other Asian background	1,444	1,541
Black or Black British – Caribbean	557	592
Black or Black British – African	1,866	1,784
Black or Black British – Any other Black background	410	416
Chinese	267	219
Any other ethnic group	1,469	1,275
Undefined	754	442
Not stated	428	413
Trust total	**15,213**	**14,531**

Average staff numbers (subject to audit)

This table represents the average whole time equivalent staff numbers through the year and so presents a different figure than the analysis tables above, which relate to the number of staff employed as of 31 March 2023.

	2022/23			2021/22		
Average staff numbers	Total	Permanently employed	Other	Total	Permanently employed	Other
Medical and dental	2,367	2,352	15	2,275	2,262	13
Ambulance staff	-	-	-	-	-	-
Administration and estates	3,854	3,782	72	3,789	3,712	76
Healthcare assistants and other support staff	2,049	1,980	69	1,898	1,810	88
Nursing, midwifery and health visiting staff	4,603	4,422	181	4,457	4,323	133
Nursing, midwifery and health visiting learners	-	-	-	-	-	-
Scientific, therapeutic and technical staff	1,145	1,063	82	1,123	1,047	76
Social care staff	-	-	-	-	-	-
Healthcare science staff	655	655	-	617	617	-
Other	8	8	-	4	4	-
TOTAL	**14,681**	**14,262**	**419**	**14,162**	**13,776**	**386**
Staff engaged on capital projects (included above)	26	26	-	24	24	0

The analysis of staff costs is shown below (subject to audit):

	2022/23			2021/22		
	Total	Permanent	Other	Total	Permanent	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	784,255	700,787	83,468	688,984	623,667	65,317
Social security costs	84,057	74,655	9,402	73,494	65,958	7,536
Apprenticeship Levy	3,549	3,095	454	3,278	2,896	382
Employer Contributions to NHS BSA	112,654	104,157	8,497	104,830	97,273	7,557
Other pension costs	151	81	70	173	122	51
Termination benefits	-	-	-	0	0	0
Total employee benefits	**984,666**	**882,776**	**101,890**	**870,759**	**789,716**	**80,943**
Employee costs capitalised	3,780	3,780	-	3,634	3,627	7
Gross Employee Benefits ex. capitalised costs	**980,886**	**878,995**	**101,891**	**867,125**	**786,289**	**80,836**

Note that staff costs presented include (in line with national guidance) estimated amounts payable in respect of 2022/23 as part of the 2023/24 pay settlement proposed at the reporting date and subsequently implemented following agreement with the NHS Staff Council.

Sickness absence

At the time of publication, validated sickness absence statistics for 2022/23 were not available. When data is released it will be available via the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Employment of staff with disabilities

The Trust is committed to attracting and developing staff with disabilities. The Trust's commitments are described in its equal opportunities policy and its policy on maintaining the employment of people with disabilities. The Trust is a 'two ticks' employer, guaranteeing an interview for any disabled person who meets the minimum criteria for a role. Information on the proportion of staff with declared disabilities is shown in the table below. Further information on the employment of people with disabilities is available in our annual equality workforce information report which is published on the Trust website.

Staff with disabilities	Headcount 22/23	Headcount 21/22
No	12,268	11,463
Not declared	1,802	2,073
Prefer not to answer	138	99
Unspecified	581	561
Yes	424	335
Trust total	**15,213**	**14,531**

Consultancy

In 2022/23, the Trust incurred consultancy costs of £258k (2021/22: £430k).

Policies and procedures in respect of countering fraud and corruption

The Trust has an approved counter-fraud policy and undertakes proactive work to enable and encourage reporting of concerns. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence.

The Trust has retained KPMG LLP to provide local counter-fraud specialist services over 2022/23 in accordance with secretary of state directions. The Trust board's audit, risk & governance committee formally approves the counter-fraud annual work plan and progress reports are provided to the committee at each meeting.

Trade union facility time publication requirements report: 2022/2023

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

Trade union facility time information required for publication

The below data refers to the relevant period which is 1 April 2022 – 31 March 2023.

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
48	44.61

Percentage of time spent on facility time – How many employees who were TU representatives 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%	41
1-50%	7
51%-99%	0
100%	0

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.

Reporting requirement	Figures
Provide the total cost of facility time	£25,922.08
Provide the total pay bill	£957,846k = total figure for 2022/2023 including apprenticeship levy (£3,905k) £954,297k = 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	0.003%

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	90%

Appendix 1

Glossary of terms

Term	Definition
Relevant public sector employer	Section 7 of the regulations defines what is a relevant public sector employer. This specifies: • Government departments, which include executive agencies and non-ministerial departments (other than the Secret Intelligence Service, the Security Service and the Government Communications Headquarters) • the Scottish Ministers and • public authorities described or listed in Schedule 1 of the regulations
TU representative	A relevant union official. An official of an independent TU recognised by the employer.
Relevant period	A period of 12 months beginning with 1 April, the first relevant period starts on 1 April 2017.
Total pay bill	Is the total amount of (the total gross amount spent on wages) + (total pension contributions) + (total national insurance contributions) during the relevant period.
Full Time Equivalent (FTE) employee number	The (total number of full time employees) + (the total fractions of full time employee hours worked by all employees who are not full time).
TU Duties	Duties where there is a statutory right to reasonable paid time off during normal working hours to undertake recognised duties and to complete training relevant to their TU role. This arises under: (a) section 168, section 168A of the 1992 Act (TULR(C)A) (b) section 10(6) of the Employment Relations Act 1999 (c) regulations made under section 2(4) of the Health and Safety at Work etc. Act 1974.
TU Activities	Means time taken off under section 170 (1) (b) of the 1992 Act. TU activities could include: • meetings – where the purpose or principal purpose is to discuss internal union matters • TU conferences • internal administration of the union e.g. answering internal union correspondence, dealing with financial matters, responding to internal surveys. There is no statutory entitlement to paid time off to undertake activities. However TU representatives are entitled to be granted reasonable unpaid time off to participate in TU activities.
Paid TU Activities	Time taken off for TU activities under section 170 (1) (b) of the 1992 Act in respect of which a TU representative receives wages from the relevant public sector employer. There is no statutory entitlement to paid time off to undertake activities. It is accepted that there could be exceptional circumstances where paid time off for activities may be appropriate, however it is recommended the organisations ensure they have appropriate controls in place to monitor this.
Total paid facility time hours	Total number of hours spent on facility time by TU representatives during a relevant period. Does not include hours attributable to time taken off under section 170(1)(b) of the 1992 Act in respect of which a TU representative does not receive wages.
Hourly cost	For each employee: (the gross amount spent on wages) + (pension contributions) + (national insurance contributions) divided by the number of hours during the relevant period.
Total cost of facility time	For each employee who was a TU representative during the relevant period, facility time cost is calculated by: • (Hourly cost for each employee x number of paid facility time hours) Total facility time cost is calculated by adding together the amounts produced by the calculation of facility time cost for each employee. In calculating this figure the wages of any employee who can be identified from the information being published must be expressed as a notional hourly cost to represent the employee's wages.

Off-payroll arrangements

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

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

Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 23, for more than £245 per day:

	Number
Number of existing engagements as of 31st March 2023	5
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	2

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

For all off – payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	9
Of which:	
Number not subject to off-payroll legislation	1
Subject to off-payroll legislation and determined as in-scope of IR35	5
Number subject to off-payroll legislation and determined as out of scope of IR35	3
Number of engagements reassessed for compliance or assurance purpose during the year	6
Number of engagements that saw a change to IR35 status following review	-

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 2022 and 31 March 2023

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number 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	20

Exit packages (subject to audit)

In 2022/23 the Trust approved severance payments to 14 staff (2021/22: eight staff).

Exit packages

2022/23								
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	27,086	4	27,086		
£10,000-£25,000	-	-	5	89,818	5	89,818		
£25,001-£50,000	-	-	4	143,883	4	143,883	1	14,300
£50,001-£100,000	-	-	1	53,005	1	53,005		
£100,001 - £150,000	-	-	-	-	-	-		
£150,001 - £200,000	-	-	-	-	-	-		
Total	**-**	**-**	**14**	**313,792**	**14**	**313,792**	**1**	**14,300**

2021/22								
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			2	11,305	2	11,305	0	0
£10,000-£25,000	1	13,852	3	40,500	4	54,352	0	0
£25,001-£50,000			1	38,683	1	38,683	0	0
£50,001-£100,000			1	54,014	1	54,014	0	0
£100,001 - £150,000							0	0
£150,001 - £200,000							0	0
Total	**1**	**13,852**	**7**	**144,502**	**8**	**158,354**	**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.

	2022/23		20021/22	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	11	219	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	10	-	-
Exit payments following employment tribunals or court orders	2	71	7	145
Non-contractual payment requiring HM Treasury approval	1	14	-	-
Total	**15**	**314**	**7**	**145**

Professor Tim Orchard, Chief executive
29 June 2023

CHIEF FINANCIAL OFFICER'S REPORT

Chief financial officer's report

Introduction and overview

The financial year 2022/23 has seen a return to largely business as usual operating, with annual budget setting process reinstated. Whilst the financial regime continued to be governed by block contracts, funding to support continued response to the Covid-19 pandemic was reduced and the requirement to deliver efficiencies to maintain financial balance was resumed. Elective recovery funding (ERF) was made available directly into provider envelopes in 2022/23 and although it was initially assumed that where activity targets were not met funding would be required to be returned back to commissioners, during the year NHS England advised that there would be 'no clawback' related to unmet activity targets. The Trust reported an adjusted surplus of £199k.

Financial review of 2022/23

Financial performance against the revenue budget

The Trust planned to achieve a breakeven position for the financial year, in line with sector funding assumptions. This breakeven position is on the adjusted financial performance measure and excludes certain 'below the line' items such as the impact of market-based valuation movements on land and building assets, and the impact of capital assets funded by donations.

Overall the Trust reported a small adjusted surplus of £199k which was favourable to the breakeven plan.

