NHS
Imperial College Healthcare
NHS Trust

Annual Report

2021/22

This report is dedicated to the commitment and expertise of all of our people. We pay special recognition to colleagues who have died between April 2021 and the end of June 2022 and celebrate their lives and contribution to the NHS:

- Akorfa Fiamavle
- Andrew Wooley
- Ann Coyne
- Fitz Hitchman
- Jenny Candelas
- Juliet Chanayil
- June Deterville
- Professor Justin Mason
- Kevin Lavington
- Michael Owens
- Paulius Pivoriunas
- Roan Tablante
- Professor Robin Touquet
- Sajda Adil
- Sean Ryan
- Sevda Hassan
- Dr Stephen Metcalf

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Welcome

Matthew Swindells, Chair

Welcome to the annual report for Imperial College Healthcare NHS Trust for 2021/22. It has been another extraordinary year in which the Trust has been simultaneously grappling with the ongoing Covid-19 pandemic and working hard to rebuild planned care capacity and respond to increasing need. That has meant navigating rapidly changing terrain while also looking to the future – a challenging task that has required huge commitment and resilience from everyone in the organisation.

Though I only joined the Trust in April 2022, it's clear that our 14,500-strong workforce are determined not just to do their best but to keep learning how to do better. Through each wave of Covid-19 infections, we have been able to achieve progressively more – better outcomes for patients and less impact on planned care capacity and 'business as usual' activities.

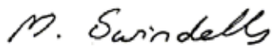
We have also benefited this year from a further strengthening of ties between health and care partners across north west London, not least in closer working between the sector's acute NHS trusts. Together, we have stepped up when an emergency department or intensive care unit has been under particular pressure, offered over 3,500 patients the opportunity to reduce their waiting time for treatment by transferring to another local hospital with more capacity and begun to create clinical networks and services to facilitate the sharing of specialist skills and learning.

It is to help make the most of the huge potential for collaboration that I have taken up my new role as chair, not just of Imperial College Healthcare, but of all four north west London acute providers. My job is to support each trust to continue to improve its own performance while ensuring that, together, we are greater than the sum of our parts. I am indebted to interim chair Bob Alexander and the board for their excellent stewardship of Imperial College Healthcare and to all of our staff, led by chief executive Professor Tim Orchard and his executive team, for everything that has been achieved to date. We now need to progress from working well with our partner trusts to being actively invested in each other's success as we look to formalise our links as an 'acute collaborative'. To our patients and communities, the joins between our services should become near invisible.

As we emerge from the pandemic, we are already seeing the same application of continuous improvement and collaboration to wider challenges and opportunities – the waiting list backlog, operational and financial pressures, the poor state of our estate, the advent of integrated care systems, a shared electronic patient record system and a growing consensus on the importance of reducing health inequalities.

We know, too, that we have to create working environments that are so much better than those we accepted before. It's vital that we build organisations where people care passionately about their work and feel truly valued and included, whatever their background, role or place of work. It is our staff who will make or break collaboration – they will need the right space, skills and support to work with our partners, patients and communities to change the way healthcare is provided for the better.

I have no doubt we are in for some very challenging times ahead, even as we move beyond the pandemic, but with such an excellent workforce, including many of the best clinicians, managers and researchers in the NHS, I am confident we will achieve much more for our patients and local communities. And, by continuing to strengthen collaboration with our health and care partners, sharing the most effective innovations and ways of working, we can help create one of the best health systems in the world.



Matthew Swindells, Chair
12 July 2022

Performance report

Overview

Professor Tim Orchard, Chief executive officer

It is tempting to reflect on 2021/22 primarily through the lens of the pandemic, as I did in our previous two annual reports. After all, we cared for a further 3,338 patients with Covid-19 this year, administered 46,796 doses of Covid-19 vaccinations in our hospital and community clinics, helped to develop and roll out a raft of new treatments and continued with a mix of measures to protect our patients, staff and visitors from the virus. However, we have also been setting the groundwork to emerge from the pandemic with renewed commitment to our three strategic goals – to work with our local communities to develop truly integrated care, to offer a sustainable portfolio of outstanding services and to build learning, improvement and innovation into everything we do.

If we consider the past year more broadly, we have managed to make important headway in three key areas alongside further improvements in our response to Covid-19:

- tackling the longer waits that have become established in planned care as well as delays in our increasingly pressured urgent and emergency care pathways
- investing more in building a motivated, healthy and inclusive workforce for the long term
- mitigating 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, often catalysed by the lessons of the pandemic but also building on improvements of the last few years. As well as maintaining our overarching commitment to quality and to innovation, we are doing more to strengthen our focus on the needs of our patients and wider stakeholders, reduce health inequalities, join up care across providers and use our financial and other resources more sustainably. We believe these work areas and ways of working – summarised below – should continue to be our priorities as we move into 2022/23 and beyond.

Reducing delays in providing safe, effective and equitable care through more joined up working and new models of care

The number of patients waiting for planned care has increased significantly across the NHS during the pandemic. Our own waiting list grew from nearly 63,000 to over 82,000 between March 2021 and March 2022.

Clinicians in north west London have developed systematic approaches 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. We managed to reduce the number of patients waiting one year for care from a peak of 2,400 in March 2021 to about 1,660 in March 2022. In January 2022, we reached a peak of 26 people waiting over two years for care – as of March 2022, this was down to two patients.

Although we have done comparatively well in our sector – there were a total of 666 patients waiting over two years across London as a whole, as of March 2022 – there is a huge amount to do to return to acceptable waiting times across all specialties, especially as we expect demand to continue to grow for some time to come.

We have been able to maintain progressively more planned care through each wave of infections and worked hard to restore lost activity as quickly as possible. As of March 2022, we are back to 87 per cent of our pre-pandemic planned care activity overall and up to 120 per cent of pre-pandemic outpatient and 97 per cent of diagnostic activity. We are committed to achieving well over 100 per cent of our pre-pandemic planned care capacity in the coming year to enable us to make a sustainable reduction in our overall waits.

Planned care improvements

Our achievements to date have depended on both incremental improvements, such as making more efficient use of our operating theatres, and strategic developments, especially joint working with our three acute care trust partners in north west London. Collectively, we have identified 14 surgical facilities across our hospitals with a good degree of separation from urgent and emergency care and focused them on 'high volume, low complexity' procedures where evidence has demonstrated improved quality and efficiency when undertaken systematically at scale. We are now building on the concept of these 'fast-track surgical hubs' by exploring the feasibility of a centre dedicated to routine orthopaedic surgery for the whole sector.

We have developed joint protocols for transferring patients from hospitals with particularly long waits in specific specialties to others which have more capacity. And to support these approaches, we have established a common data infrastructure with a single view of our waiting lists and have begun to pilot a new digital platform to give clinicians – and eventually, we hope, patients – better visualisation of demand and capacity data and greater ability to use that data to schedule work.

Another important aspect of tackling long waits has been improving our information and engagement to help patients across all of our diverse communities. We have worked to increase understanding of how we are prioritising and expanding care and what it means for patients.

The majority of our patients waiting for care are waiting for an outpatient appointment or a diagnostic procedure. We have therefore put more emphasis on establishing new models of care that enable patients to get faster answers to their health problems.

Last year, we began to roll out a plan to facilitate collaboration between clinicians across primary care and our acute hospitals. We have invested in a new sector-wide digital platform that, once fully implemented, will provide hospital teams and GPs with a single, more reliable and time-efficient route for managing advice requests and referrals.

We have also been exploring opportunities to create more 'one-stop' pathways, bringing together multidisciplinary teams to organise care around the patient and reduce the number of separate appointments. We already have these pathways in place for patients with potential cancer symptoms and we are now looking to extend them to specialties such as ear, nose and throat, gynaecology and ophthalmology.

In addition, we have begun to expand our diagnostic facilities, drawing on a national funding programme to plan for at least two new community diagnostic centres in areas where there are significant clusters of deprivation. We will be working with patients and other stakeholders to work up business cases in 2022/23.

In specialist care, too, we made progress in bringing together teams from different trusts to strengthen and share expertise for better clinical outcomes. Following engagement with patient groups and other stakeholders, complex surgery for patients with abdominal aortic aneurysms was consolidated at St Mary's Hospital last summer, with surgeons from Northwick Park Hospital continuing to carry out some of this surgery as part of a joint team at St Mary's.

We achieved a key milestone in the integration of children's health care with the appointment of a joint leadership team across children's services at Imperial College Healthcare and Chelsea and Westminster Hospital NHS Foundation Trust. While services will continue to be provided in hospitals run by both trusts, the development will help ensure best practice, reduce unnecessary variations and support closer collaboration with community and primary care partners, whilst focusing significant academic resources from our partners at Imperial College London on the common diseases of childhood.

Urgent and emergency care improvements

But it is not just planned care services that are impacted by delays and in need of new approaches. In urgent and emergency care services across the NHS, returning demand, continuation of inpatient admissions due to Covid-19 and capacity constraints due to infection prevention and control measures has led to year-round challenges.

We invested over £2 million in improvements to urgent and emergency care last year, including expanding 'same day emergency care' capacity and creating better, dedicated spaces for patients with mental health needs. Teams across the Trust have also come together to improve 'operational flow', identifying and tackling delays for patients from the A&E front door through to discharge home or closer to home. We have benefitted from specific initiatives such as our successful, new inclusion health team made up of multi-agency specialists who support patients with complex care needs including living with homelessness.

While we definitely continue to feel the same pressures as the rest of the NHS, these efforts are enabling us to minimise the impact on patients, allowing us consistently to achieve some of the shortest ambulance handover times in London, expand same day emergency care to improve experience, help prevent unnecessary hospital admissions and minimise lengths of stay. We need to continue to work to embed these efforts to bring sustained improvements for our patients.

Ensuring safe and sustainable staffing through a greater focus on the wellbeing, engagement and development of our people

Earlier in the pandemic, the generosity of the public in offering our staff food, travel and other support shone a light on longstanding gaps in how we look after our staff ourselves. The disproportionate impact of Covid-19 on people from Black, Asian and minority ethnic backgrounds highlighted further shortcomings in our approach to equality, diversity and inclusion across the Trust.

With funding from Imperial Health Charity, we created a £1.7 million staff support programme which has enabled us to make major improvements to over 90 staff spaces, double our staff counselling and mental health service and begin to transform our retail food and shops offer. Our staff have told us these approaches are making a real difference and all are continuing into 2022/23 to ensure we grow and sustain their impact for the long term.

We have expanded our equality, diversity and inclusion team who have been able to offer more support to our increasingly active and influential staff networks. We have made further progress with the overhauling of recruitment and disciplinary processes to ensure they are fair and proportionate, introducing race equity training, improvements to personal safety across our sites and investment in workplace adjustments for disabled staff.

We have built up an extensive portfolio of wellbeing resources and established a range of initiatives to recognise the huge commitment and expertise of our staff and to thank them for all they have done and continue to do. A highlight last July was the Gratitude Festival, featuring free events, food trucks and even an Imperial's Got Talent show, complementing practical benefits such as additional leave days, breakroom treats and gift vouchers.