The tables below set out the actual income and expenditure performance as at the 31 March 2023, including comparative information for 2021/22 and tracks this against the Trust agreed plan:

Statement of comprehensive income	2022/23	2021/22
	£'m	£'m
Income	1,601.5	1,483.1
Expenditure	(1,623.4)	(1,440.6)
Net financing income / (costs)	4.2	(0.4)
Gain / (Loss) on disposal of assets	(2.8)	0.0
Public dividend capital payable	(11.5)	(11.6)
Surplus / (deficit) before revaluations and impairments	**(32.2)**	**30.6**
Adjustments for revaluations and impairments	(2.8)	18.5
Surplus/(deficit) for the financial year as per annual accounts	**(34.9)**	**49.1**

Performance against plan	2022/23	2021/22
	£'m	£'m
Surplus/(deficit) for the financial year as per annual accounts	**(34.9)**	**49.1**
Donated asset adjustment	(29.0)	(12.9)
Adjust for revaluation and impairment	64.2	(36.1)
Adjusted surplus / (deficit)	**0.2**	**0.1**
Planned position	0.0	0.0
Performance against plan	**0.2**	**0.1**

Although the revenue and capital position as at 31 March 2023 represents a significant achievement, there remain two key ongoing risks:

- delivering the level of year-on-year efficiencies required to maintain ongoing financial sustainability
- insufficient levels of investment required to deal with the ongoing backlog maintenance issue at all Trust sites (due to the ongoing deterioration of the aged estate).

The Trust's revenue position was dependent on achieving savings and efficiencies of £37m across the year. This requirement was allocated out across the Trust's clinical and corporate divisions with divisions required to develop and mobilise savings schemes that improves the efficiency of services being provided, with a focus on those areas where evidence suggests that costs are higher than for peer organisations in the integrated care system (ICS) or nationally.

The financial environment in 2022/23 was extremely challenging – the combination of extremely high demand for services, wider economic disruption (including high levels of inflation) and industrial action amongst health service staff, ultimately meant the Trust was not able to make as much progress as it envisaged in identifying and delivering recurrent, cash releasing savings – the Trust achieved savings of £15.8m against a plan of £37m. This did therefore require the Trust to rely on one off (non-recurrent) measures to achieve its planned financial position.

Performance against other financial measures

The Trust successfully remained within its expected external financing limit (EFL) and capital resource limit (CRL) targets.

The year-end capital resource limit was significantly higher than that planned for at the beginning of the financial year, driven by over £29m of additional funding allocations becoming available during the year, providing an injection of cash that enabled the Trust to make further capital investments. Further information on the capital programme is included below.

Finance system downtime

During 2022/23, the Trust – along with a number of other NHS bodies – was impacted by a national cyber security incident affecting one of the significant suppliers of information communication and technology systems to the NHS, leading to the Trust not being able to access its financial systems for a period of circa six weeks in August and September 2022. Although the system downtime did have a negative impact on performance in respect of the Better Payment Practice Code (as set out in more detail below), the Trust was able to both procure essential supplies and maintain essential payments to suppliers. The Trust financial system was also not compromised; there was no direct financial loss related to this incident; and both payroll and banking facilities remained unaffected by the system issues. The resource input required to manage the Trust's finances during this period was however considerable.

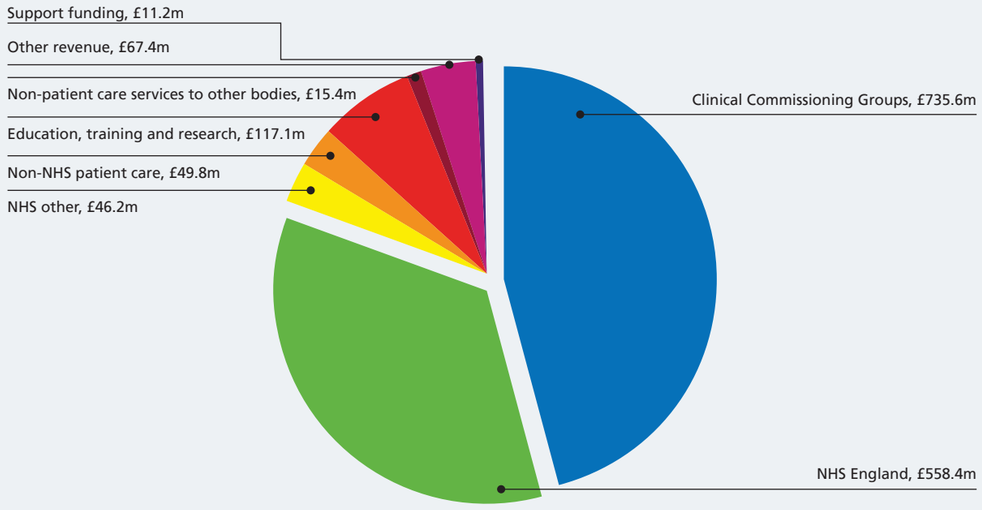
Income

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 £1,601.5m for 2022/23 (2021/22 £1,483.1m). The majority of this related to NHS patient care income for the provision of clinical services. During 2022/23 the financial regime continued to be governed by block contracts. Under these arrangements the Trust received additional income via elective recovery fund totalling £33m to enable the delivery of additional activity across the year to meet the planned recovery of services to patients. Whilst the Trust was unable to achieve the activity linked to receipt of elective recovery fund funding, in line with NHS England's 'no claw back' guidance, the Trust was able to retain and recognise all of this income in 2022/23.

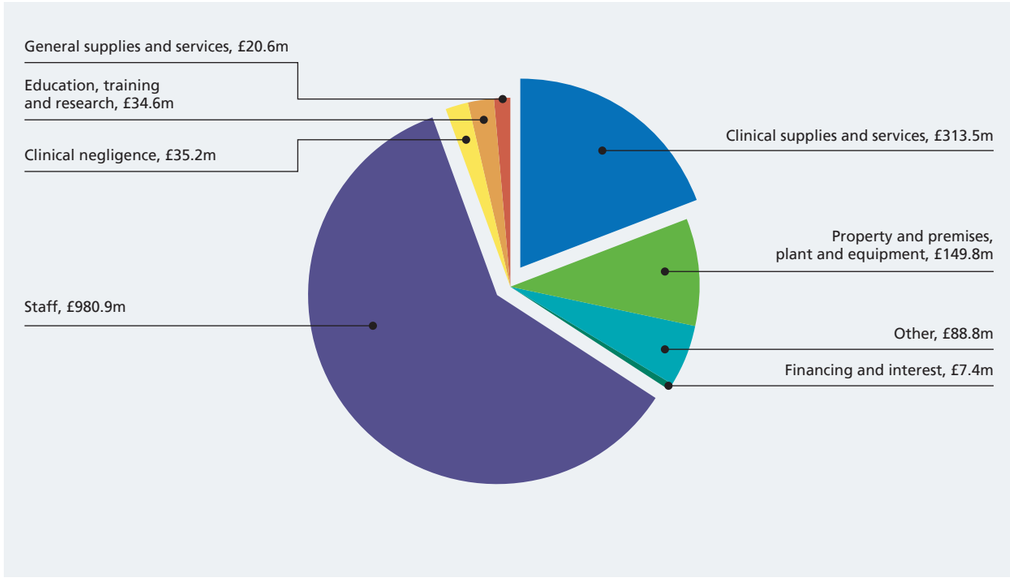
There are a number of other income sources the Trust receives, these include:

- education and training (£55m), 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; and
- research and development income (£62m) related to both government and commercially funded research carried out by the Trust.



Expenditure

Excluding financing and interest costs, the Trust expenditure for 2022/23 was £1,623.4m (2021/22 £1,440.6m). Staff costs account for 60 per cent of this spend which includes the cost associated with those staff undertaking education, training and research activities. Other key elements of spend relate to clinical supplies and drug cost. Other expenditure in the chart below includes several smaller cost elements including legal fees, consultancy, operating lease, bad debts and inventories write downs.



To achieve the breakeven plan, £37m of planned savings and efficiencies were required to be delivered during the financial year. Divisions were allocated an element of the savings target with schemes targeting opportunities to eliminate waste and variation in cost base when compared to peer organisations across the integrated care system or nationally. However, given the overarching need to focus on operational performance, recovering elective services, and industrial action, the Trust did experience a slippage in the delivery of its savings plans (achieving only around £15.8m of the planned £37m) but was able mitigate this through non-recurrent in-year fortuitous benefits including additional income from the ICB and national funding allocations for Community Diagnostic Centres.

Capital expenditure

By 31 March 2023 the Trust invested £140.3m in capital expenditure (including £34.3m of grant and charity funding, and other donated assets). A summary of the capital programme is set out below:

Sources of Funds	£m
Internal Trust Financing	72.3
National Public Dividend Capital	30.1
IFRS16 Lease Impact	4.0
Charitable Funds	0.2
Decarbonisation Grant	34.1
Other	1.0
Total Capital Resources	**141.7**
Less: Charitable Funds	-0.2
Less: Donations	34.1
Capital Resource Limit	**107.4**
Application of funds	**£m**
Backlog Maintenance	29.0
ICT	7.6
Replacement of Medical Equipment	15.1
Community Diagnostic Centres (CDCs)	5.0
Western Eye Hospital Improvements	9.9
6th Catherisation Laboratory	6.0
Endoscopy	4.6
MH Lounge	0.7
Redevelopment Programme	3.2
Other Capital Projects	19.4
IFRS16 Lease Impact	4.0
Decarbonisation	35.7
Gross Expenditure	**140.3**
Other Income & Donations	-34.3
Expenditure against CRL	**106.0**
Spend as a % of CRL	**98.7%**

In the context of an evolving capital programme with a significant level of new in-year funding and ongoing delivery and supply challenges (posed primarily by the wider economic and public health environment), the final results represent a considerable achievement by the Trust (of which £46.1m of spend took place in the month of March 2023). Against the capital resource limit of £107.4m, the Trust achieved expenditure of £106.0m (98.7 per cent of plan), leading to an under-spend of £1.4m. It should be noted that final capital limits are now not confirmed to providers until after the submission of draft accounts, and the Trust did not expect its limit to include £1m of additional funding shown as 'other' above. Excluding this, spend against the expected limit was 99.7 per cent.