We have been able to resume work on longer term initiatives to ensure our organisational culture reflects the values we co-produced with staff and stakeholders. Drawing on the results of our 2019/20 annual staff survey, we have been developing a new 'improving through people management' programme with our staff. We want to ensure all our line managers have the right skills, knowledge and confidence to support and guide all of their staff to achieve their full potential within happy and effective teams.

We have also resumed work on implementing a Trust-wide improvement and management approach to help staff at all levels connect with our vision, goals and priorities and contribute to their delivery. And we are beginning to integrate this approach with the roll out of the international Pathway to Excellence® programme which supports nurses and midwives to make their fullest contribution to high quality care.

All of this work – together with improved workforce planning – is helping us to ensure we recruit and retain the right number of staff with the right skills, with the highest levels of engagement and motivation.

In 2021/22, creating a sustainable workforce was one of our core people priorities. Nursing and midwifery vacancy levels fell to pre-pandemic levels and our pipeline of nationally and internationally qualified staff remains strong. In line with other healthcare organisations, our turnover has increased in the wake of the pandemic – our people priorities for 2022/23 are designed to address this change.

In the latest annual staff survey – carried out in 2020/21 – we remain above average for acute trusts for both staff engagement and morale and we perform especially well for staff recommending our organisation as a place to be treated and to work. However, the same survey shows that we have much more to do to tackle discrimination and improve staff perceptions of fairness.

Managing our aging estate and planning for major redevelopment

Throughout the pandemic, 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.

The need to temporarily close part of the Western Eye Hospital in early 2022 due to fire safety concerns illustrated how quickly a managed estates risk can become a major estates failure.

Following significant further work, we submitted a new strategic outline business case for the redevelopment of St Mary's Hospital in September 2021. It demonstrated the urgent need for new clinical, research and innovation facilities with a total of 840 beds, along with the case for developing a clinical life sciences cluster in partnership with industry and research.

All three of our main hospital sites are included in the 40 new hospitals the Government has committed to build by 2030. So, with the support of the Government's New Hospital Programme, we also started more detailed work on development options, feasibility and preparation. For St Mary's this includes a high-level masterplan for the whole site, exploring the scale of the total development. For Charing Cross Hospital (major refurbishment plus some significant rebuilding) and Hammersmith Hospital (a mix of redevelopment and some new building), we are building on the infrastructure and feasibility assessment undertaken in spring 2021. We have already confirmed that both hospitals will need to have at least the same number of beds as now and that there will continue to be a full A&E at Charing Cross Hospital. We aim to submit the business cases for both sites for first-stage approval early in 2023.

Within the Trust's overall redevelopment strategy, 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. For now though, we plan to invest in remedial and wider works for the Western Eye building in 2022/23 so that we can restore services there as soon as possible, in improved facilities. I am extremely grateful to all of our staff who have worked together to enable most of our displaced eye services to continue temporarily at Charing Cross Hospital, and to our patients for bearing with us.

Ways of working

As in previous years, we maintained a strong focus on quality and on research and innovation across all of our activities. Despite the impact of Covid-19, we remained in the top ten trusts nationally for the lowest hospital mortality rates (as measured by hospital standardised mortality ratios). And, while so much of our effort has been to learn all we can about Covid-19, contributing to national and international understanding and improved treatments, we supported over 898 clinical trials, 833 of which were unrelated to Covid-19.

In particular, we saw some brilliant developments last year in the use of artificial intelligence to aid diagnosis, including clinical trials of its application in helping clinicians to spot heart failure, prostate cancer and eye disease. In addition, we have been developing a growing expertise in employing data to improve healthcare, with further evidence of the value of our digital sepsis alert tool published and new thinking on data analysis to improve outcomes for ovarian cancer. Our pioneering work in the use of virtual reality technology also led us to take part in a BBC2 series last year to help explain common health conditions and their treatments.

Looking to newer ways of working, we are putting more emphasis on the sustainable use of resources. Last year, we launched our first green plan, setting out an ambitious but practical programme of activities, engaging increasing numbers of our staff, to reduce our carbon footprint.

We began to develop a systematic approach to understanding and playing our full role in reducing health inequalities within our patient population and wider communities. As part of this and working in partnership with Imperial Health Charity, we launched our compassionate communities programme, awarding small grants to – and building relationships with – local community organisations tackling a range of health barriers.

We also continued to expand our patient and public involvement activities, with a total of 62 lay partner roles in place across 33 projects in 2021/22. I really appreciate this huge commitment of time and expertise and give particular thanks to our strategic lay forum who are playing a key role in embedding a stronger 'user-focus' in the way we work overall. Partnership working with our wider stakeholders – including local authorities, patient groups and trade unions – as well as with other health and care organisations has strengthened further over the past year too and will be increasingly important in the years ahead.

I am wary about making too many predictions about the future – we are in a much better place than this time last year but Covid-19 remains a major factor in healthcare, if less so in life in general. I am sure, however, that we will continue to improve as an organisation, that we have set the right priorities and that we can achieve even more through our stronger collaborations and partnerships.

Professor Tim Orchard, Chief executive officer
12 July 2022

About the Trust

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

Our five hospitals in central and west London – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing care and treatment nationally and worldwide.

We continue to develop a growing range of integrated and digital care services and offer private healthcare in dedicated facilities on all our sites.

With our partners – Imperial College London; The Institute of Cancer Research, London; The Royal Marsden NHS Foundation Trust; and Chelsea and Westminster Hospital NHS Foundation Trust – we form 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: providing a range of acute and specialist services including cancer care and a 24/7 accident and emergency department (A&E). It also hosts a hyper-acute stroke unit and is an important hub for integrated care in partnership with local GPs and community providers.