Notable capital projects in-year include major investment in grant funded decarbonisation works, fire safety works at Western Eye Hospital and the Samaritans building, commencement of the community diagnostic centre programmes, expansion of endoscopy services, refurbishment of the 8 South ward at Charing Cross Hospital and the regular programmes of investment in estates, medical equipment and information communications and technology assets.

We remain grateful to Imperial Health Charity for its continued fundraising efforts and the financial support it provides to the Trust in respect of the capital programme and improving patient care. Funding from the Charity has helped fund a number of pieces of much needed medical equipment including: a laser, ultrasound machine and analysers as well as the installation handrails for patient safety in the Queen Elizabeth the Queen Mother building at St Mary's Hospital.

Redevelopment remains a key priority for the Trust. Confirmation of the full requirement to support the work required to progress the new hospitals programme business case at St Mary's Hospital is yet to be confirmed. The Trust did however continue to receive small amounts of NHS England funding to support the work streams associated with the redevelopment of its sites.

IFRS16

The Trust adopted the new IFRS 16 leasing standard which came into effect from 1 April 2022. The standard expands the scope of lease accounting to bring far more leases onto the balance sheet (or statement of financial position / "SOFP") than was the case under the previous standard, IAS 17.

In the 2021/22 accounts, the Trust made a disclosure of the expected implementation impact of IFRS 16 on the value of its assets and liabilities that were to be brought onto the balance sheet. As part of the impact assessment, the Trust made judgements – in line with Department of Health and Social Care (DHSC) guidance on the implementation of the standard – around the expected end dates for leases based on the substance of the arrangements where the actual contract was either expired or continuing on a rolling basis. Such arrangements are quite common between public bodies due to historical reasons/ informal agreements and therefore end up being less formal than those with commercial entities.

The judgements made were around expected end dates and ensured that the Trust's assets and liabilities were not understated and were shown consistently with the accounting concept of economic substance over legal form.

The contractual status of these arrangements are monitored extensively within the Trust and where new contracts are signed, these are reflected within the lease obligation and asset value.

As part of national request during 2022/23, the Trust submitted a return to NHS England indicating the incremental impact on capital following the implementation of the IFRS 16 standard.

Cash

The Trust continued to successfully manage its cash throughout 2022/23; thereby remaining within its external financing limit (EFL) and ending the year with a cash balance of £179.2m at 31 March 2023.

This position represents a £58.3m reduction in the cash balance over the year. It is lower than the planned reduction at the beginning of the year due to the timing of capital expenditure at the year-end (which will be settled in the new year) and the continuation of funding and payment models that require less working capital than the pre-pandemic regime.

Cash balances are expected to remain higher than historic levels going forward but are expected to continue to reduce in 2023/24 due to further use of cash for capital investment and settlement of items from 2022/23. Whilst a high cash balance is beneficial to the Trust, it should not be taken as an indication of free cash to invest in additional expenditure and the need to maintain cash resilience and timely payments to suppliers remain key areas of focus.

Better Payment Practice Code

Under the public sector Better Payment Practice Code (BPPC), the Trust is required to pay 95 per cent of all valid undisputed invoices by the due date or within 30 days of satisfactory receipt of goods and services, whichever is later.

In summary the Trust achieved a cumulative performance of 88.8 per cent and 95.8 per cent of invoices paid by value and volume respectively over the year. This compared to 93.6 per cent and 98.4 per cent for 2021/22 The 2021/22 figures have been restated in the accounts following changes to the calculation methodology made in year. Performance in 2022/23 was negatively impacted by the finance system downtime following the cyber-attack outlined above. The Trust takes payment of suppliers very seriously and is endeavouring to ensure it fully complies with the BPPC standard.

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 contracted with our new outsourced provider (KPMG LLP) during 2022/23 to provide the Trust its specialist counter-fraud services.

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, delivery of training 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 2022/23.

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. As noted above, the Trust has not met this requirement in year, paying only 92.1 per cent of invoices by volume within target, though still met the target in respect of invoices by volume with 95.8 per cent of invoices being paid within the required time. This was largely due to the impact of the system downtime issues outlined previously. The Trust has now returned payment performance to its previous levels and is focused on maintaining and building on this going forward.

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 Department of Health and Social Care's (DHSC) group accounting manual 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.

Although the level of cash savings required to achieve the 2023/24 plan is very challenging, the Trust has the reasonable expectation that it will continue to have access to adequate resources to service its operational activities in cash terms for at least the next 12 months, and continues to be confident that both the North West London Integrated Care Board and the NHS more widely, will provide resources (if required) and continue to support the delivery of the Trust's activities.

As has been highlighted in previous years, whilst the current financial position is robust, 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 remain on the national 40 New Hospital Programme and funding for these schemes continues to be forthcoming in 2023/24. However, no commitment to cover any unexpected estates failures has been provided at the point of writing this report.

2023/24 looking ahead

- 2023/24 financial planning: confirmation of the funding regime has been received for the new financial year. This confirms that commissioners will receive similar funding levels as those in 2022/23 with adjustments to reflect national guidance. Providers have been allocated settlements, adjusted for an efficiency requirement, with an agreement that the higher than funded inflationary pressure will remain an unmitigated cost pressure risk rather than being assumed into the position (in line with agreed sector wide assumptions). In addition to the baseline envelope, there is the ability to earn additional income linked to performance targets, with indicative allocations made to providers. However, these are subject to targets being achieved, and income could now be clawed back if targets are not met.
- operational focus: providers have been issued with fixed performance and activity trajectory targets for the year. Based on the latest activity plan from services, the Trust is committed to as a minimum, to meeting the trajectories set. As stated above, an initial allocation has been awarded to the Trust to achieve the minimum activity targets, however further funding is available to providers who exceed these targets but only once the sector as a whole achieves the sector target.
- as noted above, further funding of at least £1m has been awarded to continue work on the redevelopment business case in 2023/24 for the continued development of the strategic outline case (SOC). A draft SOC has been prepared and shared for review with NHS England, with initial positive feedback received. The Trust continues to emphasise the known risks around the existing estate and the need for the redevelopment project at the St Mary's site to continue to progress as the only sustainable way to mitigate these risks for this site.

- integrated care systems: the Trust continues to be actively engaged in the development of the ICS in line with national requirements. For 2023/24 the financial plans have again been agreed against a shared set of planning assumptions for all organisations ensuring a fair and equitable approach to the management of financial positions; resilience to delivery of care and attention to inequalities. Finance teams are actively collaborating in a variety of programmes which will promote and enhance sector working.
- establishment of the North West London Acute Provider Collaborative (APC): 2022/23 saw the establishment of the acute provider collaborative under a joint chair, dual roles for non-executive directors covering two organisations and each chief executive taking on the senior responsible officer for a key area of work (quality, workforce, capital infrastructure, finance and performance). The vision for the collaborative is to formalise the arrangements for collaboration to allow all four acute providers in north west London to capitalise on the opportunities joint working presents (as appropriate) to improve productivity and value for money including jointly agreeing the allocation of collaborative-specific resources.
- West London Children's Healthcare Alliance: From 1 April 2022, the Trust entered into an alliance with Chelsea and Westminster Hospital NHS Foundation Trust called West London Children's Healthcare Alliance (WLCHA), whereby all children's services across the two organisations are jointly managed under one management team. Although during 2022/23 there has been minimal change, as the alliance matures, it is expected that during 2023/24 pathways, funding, operating model, reporting and other arrangements will be subject to review and update as appropriate to drive improvements in the effectiveness and experience of children's services.

The integrated care system has an ambition to reduce the underlying deficit across provider organisations, and to this end, has introduced stretching efficiency targets underpinned by a set of financial recovery initiatives designed to identify opportunities for improved performance in a consistent and coherent way. This will include reviewing the ongoing Covid-19 requirements, considering how clinical and non-clinical work is undertaken and the possible economies of scale, and collaborating on capital priorities to leverage best value from the limited resources available. The Trust is resetting its governance processes to enhance accountability and responsibility alongside the development of the acute provider collaborative; ensuring 'grip and control' is maintained without losing the agility to respond to challenges.

INDEPENDENT AUDITOR'S REPORT

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

Report on the audit of the financial statements

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

- give a true and fair view of the financial position of the trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by the Secretary of State.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 35.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by the Secretary of State.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General, 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 Department of Health and Social Care Group Accounting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is 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 auditor's 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 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.

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

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

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, internal audit and 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 valuation and IT 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 it are described below:

- determination of whether expenditure is capital in nature is 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 and internal audit 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 and reviewing internal audit reports

Report on other legal and regulatory requirements

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 in all material respects; 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 the Act, 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.

On 27 June 2023 we reported to the trust a significant weakness in the trust's arrangements to secure financial sustainability. The significant weakness reported was that the delivery of the financial plan for 2023/24 is dependent upon material unidentified efficiency savings. Our recommendations for improvement were that the Trust accelerate its efforts to identify and realise specific opportunities to deliver its plan, and in planning for future periods, begin the identification of savings opportunities and project planning for their delivery further ahead of the start of the period. The trust is taking actions to take forward these recommendations.

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

The accountable 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) of the Act, as amended, 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 Auditor Guidance Notes issued by the Comptroller & Auditor General, 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, 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 2023 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 NHS England;
- 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.