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

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

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

Western Eye Hospital: a specialist eye hospital with an A&E department and outpatients, inpatients, day case and inpatient surgery services.

We run eight renal satellite units.

Imperial Private Healthcare (IPH)

Imperial Private Healthcare (IPH) is our private care division, offering a wide range of services across our sites. This includes the Lindo Wing at St Mary's Hospital, the Thames View at Charing Cross Hospital and the Robert and Lisa Sainsbury Wing at Hammersmith Hospital. The income from our private care is invested back into supporting all our services across the Trust.

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.

Our current five-year BRC programme is worth £91m over the period 2017-22. Following the submission of our competitive application for the next five-year programme, we expect to hear the outcome in summer 2022.

In 2021/22, the NIHR Imperial BRC supported 898 clinical research projects across 12 different disease areas.

The Trust is also part of the NIHR Health Informatics Collaborative (NIHR HIC), together with several other NHS trusts around the country. This collaboration brings together clinical, scientific and informatics expertise to enable NHS clinical data to be catalogued, shared and analysed to gain new insights into care and treatment through research.

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

We are a major provider of education and training for doctors, nurses, midwives and allied health professionals including therapists, pharmacists, radiographers and healthcare scientists. In 2021/22, some 1,900 Imperial College London medical undergraduates trained with us. We had 450 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 2021/22, the Charity invested £4.4m in a wide range of initiatives for the benefit of patients and staff.

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.

Throughout the pandemic the Charity has provided generous support to our staff in their efforts to maintain exceptional patient care during a period of such extraordinary pressure. Additional funds provided by the Charity enabled us to offer an expanded counselling service for our staff as well as progressing our staff spaces improvement programme. We have progressed with enhancements to more than 90 staff spaces so far, including a mix of basic redecoration and refurbishment of breakrooms, changing areas, showers and toilets and the supply of new furniture and kitchen equipment.

Alongside its arts and volunteering activities, the Charity has also funded a wide range of research and innovation projects through its annual grants programmes and supported our first ever Gratitude Festival – a week-long celebration dedicated to thanking all our staff and coinciding with the 73rd birthday of the NHS in July 2021.

During 2021/22, 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 2021/22, the Trust had 62 lay partner roles supporting 33 projects. Since November 2016, we have engaged with 150 lay partners on various projects.

Our commissioners

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

From April 2021, we saw the merger of the eight CCGs in north west London into a single North West London CCG. The formation of one organisation formed a key step towards forming an integrated care system (ICS) in our part of London. The role of the North West London CCG continued to be to commission health services for local people across the eight boroughs:

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

North West London integrated care system

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

During 2021/22, the Government introduced its Health and Care Bill to make ICSs statutory bodies across the country. This means that the NHS and local councils work together legally as part of ICSs, to plan health and care services around local population needs. All NHS organisations and local authorities in north west London have been working informally as an ICS ahead of the legislation, with the ICS for north west London expected to be established formally from July 2022.

Acute provider collaboration

Together with Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust we were pleased to announce the appointment of Matthew Swindells as our new joint chair. Matthew took up his position on 1 April 2022.

Our four trusts – responsible for 12 hospitals across north west London – had already begun to embed closer partnership working through a joint acute care board focusing on expanding planned care capacity and tackling waiting times in the wake of the pandemic. It was set up in March 2021 after our response to the first waves of Covid-19 infections demonstrated how much more could be achieved through greater collaboration.

The appointment of a joint chair is a key next step in strengthening collaboration as we move towards becoming a formal acute care collaborative in line with national NHS policy. While remaining separate organisations, we will seek to maximise our potential for joint working for the benefit of our local population, patients and staff.

Our regulators

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

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 / Improvement. Monitoring includes inspections, after which the CQC awards performance ratings for each domain overall, as well as the Trust overall. During 2021/22, routine activity for NHS trusts was limited to certain monitoring activities, with no routine inspections being undertaken and, as a result, the Trust has not been inspected and its overall ratings remain as they were in July 2019, after its last inspection:

- The Trust is currently rated overall as 'requires improvement'
- It is rated overall as 'good' for the caring and effective domains, 'good' for well-led, and 'requires improvement' for the safe and responsive domains
- Eight core services were inspected in February 2019 and the CQC increased its ratings for six of them; all of them were rated as 'good' or 'outstanding' and the overall rating for Queen Charlotte's and Chelsea Hospital was increased to 'outstanding'.

The CQC has continued to undertake urgent inspections throughout the pandemic, where there are concerns that people have been harmed or are at imminent risk of harm. The CQC did not undertake an urgent inspection at the Trust during 2021/22.

The Trust continued to attend CQC routine engagement meetings and to respond to CQC requests for information during 2021/22. The CQC did not take any enforcement action with the Trust during 2021/22.

The CQC launched its new five-year regulatory strategy for 2021-26 in May 2021. Methodology for implementing the new strategy was developed during 2021/22, which is why no routine inspections were carried out for NHS trusts during the past year. The new methodology for NHS trusts is anticipated to be published and take effect in spring 2022 and routine inspections are expected to resume during 2022/23.