Certificate of completion of the audit

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

Use of our report

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

Jonathan Gooding (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
30 June 2023

FINANCIAL STATEMENTS AND NOTES

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	1,390,118	1,292,126
Other operating income	4	211,341	190,995
Operating expenses	6, 9	(1,623,419)	(1,440,556)
Operating surplus/(deficit) from continuing operations		**(21,960)**	**42,565**
Finance income	11	4,992	110
Finance expenses	12	(840)	(517)
PDC dividends payable		(11,541)	(11,580)
Net finance costs		**(7,389)**	**(11,987)**
Other gains / (losses)	13	(2,808)	-
Surplus / (deficit) for the year		**(32,158)**	**30,578**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(13,787)	(39)
Revaluations	15	11,020	18,540
Total Other comprehensive income		**(2,767)**	**18,501**
Total comprehensive income / (expense) for the period		**(34,925)**	**49,079**
Adjusted financial performance:			
Surplus / (deficit) for the period		(32,158)	30,578
Remove net impairments not scoring to the Departmental expenditure limit		61,391	(17,564)
Remove I&E impact of capital grants and donations		(32,437)	(13,982)
Remove net impact of inventories received from DHSC group bodies for COVID response		212	1,051
Remove loss recognised on return of donated COVID assets to DHSC		3,190	-
Adjusted financial performance surplus / (deficit)		**199**	**83**

An NHS trust's financial performance is derived from its accounting 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 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	14	18,932	18,984
Property, plant and equipment	15	632,856	622,858
Right of use assets	16	44,503	-
Receivables	18	2,818	3,215
Total non-current assets		**699,109**	**645,057**
Current assets			
Inventories	17	17,604	17,401
Receivables	18	118,140	63,682
Cash and cash equivalents	19	179,215	237,469
Total current assets		**314,958**	**318,552**
Current liabilities			
Trade and other payables	20	(285,537)	(272,703)
Borrowings	22	(8,984)	(3,267)
Provisions	23	(36,762)	(40,586)
Other liabilities	21	(32,701)	(30,900)
Total current liabilities		**(363,985)**	**(347,456)**
Total assets less current liabilities		**650,082**	**616,153**
Non-current liabilities			
Borrowings	22	(46,459)	(15,910)
Provisions	23	(7,714)	(3,965)
Other liabilities	21	(2,058)	(2,058)
Total non-current liabilities		**(56,231)**	**(21,933)**
Total assets employed		**593,851**	**594,220**
Financed by			
Public dividend capital		827,189	797,116
Revaluation reserve		18,765	20,914
Income and expenditure reserve		(252,103)	(223,810)
Total taxpayers' equity		**593,851**	**594,220**

The notes on pages 166 to 210 form part of these accounts.

Professor Tim Orchard, Chief executive
29 June 2023

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 – brought forward	**797,116**	**20,914**	**(223,810)**	**594,220**
Implementation of IFRS 16 on 1 April 2022	-	-	4,483	4,483
Surplus/(deficit) for the year	-	-	(32,158)	(32,158)
Other transfers between reserves	-	(589)	589	-
Impairments	-	(13,787)	-	(13,787)
Revaluations	-	11,020	-	11,020
Public dividend capital received	30,073	-	-	30,073
Other reserve movements	-	1,207	(1,207)	-
Taxpayers' and others' equity at 31 March 2023	**827,189**	**18,765**	**(252,103)**	**593,851**

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 – brought forward	773,873	2,413	(254,388)	521,898
Surplus/(deficit) for the year	-	-	30,578	30,578
Impairments	-	(39)	-	(39)
Revaluations	-	18,540	-	18,540
Public dividend capital received	23,243	-	-	23,243
Other reserve movements	-	-	-	-
Taxpayers' and others' equity at 31 March 2022	**797,116**	**20,914**	**(223,810)**	**594,220**

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 PDC 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 & Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(21,960)	42,565
Non-cash income and expense:			
Depreciation and amortisation	6	58,658	48,813
Net impairments / (reversal of previous impairments)	6 / 8	61,517	(12,642)
Income recognised in respect of capital donations	4	(34,261)	(16,036)
(Increase) / decrease in receivables and other assets		(51,750)	26,227
(Increase) / decrease in inventories		(203)	(336)
Increase / (decrease) in payables and other liabilities		3,954	42,585
Increase / (decrease) in provisions		(75)	7,744
Other movements in operating cash flows		-	1,356
Net cash flows from / (used in) operating activities		**15,880**	**140,276**
Cash flows from investing activities			
Interest received		4,298	110
Purchase of PPE, intangible assets & investment property		(120,498)	(76,158)
Sales of PPE and investment property		382	-
Receipt of cash donations to purchase assets		34,261	14,802
Net cash flows from / (used in) investing activities		**(81,557)**	**(61,246)**
Cash flows from financing activities			
Public dividend capital received		30,073	23,243
Movement on loans from DHSC		(1,226)	(1,226)
Movement on other loans		(655)	(446)
Capital element of lease rental payments		(6,559)	(828)
Interest on loans		(423)	(477)
Interest paid on lease liabilities		(426)	(35)
PDC dividend (paid) / refunded		(13,361)	(10,847)
Net cash flows from / (used in) financing activities		**7,423**	**9,384**
Increase / (decrease) in cash and cash equivalents		**(58,254)**	**88,414**
Cash and cash equivalents at 1 April – brought forward		**237,469**	**149,055**
Cash and cash equivalents at 31 March	19.1	**179,215**	**237,469**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain right of use assets.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case, and that the Trust will continue to have access to adequate resources to service its operational activities in cash terms for the next 12 months. The directors also note that the condition of the Trust's estate continues to represent a significant risk in terms of the level of backlog maintenance committments and the potential for failures that impact services and which would be unaffordable for the Trust to rectify within its own resources.

Note 1.3 Interests in other entities

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more counterparties 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), of which it is a joint operator, with a corresponding debtor or creditor with the other joint operators for their share of operational performance. NWLP provides pathology testing service to the Trust and other partners, primarily Chelsea & Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. Services are provided primarily at the sites of partner trusts. Imperial College Healthcare holds a 61.2 per cent share in the arrangement.

Note 1.4 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/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.

The Trust expects to receive income broadly in line with the satisfaction of performance obligations. Most of the Trust's funding is provided on a monthly basis from commissioners and of this, most pertains to the performance obligation of delivery of healthcare. In relation to other performance obligations, the Trust would expect to receive payment in line with the satisfaction of those obligations. Where payments are delayed, the Trust takes standard credit control actions to secure settlement.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. In 2022/23 the majority of the Trust's income is earned from NHS commissioners in the form of fixed payments assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts, though in 2022/23 NHSE confirmed that there will be no claw back of funding where activity levels fell below agreed targets.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts as outlined above. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria, with no adjustment of income based on actual performance.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Private patient income

The Trust operates a private healthcare operation – Imperial Private Healthcare. Revenue is recognised in line with completion of the performance obligations – a performance obligation relating to delivery of a spell of healthcare to a private patient is generally satisfied over time, as the healthcare is received and consumed simultaneously by the private patient as the Trust performs it.

Education & training income

Health Education England (HEE) provide funding to maintain education and training capacity, retain students on eduction and training programmes, and enable students to provide their skills to the NHS to support service delivery. Income is recognised in line with the requirements of IFRS 15. Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations.

Note 1.5 Other forms of income

Grants and donations

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 grant is 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.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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 operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 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 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

The Trust has not discontinued any operations in 2022/23 or 2021/22.

Note 1.9 Property, plant and equipment

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 a 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into operational 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 lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction 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

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 expenditure.

The valuation carried out as at 31 March 2023 is based on assumptions made by a suitably qualified professional in accordance with HM Treasury guidance and the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards. The valuer has used the BCIS index for construction cost with adaptations for locations. The valuer provided the Trust with a valuation of land and building assets – this process leads to revaluation adjustments as set out in Note 15 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a 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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment 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 items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	60
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	5	10

Note 1.10 Intangible assets

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 is greater than £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research into internally generated intangible assets is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset. Expenditure on research into software development is not capitalised. It is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised 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.

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. Revaluation 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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	3	6

Note 1.11 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.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care 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 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

The Trust holds financial assets and liabilities at amortised cost unless the criteria for recognition at fair value through other comprehnsive income or through profit or loss are met. For receivable and payable items, the transaction price (less impairments in respect of receivables) is determined to be a reliable measure of fair value and no discounting is applied. The Trust also holds interest-free loans as part of its arrangement with other NHS partners for hosting the North West London Pathology service. Repayment of these balances is conditional on arrangements around NWLP and is not timebound, therefore no discounting has been applied.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit loss allowances are determined according to the category of financial asset based on assessment of previous losses incurred on the relevant category.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

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

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

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease.

The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95 per cent was applcable to new leases commencing in 2022 and 3.51 per cent to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by HM Treasury's interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's 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

Income from operating leases is recognised on a straight-line basis. 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.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining Whether an Arrangement Contains a Lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95 per cent. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is the lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.15 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 HM Treasury's discount rates effective from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70 per cent in real terms (prior year: minus 1.30 per cent).

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 23.2 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 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable (none disclosed in 2022/23). Contingent liabilities are not recognised, but are disclosed in note 24, 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 1.17 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.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts.

The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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 1.19 Corporation tax

The Trust does not undertake any activities that would fall due for corporation tax. All activities are carried out directly by the Trust as an NHS body.

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 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 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.

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 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The accounting standard IFRS 17 Insurance Contracts has been issued but not yet adopted in the NHS. The standard is not expected to have a significant impact on the Trust as it does not relate closely to any activities undertaken in the course of the Trust's business.

Note 1.26 Critical judgements 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.

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Note 1.26.1 Estimated end dates of leases

In implementing the IFRS 16 accounting standard on leasing, the Trust has made judgements in respect of the estimated end dates of arrangements where leases have lapsed or are on a rolling basis. The Trust's judgement is that the present state of the legal arrangements (which are in the course of being updated) are not representative of the likely substantive duration of the Trust's use of the assets. The Trust has therefore made judgements about representative end dates of leases where the legal form does not represent the expected economic substance, and based its lease accounting entries on these judgements. Approximately £24.5m of RoU assets were brought onto the SOFP based on these judgements.

Note 1.26.2 Redevelopment Asset Under Construction

The Trust holds spend on the design and business case supporting the New Hospitals Programme redevelopment as Assets Under Construction as it is judged that this expenditure is, at the relevant reporting date, more likely than not to directly result in the creation of an asset. In applying its accounting policies, the Trust makes a judgement about the liklihood of future events, informed by the best available evidence.

Note 1.26.3 Asset disposal

In undertaking the project around asset disposals detailed in Note 15.8, the Trust has had to make judgements in respect of older assets that remain on the asset register at nil Net Book Value, but for which the records do not facilitate identification several years after the expected end of the assets' useful life. Where it is not posible to ascertain the necessary information to conclusively identify the assets in order to determine if they are still in use, the Trust has had to make judgements around the liklihood of the assets still being in use. These judgements are based on experience of similar assets, as well as the age profile of the assets in question.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Note 1.27.1 Land & buildings valuations

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.