Trust in numbers 2021/22

Our services*

1,324,000
Patient contacts
(including inpatients, outpatients and days cases)

292,000
Emergency attendees
(including A&E and ambulatory emergency care)

9,500
Babies born

33,000
Operations

96%
Positive overall rating of care for inpatients

*all rounded

Our staff

2,040 Admin and clerical	762 Allied health professionals (qualified)	126 Allied health professionals (support)
993 Ancillary	37 Doctor (career grade)	1,284 Doctor (consultant)
1,812 Doctor (Trust and training grade)	4,140 Nursing and midwifery (qualified)	1,157 Nursing and midwifery (support)
153 Pharmacist	6 Physician associate	851 Scientific and technical (qualified)
416 Scientific and technical (support)	754 Senior managers	14,531 Trust total

Our students

1,900 Medical students	450 Nurses in education, pre-registration

Our finances

+ £30.578m Surplus	+ £0.1m Adjusted financial performance surplus*	£ £1.483bn Turnover
£24.7m Efficiencies		£94.9m Capital investments including buildings, infrastructure and IT

*NHS Improvement 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.

Performance analysis

Introduction

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

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

Our executive management team regularly reviews a comprehensive set of quality and performance indicators known as our Trust scorecard. A broad summary of our scorecard is published on our website every two months and reviewed by our Trust board at its public meetings. Our scorecard report is aligned with the Trust's strategic goals and improvement priorities.

To ensure we continue to improve our operational processes and performance in a rapidly changing healthcare landscape, we reintroduced the chief operating officer role. This move supports greater oversight and co-ordination across our sites and clinical divisions as we move towards more integrated working at sector and regional levels. Moving from her previous role as director of operational performance, Claire Hook was appointed chief operating officer in July 2021.

Performance against national standards and our own organisational objectives cannot be assessed in the usual way as for the second successive year we have had to reprioritise our efforts to caring for patients with Covid-19 and other urgent and emergency conditions. As anticipated, operational performance has been impacted by the pandemic which has meant that many elective patients currently have extended waits for care.

From the end of the summer 2021, following the first and second waves of the Covid-19 pandemic, we experienced increasing operational pressure across our services. We saw higher demand for our A&E departments than usual – for example, in September 2021, we treated 20 per cent more patients in our emergency departments and urgent treatment centres than during the same period in 2019, before the pandemic.

Like other hospitals in London, we saw an increase in the number of patients with Covid-19 during December 2021 and into January 2022, as well as a more general increase in operational pressures. Fortunately, the rise in numbers during this third wave relating to the Omicron variant did not translate into significantly increased demand for critical care as experienced with the previous two waves.

During the third wave it was essential that we provided as much elective, planned care as possible given the long-term impacts now evident from the earlier Covid-19 waves.

Although we limited some non-urgent planned surgery in the first half of January 2022, our total elective activity steadily improved and by March 2022 it was at the same level as was being provided before the start of the third wave. A focus on higher priority and more complex elective surgical operations (reflecting alterations in the case mix) has meant fewer elective cases being completed overall.

We continued to maintain our diagnostic and care pathways for patients who had, or may have had, time-critical needs or conditions, including cancer, as well as antenatal and maternity care and screening services. The level of outpatient attendances was sustained at a high level throughout the year, above 2019 pre-pandemic levels and exceeding our planned recovery target.

Our collaborative approach to working across our 12 acute and specialist hospitals in north west London was a key enabler to maintaining more planned care during the third wave of Covid-19 infections. As we move into the new financial year and hopefully emergence from the pandemic, we are collectively focusing on both immediate measures to increase emergency, urgent and planned capacity while continuing to minimise the risks of Covid-19 and longer-term plans to develop better ways of working to reduce waiting times, improve our care and outcomes and help tackle underlying health inequalities.

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.

While in 2021/22, our response to the Covid-19 pandemic has continued to be a significant focus, we have also progressed recovery of elective care services and worked to improve services and support for staff. We have also continued to consider our long-term strategic goals in our activities throughout the year. Here, we report on progress towards our strategic goals through developments this year, set out under the goals to which they most relate.

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

Restoring elective care and reducing long waits

During the last year we have worked hard to recover our elective care services and reduce long waiting times as a result of the Covid-19 pandemic. During the pandemic, we had to pause some elective and non-urgent care in order to prioritise the care of patients with Covid-19 and other time-critical healthcare conditions.

As of 31 March 2022, with the benefit of greater collaboration across acute providers, we are close to operating at the same level of planned care capacity – 87 per cent – compared to pre-pandemic levels. We aim to achieve 104-110 per cent during 2022/23.

Our clinicians have developed shared systems to prioritise patients according to clinical need and, at the same time, we are targeting patients who have been waiting the longest. We continue to run additional clinics and, where appropriate, commission independent providers of NHS services to boost capacity.

We are helping to develop a single view of waits across hospitals in north west London to make best use of our collective capacity and to make access fairer. Where waits and capacity for a particular service in one trust are especially challenged, we look to offer patients there the opportunity to transfer to another trust in the sector where capacity is greater. In 2020/21, over 3,500 patients were able to have their care transferred to another local hospital to reduce their wait.

With our acute provider partners, we have set up surgical facilities, known as 'fast track surgical hubs', to help maintain and boost planned care. The facilities are separated as much as possible from urgent and emergency care pathways, to reduce impact from urgent demand. They are used to provide 'high volume, low complexity' procedures within six specialties – gynaecology, urology, ophthalmology, orthopaedics, ears, nose and throat and general surgery – which represent our longest waits. Evidence has demonstrated improved quality and efficiency when a surgical team undertakes a high number of these procedures in a systematic way. Building on the concept of fast-track surgical hubs, we have begun to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery for the population of north west London. With our acute trust partners, we have begun to explore plans for a shared elective orthopaedic centre, with the Central Middlesex Hospital as the most likely site option.

In addition, we are working to improve communications and information for patients who are waiting longer than usual for care. We have designed and are piloting new communications across a variety of channels. Our website now links to the national My Planned Care application, which provides patients with details on the average waiting times for each service,

and information on how to keep well physically and mentally, how to prepare for treatment and what do if they find their symptoms are worsening while they are waiting.