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.

The Trust values its overall estate on an 'alternative site' valuation basis assumed to be held in one, notional North West London location broadly consistent with the Hammersmith site. This judgement has been revisited in light of the redevelopment works and the Trust is satisfied that it continues to be appropriate. The judgement is appropriate becasue for the purposes of deriving a suitable MEA valuation basis, it is assumed that redevelopment would be on one site which would not be based in central London. This judgement is informed by analysis of fully anonymised post-code data for the Trust's patients to demonstrate the validity of the generic location used.

The Trust works with its valuer to ensure that judgements are appropriate, but these judgements are inherently based on estimates of the application of market conditions, building costs and land values that are uncertain. The total value of assets subject to this estimation uncertainty at the 31st March 2023 is £512m, so movements in the basis for estimation can have a material impact on the financial statements (though it is less likely that they would impact on the Trust's adjusted financial performance measure).

Note 1.27.2 Provisions

Where the Trust is subject to challenge or outcome on as yet undetermined matters e.g. employment tribunal, redundancy claim, pay claims, etc. the Trust provides for such claims within the accounting period in which they arose. See Note 1.15 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 23 to these accounts.

Note 2 Operating Segments

From autumn 2022, the Trust Board meets as part of a 'Board in Common' covering the acute providers within the North West London Integrated Care Sytem. However, the Trust Board retains decision making authority for the Trust and individual Trust boards at the Board in Common continue to make decisions on behalf of their organisations.

The Trust Board 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 six divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and clinical support services; West London Children's Healthcare Alliance (a collaborative management arrangement for children's services with Chelsea & Westminster NHS Foundation Trust;); private healthcare; and, corporate services. The Trust is also hosts the North West London Pathology service.

However, having considered the requirements, the 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)

	2022/23 £000	2021/22 £000
Acute services		
Income from commissioners under API contracts*	1,222,437	1,136,915
Other NHS clinical income	19,502	15,997
Community services		
Income from commissioners under API contracts*	3,705	10,119
Income from other sources (e.g. local authorities)	197	154
All services		
Private patient income	37,146	38,184
Elective recovery fund	-	32,931
Agenda for change pay offer central funding	24,650	
Additional pension contribution central funding**	33,857	31,965
Other clinical income	48,624	25,861
Total income from activities	**1,390,118**	**1,292,126**

Other clinical income includes income from pathology services, services provided to Overseas Visitors and recognition of agreed values relating to specific commissioner income.

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National Tariff payments system documents. This includes 2022/23 Elective Recovery Fund payments as these were paid on a block basis in the year.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**The employer contribution rate for NHS pensions increased from 14.3 per cent to 20.6 per cent (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)

Income from patient care activities from:	2022/23 £000	2021/22 £000
NHS England	558,440	467,271
Clinical commissioning groups	173,558	727,380
Integrated care boards	562,059	
Department of Health and Social Care	120	19
Other NHS providers	45,548	43,962
NHS other	551	2,227
Local authorities	191	203
Non-NHS: private patients	37,146	38,184
Non-NHS: overseas patients (chargeable to patient)	4,878	4,358
Injury cost recovery scheme	1,988	1,806
Non NHS: other	5,639	6,716
Total income from activities	**1,390,118**	**1,292,126**

All income relates to continuing operations in both 2022/23 and 2021/22.

Of funding from CCGs / ICBs, the North West London ICB (formerly the NWL CCG) provides a material level of funding.

Total income recognised from the NWL ICB in 2022/23 was £644.8m

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2022/23 £000	2021/22 £000
Income recognised this year	4,878	4,358
Cash payments received in-year	3,618	4,923
Amounts added to provision for impairment of receivables	1,647	2,453
Amounts written off in-year	1,197	2,108

Note 4 Other operating income

	2022/23			2021/22		
	Contract income £000	Non-contract income £000	Total £000	Contact income £000	Non-contract income £000	Total £000
Research and development	14,131	48,000	62,131	8,292	42,984	51,276
Education and training	53,384	1,613	54,997	46,167	1,522	47,689
Non-patient care services to other bodies	15,361		15,361	13,413		13,413
Reimbursement and top up funding	8,182		8,182	22,030		22,030
Income in respect of employee benefits accounted on a gross basis	12,544		12,544	9,774		9,774
Receipt of capital grants and donations and peppercorn leases		34,261	34,261		16,036	16,036
Charitable and other contributions to expenditure		4,408	4,408		4,653	4,653
Revenue from finance leases (variable lease receipts)		227	227		-	-
Rental revenue		1,907	1,907		1,827	1,827
Other income	17,323	-	17,323	24,297	-	24,297
Total other operating income	**120,925**	**90,416**	**211,341**	**123,973**	**67,022**	**190,995**

All income relates to continuing operations – the Trust has not discontinued any operations in 2022/23 or 2021/22.

Other income includes income relating to goods, services or other items which are outside of the Trust's core activity of delivery of healthcare, including funding for clinical excellence awards and other income including car parking, catering and other services.

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2022/23 £000	2021/22 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	19,763	14,351
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 4.2 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less, and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5 Imperial College Healthcare NHS Trust as lessor

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

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

The Trust is the lessor for a number of arrangements including the use of space in Trust sites by other parties for purposes including retail and healthcare activities, as well as the use of Trust buildings to site telecommunications equipment.

The Trust has granted a finance lease over staff accommodation to a housing association over 99 years running to 2098. The Trust has a right under a nomination agreement to nominate staff for tenancies in the properties as space becomes available.

The Trust recognised a disposal of the asset on receipt of an initial payment for the property of £5.7m in 1999 (with subsequrnt rent being at a peppercorn rate). Following subsequent amendment to the agreement, the Trust receives variable payments dependent upon occupancy and rental income for certain of the units in the properties. The income for the 2022/23 year was £227k.

As future lease payments are variable payments dependent on usage, no disclosure is possible of future lease payments receivable, but if at the same annual income for the remainder of the lease the total undiscounted value of receipts would be £17,095k. Following reassessment of the Trust's lease arrangements as part of the transition to IFRS 16, the Trust has concluded it is appropriate to disclose this as variable finance lease income, rather than operating lease income.

The comparative disclosures in this includes £220k in operating lease income and £16,746k within future operating lease receivables. The comparative has not been restated as the Trust does not consider the impact of the change in presentation to be material.

Note 5.1 Lease income

	2022/23 £000	2021/22 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,907	1,827
Variable lease receipts / contingent rents	227	-
Total in-year lease income	**2,134**	**1,827**

Note 5.2 Future lease receipts

	31 March 2023 £000
Future minimum lease receipts due at 31 March 2023:	
- not later than one year	1,898
- later than one year and not later than five years	5,339
- later than five years	3,120
Total	**10,357**

	31 March 2022 £000
Future minimum lease receipts due at 31 March 2022:	
- not later than one year	1,324
- later than one year and not later than five years	4,495
- later than five years	18,163
Total	**23,982**

Note 6 Operating expenses

	2022/23 £000	2021/22 £000
Purchase of healthcare from NHS and DHSC bodies	13,451	11,410
Purchase of healthcare from non-NHS and non-DHSC bodies	12,731	12,174
Staff and executive directors costs	953,808	843,462
Remuneration of non-executive directors	172	135
Supplies and services – clinical (excluding drugs costs)	143,627	169,088
Supplies and services – general	20,626	20,458
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	146,931	134,096
Inventories written down	601	520
Consultancy costs	258	430
Establishment	10,101	10,300
Premises	58,206	73,574
Transport (including patient travel)	22,876	19,635
Depreciation on property, plant and equipment & right of use assets	52,920	44,418
Amortisation on intangible assets	5,738	4,395
Net impairments / (reversal of previous impairments)	61,517	(12,642)
Movement in credit loss allowance: contract receivables / contract assets	3,276	2,557
Increase/(decrease) in other provisions	(49)	-
Change in provisions discount rate(s)	593	-
External audit services – statutory audit	771	248
Internal audit costs	288	279
Clinical negligence	35,225	36,651
Legal fees	1,029	924
Insurance	524	617
Research and development	52,564	50,575
Education and training	8,784	7,216
Operating lease expenditure (comparative only)		4,766
Redundancy	313	14
Hospitality	85	44
Other	16,453	5,212
Total	**1,623,419**	**1,440,556**

All expenditure relates to continuing operations – the Trust has not discontinued any operations in 2022/23 or 2021/22.

Note 7 External Audit

Note 7.1 Auditor remuneration

	2022/23 £000	2021/22 £000
Remuneration paid to the external auditor:		
Statutory external audit fee	771	248
All other services	-	-
Total	**771**	**248**

Costs shown include VAT. The remuneration paid for 2022/23 relates to both audit fees for the year and £155k (plus VAT) in respect of overruns on the audit of the 2021/22 accounts agreed following the end of the financial year.

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2021/22: £1 million).

Note 8 Impairment of assets

	2022/23 £000	2021/22 £000
Net impairments charged to operating surplus / (deficit) resulting from:		
Loss or damage from normal operations	-	1,504
Abandonment of assets in course of construction	126	3,418
Impairments resulting from asset valuation	61,391	(17,564)
Total net impairments charged to operating surplus / (deficit)	**61,517**	**(12,642)**
Impairments charged to the revaluation reserve	13,787	39
Total net impairments	**75,304**	**(12,603)**

Note 9 Employee benefits

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	757,435	663,983
Social security costs	84,057	73,494
Apprenticeship levy	3,549	3,278
Employer's contributions to NHS pensions	112,654	104,830
Pension cost – other	151	173
Temporary staff (including agency)	26,820	25,001
Total staff costs	**984,666**	**870,759**
Of which		
Costs capitalised as part of assets	3,780	3,634
Redundancy	313	14

The salaries and wages figure for 2022/23 includes – in line with national guidance – an accrual of £24.7m relating to the Agenda for Change pay award for 2023/24 which includes a payment in respect of 2022/23. This pay award was under discussion at the reporting date but has subsequently been agreed by the NHS Staff Council and implemented in June 2023.

Note 9.1 Retirements due to ill-health

During 2022/23 there were four early retirements from the Trust agreed on the grounds of ill-health (two in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £520k (£102k in 2021/22).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Note 10.1 Defined benefit pension schemes

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 is as 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 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 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 per cent of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 10.2 Defined contribution pension scheme

Whilst the standard NHS pension offer remains a defined benefit scheme, the Trust meets its obligations around pensions auto-enrolement through providing access to the NEST defined contribution pension scheme for those who opt-out of the main NHS pension scheme. The Trust pays employer's contributions to this scheme at the minimum rate of 3 per cent. Employees may also choose to opt out of this scheme if they wish.

Note 11 Finance income

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

	2022/23 £000	2021/22 £000
Interest on bank accounts	4,992	110
Total finance income	**4,992**	**110**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2022/23 £000	2021/22 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	414	482
Interest on lease obligations	426	35
Total finance costs	**840**	**517**

Note 13 Other gains / (losses)

	2022/23 £000	2021/22 £000
Gains on disposal of assets	382	-
Losses on disposal of assets	(3,190)	-
Total gains / (losses) on disposal of assets	**(2,808)**	**-**

Note 14 Intangible Assets

Note 14.1 Intangible assets - 2022/23

	IT (internally generated & 3rd party) construction £000	Intangible under assets construction £000	Total £000
Valuation / gross cost at 1 April 2022 – brought forward	**34,756**	**-**	**34,756**
Additions	3,489	2,197	5,686
Reclassifications	391	(391)	-
Disposals / derecognition	(5,400)	-	(5,400)
Valuation / gross cost at 31 March 2023	**33,236**	**1,806**	**35,042**
Amortisation at 1 April 2022 – brought forward	**15,772**	**-**	**15,772**
Provided during the year	5,738	-	5,738
Disposals / derecognition	(5,400)	-	(5,400)
Amortisation at 31 March 2023	**16,110**	**-**	**16,110**
Net book value at 31 March 2023	**17,126**	**1,806**	**18,932**
Net book value at 1 April 2022	**18,984**	**-**	**18,984**

Note 14.2 Intangible assets – 2021/22

	IT (internally generated & 3rd party) £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2021	**25,466**	**-**	**25,466**
Reclassifications	9,290	-	9,290
Valuation / gross cost at 31 March 2022	**34,756**	**-**	**34,756**
Amortisation at 1 April 2021	**11,377**	**-**	**11,377**
Provided during the year	4,395	-	4,395
Amortisation at 31 March 2022	**15,772**	**-**	**15,772**
Net book value at 31 March 2022	**18,984**	**-**	**18,984**
Net book value at 1 April 2021	**14,089**	**-**	**14,089**

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment – 2022/23

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2022 – brought forward	**151,121**	**343,309**	**-**	**23,655**	**223,239**	**-**	**77,985**	**2,400**	**821,709**
IFRS 16 implementation – reclassification of existing finance leased assets to right of use assets	-	(3,918)	-	-	(875)	-	(3,464)	-	(8,257)
Additions	-	66,162	-	43,157	13,774	-	2,606	-	125,699
Impairments	(13,479)	(113)	-	(54)	-	-	-	-	(13,646)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	(12,161)	(58,697)	-	-	-	-	-	-	(70,858)
Reclassifications	-	26,611	-	(36,195)	7,223	-	2,362	-	0
Disposals / derecognition	-	-	-	-	(60,767)	-	(22,855)	(229)	(83,851)
Valuation/gross cost at 31 March 2023	**125,481**	**373,353**	**-**	**30,563**	**182,594**	**-**	**56,634**	**2,171**	**770,796**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	148,545	-	48,922	1,384	198,851
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(64)	-	(810)	-	(874)
Provided during the year	-	25,595	-	-	12,496	-	7,852	276	46,219
Impairments	12,160	66,533	-	-	-	-	-	-	78,693
Reversals of impairments	-	(22,988)	-	-	-	-	-	-	(22,988)
Revaluations	(12,160)	(69,140)	-	-	-	-	-	-	(81,300)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(57,577)	-	(22,855)	(229)	(80,661)
Accumulated depreciation at 31 March 2023	**-**	**0**	**-**	**-**	**103,400**	**-**	**33,109**	**1,431**	**137,940**
Net book value at 31 March 2023	**125,481**	**373,353**	**-**	**30,563**	**79,194**	**-**	**23,525**	**740**	**632,856**
Net book value at 1 April 2022	**151,121**	**343,309**	**-**	**23,655**	**74,694**	**-**	**29,063**	**1,016**	**622,858**

Note 15.2 Property, plant and equipment – 2021/22

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2021	**104,924**	**335,283**	**-**	**19,042**	**204,488**	**-**	**68,174**	**2,273**	**734,184**
Additions	-	-	-	92,753	2,108	-	-	-	94,861
Impairments	-	(32,924)	-	(3,418)	-	-	-	-	(36,342)
Reversals of impairments	29,224	(2,448)	-	-	-	-	-	-	26,776
Revaluations	16,973	256	-	-	-	-	-	-	17,229
Reclassifications	-	43,142	-	(84,722)	21,095	-	11,068	127	(9,290)
Disposals / derecognition	-	-	-	-	(4,452)	-	(1,257)	-	(5,709)
Valuation/gross cost at 31 March 2022	**151,121**	**343,309**	**-**	**23,655**	**223,239**	**-**	**77,985**	**2,400**	**821,709**
Accumulated depreciation at 1 April 2021	**-**	**-**	**-**	**-**	**140,261**	**-**	**42,251**	**1,110**	**183,622**
Provided during the year	-	23,480	-	-	12,736	-	7,928	274	44,418
Impairments	-	(9,607)	-	-	-	-	-	-	(9,607)
Reversals of impairments	-	(12,562)	-	-	-	-	-	-	(12,562)
Revaluations	-	(1,311)	-	-	-	-	-	-	(1,311)
Disposals / derecognition	-	-	-	-	(4,452)	-	(1,257)	-	(5,709)
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**148,545**	**-**	**48,922**	**1,384**	**198,851**
Net book value at 31 March 2022	**151,121**	**343,309**	**-**	**23,655**	**74,694**	**-**	**29,063**	**1,016**	**622,858**
Net book value at 1 April 2021	**104,924**	**335,283**	**-**	**19,042**	**64,227**	**-**	**25,923**	**1,163**	**550,562**

Note 15.3 Property, plant and equipment financing – 31 March 2023

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned – purchased	125,481	347,983	-	30,563	72,495	-	23,505	740	600,767
Owned – donated/granted	-	25,370	-	-	6,699	-	20	-	32,089
Total net book value at 31 March 2023	**125,481**	**373,353**	**-**	**30,563**	**79,194**	**-**	**23,525**	**740**	**632,856**

Note 15.4 Property, plant and equipment financing – 31 March 2022

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned – purchased	151,121	322,526	-	23,655	63,093	-	26,409	1,016	587,820
Finance leased	-	3,918	-	-	811	-	2,654	-	7,383
Owned – donated/granted	-	16,865	-	-	10,790	-	-	-	27,655
Total net book value at 31 March 2022	**151,121**	**343,309**	**-**	**23,655**	**74,694**	**-**	**29,063**	**1,016**	**622,858**

Balances within this note have been restated to show the correct split of donated asset valued at the end of 2021/22 between Buildings assets and Plant & Machinery assets. More information is provided in Note 29. Where values have been amended, column headings indicate "(Restated)". The changes do not affect the overall Net Book Value of assets presented.

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) – 31 March 2023

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	3,424	-	-	-	-	-	-	3,424
Not subject to an operating lease	125,481	369,929	-	30,563	79,194	-	23,525	740	629,432
Total net book value at 31 March 2023	**125,481**	**373,353**	**-**	**30,563**	**79,194**	**-**	**23,525**	**740**	**632,856**

Note 15.6 Donations of property, plant and equipment

The Trust has recognised grant funding in the year of £34,061k. The funding was provided by the Salix company acting on behalf of the Department for Business, Energy & Industrial Strategy. The grant was awarded to fund decarbonisation works on the Trust's estate. The Trust also received £200k of donations from the Imperial Health Charity to fund capital investments in line with the Charity's objectives.

Note 15.7 Revaluations of property, plant and equipment

The Trust's land and buildings assets have been valued by a suitably qualified and independent suveyor (Avison Young Ltd provide valuations, carried out by fully RICS qualified staff). The effective date of the valuation was 31 March 2023.

The valuation was carried out in accordance with International Financial Reporting Standards, The DHSC Group Accounting Manual for 2022/23 and the RICS Global Standards ("Red Book"). Most assets are in use by the Trust for the delivery of healthcare services and are valued on the Depreciated Replacement Cost with reference to the cost of a Modern Equivalent Asset, as set out in the Trust's accounting policies. A small number of assets that are not used for delivery of healthcare services are valued under the IAS40 standard.

The Trust's operational land and buildings assets are valued on the basis that a modern equivalent asset would take the form of a single site in a general North-West London location that would be suitable for delivery of the Trust's services based on analysis of the population served by the Trust. In calculating the cost of this Modern Equivalent Asset, the Trust and the valuer have had regard to both the nature and size of the facilities that would be required. The valuer has taken the present area of the Trust's land and buildings as the baseline figure but has excluded areas which are not relevant for the comparison (such as courtyards or unused spaces).

The Trust has not made any significant changes to its approach to the accounting estimates used in 2022/23 as compared to previous years. The expected Useful Economic Lives of buildings assets are assessed by the valuer annually based on information povided by the Trust and their own inspections of the estate. The Trust places reliance on these assessments unless it has awareness of information or circumstances that would supersede them. The Trust also assesses the valuation methodologies and accounting treatments being applied to land and buildings assets and advises the valuer if, in its view, there is a need to adopt alternative accounting treatments to those in place previously.