West London children's healthcare

West London children's healthcare is an initiative to develop more integrated, 'user-centred' care for children and young people with a stronger focus on health and wellbeing and disease prevention. It brings together the management of our acute and specialist children's services with those provided by Chelsea and Westminster Hospital NHS Foundation Trust to help ensure best practice, reduce unnecessary variations and support closer collaboration with community and primary care partners. We are also working with our academic partner Imperial College London to embed research and learning into the development of children's services and clinical practice.

Our children's healthcare services at both trusts have a combined workforce of more than 1,500, across four main hospital sites – Chelsea and Westminster, Hammersmith, St Mary's and West Middlesex. Collectively, we provide 115,000 outpatient consultations and over 20,000 planned operations or other planned procedures every year.

While acute and specialist children's services will continue to be provided from their current locations across both trusts' sites, the leadership structures are now being formally unified. A key milestone for the initiative saw the appointment of both a joint medical director and a joint director of nursing under a single managing director from April 2022.

Covid-19 and flu vaccination programmes

The Trust's Covid-19 vaccination programme, launched in December 2020, continues to be a key part of our response to the pandemic. We offer vaccination hubs at all three of our main hospital sites, offering pre-booked and walk-in appointments for staff as well as availability for patients who are inpatients or on site for outpatient appointments as required. A roaming vaccination service and pop-up 'mini hubs' have been mobilised periodically across our hospitals to improve ease of access for eligible groups.

In June and July 2021, we worked with Brent Council and the north west London clinical commissioning groups to provide pop-up mass vaccination events, delivering up to 3,000 appointments a day for our community.

In September 2021, we expanded our Covid-19 vaccination service to co-administer annual flu vaccinations in an effort to 'boost' the immunity of our staff and most vulnerable patients.

We dramatically increased the capacity available in December in response to the national direction for hospital hubs to support the expedited national booster programme. This included opening additional vaccination centres in our main outpatient departments on each site. From 16 to 31 December 2021, over 11,000 vaccinations were administered through our vaccination programme.

The first Covid-19 vaccination given by the Trust was administered on 20 December 2020. Between then and 19 April 2022 we have:

- administered 85,000 doses of approved Covid-19 vaccines
- administered 49,000 doses to our staff and other health and social care workers
- vaccinated 92 per cent of our frontline staff with first and second doses, and 88 per cent of eligible frontline staff with their booster dose.

The vaccination programme continues to serve staff and our community, with plans for a children's vaccination hub and additional booster doses to be offered to people over 75 and extremely clinically vulnerable people aged 12 and up.

Compassionate communities

Working in partnership with Imperial Health Charity, the Trust launched a pioneering new funding programme – compassionate communities – to improve health and wellbeing of people most affected by Covid-19 in north west London, as part of our strategy to expand our reach and support the health of our population, beyond our hospital walls.

From April 2021, 20 community organisations received up to £30,000 each in vital funding to tackle issues such as food poverty and obesity, mental health and wellbeing, digital poverty and exclusion, as well as language barrier and misinformation. Grantees included The Advocacy Project's 'Speak Up Radio', an online radio station broadcasting news, entertainment and advice for people with learning disabilities in our area, and Shop & Donate's 'social supermarket', which provides quality, healthy food at significantly reduced prices for people living in poverty in Hammersmith & Fulham and Kensington & Chelsea.

Sponsored nursing associate programme

In July 2021, we launched a new sponsored nursing associate programme in partnership with Buckinghamshire New University, University of East London and The Open University. The programme was developed to give members of our local communities the opportunity to begin a nursing career at the Trust, while also developing our nursing workforce.

Partnering with three universities who each run well-established nursing programmes provides students with flexible options to choose from. This includes traditional scheduled teaching, online learning and blended approaches, across different locations.

Successful applicants to the programme undertake a two-year nursing associate programme and benefit from placements at our hospitals and with community partners, fully-funded second year tuition fees and a guaranteed job offer upon successful completion of the programme.

Since July 2021, 17 students have started the programme, and our aim is to recruit 40 applicants to the nursing associate programme twice a year for the next four years.

North West London Clinical Trials Alliance launched

A new collaboration between clinical trial teams in north west London was announced in September 2021. The collaboration aims to improve access to – and the quality of – clinical research across the sector.

Clinical research facilities (including Imperial College Healthcare's), primary care networks and the NIHR Clinical Research Network in north west London have all joined the alliance which will be dedicated to delivering co-ordinated clinical trials and effectively utilising existing, purpose-designed facilities to deliver both early and late-phase trials.

When the Covid-19 pandemic hit in early 2020, clinical research teams across north west London joined together to respond collaboratively to the research need. The teams co-ordinated across the different facilities, meaning that research studies could be shared out more effectively, resulting in evidence that could inform national guidelines and policy more quickly.

The approach worked so well in response to the pandemic that teams from across the clinical research networks and the universities and NHS institutions which host the clinical research facilities decided to formalise the arrangement to build on the success of the collaboration and improve access to clinical trial resources for future research.

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

Improving urgent and emergency care and wider operational flow

We invested over £2 million in improvements to urgent and emergency care last year, including expanding 'same day emergency care' capacity to help avoid unnecessary admissions to hospital and improving dedicated spaces for patients with mental health needs.