Note 15.8 Disposals of fixed assets

The Trust has undertaken a project over 2022/23 to assess its fixed asset register and ensure that fully-depreciated assets that are no longer in use are recorded as disposed. The Trust has disposed of assets with a gross cost of £89.3m in 2022/23 (with a nil net impact). The Trust continues to hold assets on the SoFP which are fully depreciated (i.e. have zero Net Book Value) with a gross cost (i.e. cost when purchased) of £75.6m. The assessment of remaining fully-depreciated assets is ongoing.

Note 16 Right of Use Assets

Note 16.1 Leases – Imperial College Healthcare NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases a number of property assets from other parties (both public and private bodies) for use in the delivery of healthcare, particularly for renal services delivered at community 'satellite' locations. The Trust also leases items of medical and other equipment for use in the delivery of healthcare services.

Note 16.2 Right of use assets – 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Information technology £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation – reclassification of existing finance leased assets from PPE or intangible assets	3,918	875	3,464	8,257	-
IFRS 16 implementation – adjustments for existing operating leases / subleases	36,228	4,076	-	40,304	11,610
Additions	177	4,670	2,976	7,823	-
Remeasurements of the lease liability	1,069	-	-	1,069	-
Impairments	(267)	-	-	(267)	-
Revaluations	**(6,711)**	**-**	**-**	**(6,711)**	**(1,307)**
Valuation/gross cost at 31 March 2023	**34,414**	**9,621**	**6,440**	**50,475**	**10,303**
IFRS 16 implementation – reclassification of existing finance leased assets from PPE or intangible assets	-	64	810	874	-
Provided during the year	3,337	2,253	1,111	6,701	1,912
Impairments	5,686	-	-	5,686	1,146
Revaluations	(7,289)	-	-	(7,289)	(1,885)
Accumulated depreciation at 31 March 2023	**1,734**	**2,317**	**1,921**	**5,972**	**1,173**
Net book value at 31 March 2023	**32,680**	**7,304**	**4,519**	**44,503**	**9,130**
Net book value of right of use assets leased from other NHS providers					2,464
Net book value of right of use assets leased from other DHSC group bodies					6,666

Note 16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 22.

	2022/23 £000
Carrying value at 31 March 2022	**4,454**
IFRS 16 implementation – adjustments for existing operating leases	35,823
Lease additions	7,823
Lease liability remeasurements	1,069
Interest charge arising in year	426
Early terminations	-
Lease payments (cash outflows)	(6,985)
Other changes	-
Carrying value at 31 March 2023	**42,610**

Note 16.4 Maturity analysis of future lease payments at 31 March 2023

	Total 31 March 2023 £000	Of which leased from DHSC group bodies: 31 March 2023 £000
Undiscounted future lease payments payable in:		
- not later than one year	7,565	1,963
- later than one year and not later than five years	15,956	4,164
- later than five years	21,547	3,991
Total gross future lease payments	**45,068**	**10,118**
Finance charges allocated to future periods	(2,458)	(375)
Net lease liabilities at 31 March 2023	**42,610**	**9,743**
Of which:		
Leased from other NHS providers		3,623
Leased from other DHSC group bodies		6,120

Note 16.5 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	31 March 2022 £000
Undiscounted future lease payments payable in:	
- not later than one year	1,359
- later than one year and not later than five years	2,142
- later than five years	953
Net finance lease liabilities at 31 March 2022	**4,454**
of which payable:	
- not later than one year	1,359
- later than one year and not later than five years	2,142
- later than five years	953

Note 16.6 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	4,766
Total	**4,766**

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	2,502
- later than one year and not later than five years;	4,939
- later than five years.	1,459
Total	**8,900**
Future minimum sublease payments to be received	-

Note 16.7 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.14.

Where leases, particularly with other public sector bodies, had expired or were operating on a rolling basis, the Trust has recognised these on the basis of its view of the underlying substance of the arrangement, assuming a longer lease term where this better represents the intentions of the Trust and the counterparty.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95 per cent.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**8,900**
Impact of discounting at the incremental borrowing rate	(577)
IAS 17 operating lease commitment discounted at incremental borrowing rate	**8,323**
Less:	
Commitments for short term leases	(26)
Commitments for leases of low value assets	-
Irrecoverable VAT previously included in IAS 17 commitment	(840)
Other adjustments:	
Differences in the assessment of the lease term	4,812
Public sector leases without full documentation previously excluded from operating lease commitments	15,645
Finance lease liabilities under IAS 17 as at 31 March 2022	4,454
Other adjustments	7,909
Total lease liabilities under IFRS 16 as at 1 April 2022	**40,277**

Note 17 Inventories

	31 March 2023 £000	31 March 2022 £000
Drugs	7,899	6,921
Consumables	8,964	10,129
Energy	740	351
Total inventories	**17,604**	**17,401**

Inventories recognised in expenses for the year were £220,050k (2021/22: £205,822k). Write-down of inventories recognised as expenses for the year were £601k (2021/22: £520k).

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 2022/23 the Trust received £3,033k of items purchased by DHSC (2021/22: £3,152k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 18 Receivables & Credit Loss Allowance

Note 18.1 Receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables	112,377	58,933
Allowance for credit losses	(11,197)	(9,233)
Prepayments (non-PFI)	4,281	6,723
Interest receivable	694	-
PDC dividend receivable	1,759	-
VAT receivable	6,975	4,818
Other receivables	3,251	2,441
Total current receivables	**118,140**	**63,682**
Non-current		
Other receivables	2,818	3,215
Total non-current receivables	**2,818**	**3,215**

The contract receivables balance for 2022/23 includes – in line with national guidance - an accrual of £24.7m relating to funding for the Agenda for Change pay award for 2023/24, which includes a payment in respect of 2022/23. The funding was confirmed during 2022/23.

Note 18.2 Allowances for credit losses

	2022/23 Contract receivables and contract assets £000	2021/22 Contract receivables and contract assets £000
Allowances as at 1 April	**9,233**	**8,842**
New allowances arising	3,276	2,557
Utilisation of allowances (write offs)	(1,312)	(2,166)
Allowances as at 31 March 2023	**11,197**	**9,233**

Note 19 Cash and cash equivalents

Note 19.1 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.

	2022/23 £000	2021/22 £000
At 1 April	**237,469**	**149,055**
Net change in year	(58,254)	88,414
At 31 March	**179,215**	**237,469**
Broken down into:		
Cash at commercial banks and in hand	76	200
Cash with the Government Banking Service	179,140	237,269
Total cash and cash equivalents as in SoFP	**179,215**	**237,469**

Note 19.2 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 2023 £000	31 March 2022 £000
Monies on deposit	82	72
Total third party assets	**82**	**72**

Note 20 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	54,342	51,299
Capital payables	44,198	33,311
Accruals	141,306	145,677
Social security costs	10,936	10,390
Other taxes payable	10,394	9,387
PDC dividend payable	-	61
Pension contributions payable	11,399	11,555
Other payables	12,963	11,023
Total current trade and other payables	**285,537**	**272,703**
Of which payables to NHS and DHSC group bodies:	24,304	22,376

The accruals balance includes – in line with national guidance – £24.7m payable to staff relating to the Agenda for Change pay award for 2023/24, which includes a payment in respect of 2022/23. The pay award was under discussion at the reporting date but was subsequently agreed by the NHS Staff Council and implemented in June 2023.

Note 21 Other liabilities

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income	32,701	30,900
Total other current liabilities	**32,701**	**30,900**
Non-current		
Deferred income	2,058	2,058
Total other non-current liabilities	**2,058**	**2,058**

Note 22 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from DHSC	1,243	1,252
Other loans	551	656
Lease liabilities*	7,190	1,359
Total current borrowings	**8,984**	**3,267**
Non-current		
Loans from DHSC	8,562	9,788
Other loans	2,477	3,027
Lease liabilities*	35,420	3,095
Total non-current borrowings	**46,459**	**15,910**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in Note 16 Right of Use Assets.

The Trust is party to five loans as follows:

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

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 £1.87m. 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 August 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 22.1 Reconciliation of liabilities arising from financing activities – 2022/23

	Loans from DHSC £000	Other loans £000	Lease Liability £000	Total £000
Carrying value at 1 April 2022	**11,040**	**3,683**	**4,454**	**19,177**
Cash movements:				
Financing cash flows – payments and receipts of principal	(1,226)	(655)	(6,559)	**(8,440)**
Financing cash flows – payments of interest	(423)	-	(426)	**(849)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022	-	-	35,823	**35,823**
Additions	-	-	7,823	**7,823**
Lease liability remeasurements	-	-	1,069	**1,069**
Application of effective interest rate	**414**	**-**	**426**	**840**
Carrying value at 31 March 2023	**9,805**	**3,028**	**42,610**	**55,443**

Note 22.2 Reconciliation of liabilities arising from financing activities – 2021/22

	Loans from DHSC £000	Other loans £000	Lease Liability £000	Total £000
Carrying value at 1 April 2021	**12,261**	**4,128**	**2,027**	**18,416**
Cash movements:				
Financing cash flows – payments and receipts of principal	(1,226)	(446)	(828)	**(2,500)**
Financing cash flows – payments of interest	(477)	-	(35)	**(512)**
Non-cash movements:				
Additions	-	-	3,255	**3,255**
Application of effective interest rate	482	-	35	**517**
Other changes	**-**	**1**	**-**	**1**
Carrying value at 31 March 2022	**11,040**	**3,683**	**4,454**	**19,177**

Note 23 Provisions for liabilities and charges

Note 23.1 Analysis of provisions for liabilities and charges

	2022/23 £000	2021/22 £000
Opening balance at 1 April	44,551	36,807
Change in the discount rate	(1,934)	-
Arising during the year	6,190	8,035
Utilised during the year	(297)	(101)
Reversed unused	(4,092)	(190)
Unwinding of discount	58	-
Closing balance at 31 March	**44,476**	**44,551**
Expected timing of cash flows:		
- not later than one year	36,762	40,586
- later than one year and not later than five years	150	3,215
- later than five years	7,565	750
Total	**44,476**	**44,551**

Provision balances include potential liabilities in respect of legal claims, redundancy and exit costs, dilapidation liabilities on leased properties and other amounts that may be payable to employees or other third parties.

Note 23.2 Clinical negligence liabilities

At 31 March 2023, £550,505k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2022: £833,390k).

Note 24 Contingent assets and liabilities

	31 March 2023 £000	31 March 2022 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(114)**	**(77)**
Net value of contingent liabilities	**(114)**	**(77)**

Note 25 Contractual capital commitments

	31 March 2023 £000	31 March 2022 £000
Property, plant and equipment	19,773	26,805
Intangible assets	**-**	**-**
Total	**19,773**	**26,805**

Note 26 Financial instruments

Note 26.1 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 therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust can borrow 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 can also borrow from government for revenue financing subject to approval by the regulator.

Interest rates on both capital and revenue loans are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations in respect of loans. At present, the Trust does not have any loans taken out for the purpose of revenue financing and has one capital loan.

The Trust also has borrowings funded by the Department for Business, Energy & Industrial Strategy which are interest-free, and obligations under finance leases where the interest rate is implicit in the lease. The Trust therefore has no exposure to interest rate fluctuations in respect of these borrowings.

The Trust holds significant cash balances via the Governent Banking Service (operated by NatWest Bank Plc) for which it receives interest income. The Trust includes this income in its financial planning based on prudent assumptions around likely cash balances and interest rates but could therefore be exposed to interest rate fluctuations in respect of this income.

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 2023 is in receivables from non-NHS customers, as disclosed in the trade and other receivables note, 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 1.2. Mitigating this, the Trust's operating costs are incurred in relation to contracts with ICBs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure primarily 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 26.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	Held at amortised cost £000	Totalbook value £000
Trade and other receivables excluding non financial assets	107,942	107,942
Cash and cash equivalents	179,215	179,215
Total at 31 March 2023	**287,157**	**287,157**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	55,356	55,356
Cash and cash equivalents	237,469	237,469
Total at 31 March 2022	**292,825**	**292,825**

Note 26.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	9,805	9,805
Obligations under leases	42,610	42,610
Other borrowings	3,028	3,028
Trade and other payables excluding non financial liabilities	253,881	253,881
Total at 31 March 2023	**309,324**	**309,324**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	11,040	11,040
Obligations under leases	4,454	4,454
Other borrowings	3,683	3,683
Trade and other payables excluding non financial liabilities	234,470	234,470
Total at 31 March 2022	**253,647**	**253,647**

Note 26.4 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 2023 £000	31 March 2022 £000
In one year or less	263,616	238,312
In more than one year but not more than five years	22,483	8,203
In more than five years	**27,327**	**7,708**
Total	**313,426**	**254,223**

Note 26.5 Fair values of financial assets and liabilities

The Trust holds financial assets and liabilities at amortised cost unless the criteria for recognition at fair value through other comprehnsive income or through profit or loss are met. For receivable and payable items, the transaction price (less impairments in respect of receivables) is determined to be a reliable measure of fair value and no discounting is applied. The Trust also holds interest-free loans as part of its arrangement with other NHS partners for hosting the North West London Pathology service. Repayment of these balances is conditional on arrangements around NWLP and is not timebound, therefore no discounting has been applied.

Note 27 Losses and special payments

	2022/23		2021/22 Restated	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	63	31	38	46
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	269	1,281	416	2,123
Stores losses and damage to property	**12**	**601**	**12**	**520**
Total losses	**344**	**1,913**	**466**	**2,689**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	68	777	55	1,798
Special severance payments	1	14	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**69**	**791**	**55**	**1,798**
Total losses and special payments	**413**	**2,704**	**521**	**4,487**
Compensation payments received				

During 2022/23, the Trust (in conjunction with other Trusts in the North West London sector) gave all staff a voucher for £45 prior to Christmas as part of efforts to encourage staff to feel valued and to boost morale during a very challenging period. This payment has been judged to fall within the definition of special payments set out in HM Treasury's Managing Public Money guidance, and so is disclosed in the figures above. The payment will require retrospective approval from HM Treasury, in line with similar payments made by many other NHS organisations. Payments were made to all substantive staff and those bank staff meeting an eligibility threshold. The collective value of the payments was £753k. The 2021/22 comparative figures have been updated to include an equivalent payment made in that year totalling £627k

Comparative figures for special payments in 2021/22 include costs for backdated payments for unsocial hours on overtime payments made to staff under the Working Time Directive to bring overtime payments in to line with other forms of pay when the overtime is worked regularly. The need to make these payments has been clarified by court judgements and from 1st April 2022 they are no longer regarded as special payments.

The Trust is required to report on individual losses in excess of £300k in value. One such loss totalling £320k was incurred in 2022/23 upon the write off of a debt related to an overseas visitor (i.e. a foreign national who accessed NHS services without having proper insurance or reciprocal entitelement to health services). The Trust is obliged to provide treatment but in many cases is unable to recover the full value of services chargeable, particularly when the treatment related to long stays in hospital, often including use of intensive care facilities. Overseas visitor debt is included in the calculation of the credit loss allowance.

Note 28 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 other than receipt of employment benefits and accrual of entitlement to post employment benefits. Remuneration of board members is disclosed in the remuneration report.

During the year 2022/23 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 2023. This list is indicative and not exhaustive.

- Department of Health and Social Care
- NHS England

NHS foundation trusts including:

- Chelsea and Westminster NHS Foundation Trust
- Hillingdon Hospitals NHS Foundation Trust

ICBs including:

North West London ICB

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 and Transplant

Other non-NHS entities:

- HM Revenue and Customs

Though not required to be disclosed under IAS24, the Trust has elected to disclose three further items of information which readers of the accounts may find useful.

The Trust enjoys a collaborative relationship with the Imperial Health Charity. The Charity is independent of the Trust. The Trust nominates trustees to the board of the Charity (at present three of the Trust's executive directors undertake this role) but the Charity's governing arrangements prevent these trustees from exercising control. The Charity's aim is to support public health and the work of the NHS as a whole. The Trust benefits from this through receipt of grant funding for agreed purposes in line with the Charity's aims. Grants can cover revenue items and capital expenditure.

The Trust is also closely connected to Imperial College London. The two organisations are not related parties under IAS 24 but work together in a range of areas including research activities and medical education. The College occupies space within the Trust's sites and a number of the Trust's medical staff also hold roles with the College.

Professor Julian Redhead (the Trust's Medical Director) has undertaken private medical practice during 2022/23 through Imperial Private Healthcare (IPH). This is carried out on the same basis as IPH's other business. This work is not included in the remuneration report because it does not pertain to Prof. Redhead's role as an employee of the Trust.

Note 29 Prior period adjustments

The Trust has made a prior period adjustment in respect of Note 15.4 disclosing the financing source of property, plant & equipment assets.

The disclosure in 2021/22 was correct in total and the overall net book value of assets in the table has not changed. The table understated the value of the donated element of the Trust's building assets by £16,865k and understated the financed leased element of buildings by £130k and overstated the purchased element of buildings by £16,995k. The value of purchased plant and machinery was understated by £16,854k and the value of donated plant & machinery was overstated by £16,854k.

The error arose due to values not being broken down correctly during the process of preparing the accounts. The restatement does not impact on any key measure of financial performance but ensures the value of donated buildings is consistent with the implementation of the Trust's new fixed asset register system in 2022/23.

Note 30 Events after the reporting date

There are no events after the reporting date that warrant disclosure in these accounts.

Note 31 Better Payment Practice code

Non-NHS Payables	2022/23 Number	2022/23 £000	2021/22 Restated Number	2021/22 Restated £000
Total non-NHS trade invoices paid in the year	163,462	672,054	159,715	553,889
Total non-NHS trade invoices paid within target	156,979	602,406	157,669	521,950
Percentage of non-NHS trade invoices paid within target	96.0%	89.6%	98.7%	94.2%
NHS Payables				
Total NHS trade invoices paid in the year	4,622	58,190	5,112	68,134
Total NHS trade invoices paid within target	3,989	46,222	4,532	60,558
Percentage of NHS trade invoices paid within target	86.3%	79.4%	88.7%	88.9%
Total Payables				
Total trade invoices paid in the year	168,084	730,244	164,827	622,023
Total trade invoices paid within target	160,968	648,628	162,201	582,508
Percentage of trade invoices paid within target	95.8%	88.8%	98.4%	93.6%

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. The disclosure in 2021/22 included amounts paid to HMRC which were not invoiced expenses, and which are more appropriate to exclude from the disclosure. The non-NHS amount invoiced and paid have been reduced by £232.3m and this has reduced performance by value for 2021/22 from 95.4% to 93.6%. Performance by volume was unaffected at 98.4 per cent.

Note 32 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2022/23 £000	2021/22 £000
Cash flow financing	79,887	(67,054)
External financing requirement	**79,887**	**(67,054)**
External financing limit (EFL)	81,312	(67,054)
Under / (over) spend against EFL	**1,425**	**-**

Note 33 Capital Resource Limit

	2022/23 £000	2021/22 £000
Gross capital expenditure	140,277	94,861
Less: Disposals	(3,190)	-
Less: Donated and granted capital additions	(34,261)	(16,036)
Plus: Loss on disposal from capital grants in kind	3,190	-
Charge against Capital Resource Limit	**106,016**	**78,825**
Capital Resource Limit	107,441	80,855
Under / (over) spend against CRL	**1,425**	**2,030**

Note 34 Breakeven duty financial performance

	2022/23 £000
Adjusted financial performance surplus / (deficit) (control total basis)	199
Remove impairments scoring to Departmental Expenditure Limit	126
Breakeven duty financial performance surplus / (deficit)	**325**

Note 35 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905
Cumulative breakeven position as a percentage of operating income		3.8%	4.2%	3.2%	4.1%	5.6%	7.0%	2.2%

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
Breakeven duty in-year financial performance	(15,330)	3,023	32,996	11,255	47	5,005	325
Breakeven duty cumulative position	6,953	9,976	42,972	54,227	54,274	59,279	59,604
Operating income	1,096,575	1,160,803	1,212,959	1,300,616	1,422,789	1,483,121	1,601,459
Cumulative breakeven position as a percentage of operating income	0.6%	0.9%	3.5%	4.2%	3.8%	4.0%	3.7%

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