- **Getting patients on the right care pathway, quicker:** following a successful trial, from 1 November 2021, the Trust now directly triages all patients needing urgent and emergency care at St Mary's Hospital rather than via our urgent treatment centre provider. This allows our clinicians to assess and get patients to the right care pathway as quickly as possible.
- **Expanding our 'same day emergency care' facilities:** enabling us to see 25 per cent more patients who need urgent care in a purpose-designed area separate to the emergency department, than before the Covid-19 pandemic. We recruited to 12 new posts to work within our same day emergency care facility at St Mary's Hospital, including junior doctors, nursing, healthcare assistants and receptionists. In addition, we recruited eight additional consultant posts, allowing for more senior clinical input in both our emergency departments and same day emergency care units, including in the evenings and at weekends.
- **Improving specialty pathways:** we opened a same day emergency care unit for gynaecology patients in February 2022 and have worked with London Ambulance Service to ensure renal patients are taken directly to Charing Cross Hospital which best meets dialysis and urgent care needs.
- **Improving spaces and facilities for patients with mental health needs:** we have created an additional space for mental health patients at St Mary's Hospital and improved the space at Charing Cross Hospital, allowing for a calmer and safer environment. In addition, a mental health 'divert to admit scheme', moving patients to safe spaces away from emergency departments and developed with mental health trusts and MIND, has shown some early positive impact.
- **Increased 'fit to sit' space in our emergency departments:** allowing patients to wait in a 'trolley chair' if they are well enough to do so, to help optimise the use of space.

Teams across the Trust have also come together to improve 'operational flow', identifying and tackling delays for patients from the A&E front door to discharge home or closer to home. We worked closely with our partners across north west London on improvements including:

- **Discharge hubs:** building on the success of collaborative working throughout the pandemic, hospital-based hubs in our sector are beginning to work with health and social care organisations to resolve delays and find innovative solutions to systemic challenges that we know prevent timely discharge, ensuring that patient experience is always at the forefront of such decision making.
- **Improving inclusion health:** a new multiagency inclusion health team that works with local primary care, community providers, local authorities and voluntary sector partners to provide specialist support for patients with complex health and social care needs such as living with homelessness. This model has been successfully implemented in a number of other trusts across the country with evidence of improved continuity of care.

Green plan

Our green plan, launched in May 2021, is underpinned by 12 key goals, including for cleaner air, reduced energy use, better waste management and the sustainable use of medicines. Recognising the NHS as a significant polluter, responsible for five per cent of the UK's carbon emissions and for 3.5 per cent of all road travel, we know we have an important role to play in reducing those emissions, particularly as we are one of the largest NHS trusts in the country. We have already started implementing major energy efficiency measures, that will result in 15 per cent emissions reductions across Charing Cross and Hammersmith hospitals, under a £26.9 million decarbonisation fund, secured through the Government's Public Sector Decarbonisation Scheme. The works include replacing old boilers and lighting and the installation of an air source heat pump at Charing Cross Hospital, which works like a refrigerator but in reverse, by extracting heat from the air to provide heating and hot water across the site.

Innovation is at the heart of our green plan, alongside a commitment to continuous learning. Green projects are being led and tested by our staff in a wide range of clinical and non-clinical areas, such as an innovation in the Charing Cross emergency department to reduce the carbon impact of unnecessary cannulation, or projects focused on substituting local in place of general anaesthesia for inguinal hernia repair and introducing reusable surgical gowns.

Milestones on redevelopment

We have worked hard to progress the redevelopment plans for all our three main sites while managing the ongoing maintenance issues caused by the generally old and poor condition of our estate.

The need to temporarily close part of the Western Eye Hospital in early 2022 due to fire safety concerns illustrates how quickly a managed estates risk can become a major estates failure. Redevelopment of our three main hospital sites remains a top priority, and all are included in the 40 new hospitals the Government has committed to build by 2030.

Following significant further work, we submitted a new strategic outline business case for the redevelopment of St Mary's Hospital in September 2021. It concluded that the existing Paddington site is the only viable location for the redevelopment, especially given St Mary's role as a major trauma centre. It makes the strategic case for new clinical, research and innovation facilities with a total of 840 beds, along with a clinical life sciences cluster in partnership with industry and research. Investment is currently estimated at £1.2-1.7 billion net once receipts from the sale of surplus land are taken into account.

With the support of the Government's new hospital programme, we also started more detailed work on the options, feasibility and preparation for all three sites. For St Mary's this includes a high-level masterplan for the whole site, exploring the scale of the total development. For Charing Cross Hospital (major refurbishment plus some significant rebuilding) and Hammersmith Hospital (a mix of redevelopment and some new building), we are building on the infrastructure and feasibility assessment undertaken in spring 2021. We have already confirmed that both hospitals will need to have at least the same number of beds as now and that there will continue to be a full A&E at Charing Cross Hospital. We aim to submit the business cases for both sites for first-stage approval early in 2023.

Within the Trust's overall redevelopment strategy, 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.

Community diagnostic centres

Community diagnostic centres are a national initiative to build diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. This 'one stop' 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.

National funding of £2.3 billion has been allocated for developing diagnostic services and an assurance and business case approval process was issued for schemes to deliver new community diagnostic centres. We are looking to have new community diagnostic centres situated in at least two areas of north west London where there are significant clusters of deprivation – including one in the area of Hanwell, Southall and Greenford; and another in the area of Neasden, Stonebridge, Harlesden, north Hammersmith and Fulham, north Kensington, Queen's Park and Church Street in north Westminster.

We worked up plans and business cases to progress the new community diagnostic centres with capital investment from 2022/23.

Key service changes

With the involvement of our patients and partners, we have been continuing to improve our models of care and care pathways, including:

Infectious diseases: In October 2021, we relocated the specialist infectious diseases inpatients service from Hammersmith Hospital to St Mary's Hospital. The A&E department at St Mary's is the main route of admission to hospital for patients with infectious diseases though we are still able to admit patients who present at Charing Cross A&E too. The infectious diseases service continued to provide in-reach services for patients being cared for at Charing Cross and Hammersmith hospitals, as well as maintaining outpatient services across all our three main sites. The eight inpatient beds previously used for specialist infectious diseases at Hammersmith Hospital were repurposed to care mainly for local elderly medicine and gastroenterology patients, together with some recovering patients having already received intensive care on the Hammersmith site.

Hydrotherapy: Pre-dating the Covid-19 pandemic, estates challenges led to repeated, unplanned closures of the hydrotherapy pool at Charing Cross Hospital, often at short notice and for prolonged periods, affecting the quality of care for patients and causing inconvenience to all users. With input from a range of stakeholders, including the local authority, we developed a proposal to permanently close the Charing Cross pool and instead provide the service in other local pools, including the hydrotherapy pool at the Jack Tizard School and Charing Cross Sports Club pool. Following a pilot, we anticipate the change should bring greater stability and consistency of service delivery compared to previous years, at a significantly reduced cost. In addition the Trust is able now to use our own hydrotherapy pool space to provide much-needed capacity for other clinical services.

Vascular: With our acute partners, we are working to bring together low volume, high complexity surgery where it will improve patient outcomes. A successful move of complex surgery for patients with abdominal aortic aneurysms from Northwick Park to St Mary's Hospital was completed in July 2021. This move aligned with national guidance on the minimum volume for this surgical procedure to ensure safety and effectiveness for this specialist surgery and followed engagement with patients and stakeholders. Clinicians developed the joint proposal that involves surgeons across the two hospitals working together as one team, with surgeons from Northwick Park Hospital undertaking some complex surgery for abdominal aortic aneurysms at St Mary's Hospital. During the Covid-19 pandemic, the two clinical teams adopted this model of care on a temporary basis. This 'pilot' of the new way of joint working was successful and the two teams continue to work together to develop more joined up services across north west London.

Investing in staff health and wellbeing

One of the key legacies of the pandemic is a commitment to ensure the health and wellbeing of our staff, fairly and for the long term. We have been developing a whole range of support for our people, including a major, permanent expansion of our staff counselling service with initial funding from Imperial Health Charity; dedicated clinics for staff experiencing long Covid symptoms; and a new suite of support resources including 'Well Pod', our own series of wellbeing podcasts created for staff.

With funding from Imperial Health Charity, we also initiated a major staff spaces improvement programme. We opened three fully refurbished staff 'rest nests' – designed free of charge by interior design company Taylor Howes – in January 2022. More than 350 staff from Hammersmith, St Mary's and Charing Cross hospitals are now benefiting from these fully fitted-out staff breakrooms.

The three rest nests are acting as pilots to inform the planned roll out of premium breakrooms across the organisation. The staff spaces programme also includes improvements to more than 90 other staff spaces so far, including a mix of basic redecoration and refurbishment of breakrooms, changing areas, showers and toilets and the supply of new furniture and kitchen equipment.

In addition, we have started work on new 'flagship' staff lounges at Hammersmith and Charing Cross hospitals. Plans are being developed for a similar space at St Mary's Hospital. This work is linked to another project, to transform our retail food and shops offer across all of our sites. The groundwork for this project has been laid in the past year and we are now beginning a 'proof of concept' at Hammersmith Hospital restaurant that will trial a new approach to menus and product ranges, the environment and sustainability.

Equality, diversity and inclusion

A key priority for the Trust is to improve and embed inclusion into everyday practice, creating truly inclusive services for our patients and a workplace where our staff can flourish, achieve their full potential and bring their whole selves to work.

In the past year we have made progress with our equality agenda but recognise there is much more to do.

We delivered the nationally funded Calibre leadership programme, specifically designed to help disabled staff gain confidence and leadership skills, as well as facilitating four further cohorts across the London integrated care systems. Seventeen of our staff have successfully graduated and have shared their learning with our executive team and our disability network, I-CAN; a second cohort at the Trust is planned for the next financial year.

We relaunched an inclusive recruitment approach for senior roles to help us improve workforce representation of Black, Asian and minority ethnic (BAME) staff at senior levels, meaning every interview panel for roles band 7 and above must be diverse in both ethnicity and gender.

In a further commitment to drive improvement, six senior leaders took part in a national white allies programme, helping them to use their position to open up dialogue around racism and build a workplace that celebrates diversity.

Collaboration is a key focus of our equality, diversity and inclusion agenda and our staff networks, in their crucial role as critical friend, have focused change in key areas of concern for staff, including women's safety on our estates and the implementation of reasonable adjustments for disabled staff. We introduced 19 BAME ambassadors across the Trust, created as a response to the disproportionate impact of Covid-19 on BAME communities, to provide a safe and supportive space to raise concerns and issues within the organisation.

We recognise that, in order to provide the best care to our patients, equality and diversity must be a key priority. We've relaunched our equality impact assessment process to help us improve the way we develop our policies to consider the impact on different groups of people. The new process encourages decision-makers to consider not only negative impacts, but to highlight where there is inclusive best practice to promote wider learning.

Our central equality, diversity and inclusion team have developed interactive tools and resources to support staff in learning more about subjects such as allyship and microaggressions, as well as how to have conversations about race. We have also launched our bespoke race equity training for managers.

Imperial Private Healthcare

Imperial Private Healthcare (IPH) is our private care division, offering a wide range of services across our sites. This includes the Lindo Wing at St Mary's Hospital, the Thames View at Charing Cross Hospital and the Robert and Lisa Sainsbury Wing at Hammersmith Hospital.

Throughout the Covid-19 pandemic IPH has adhered to the same prioritisation protocols as the wider Trust, and IPH has continued to support the NHS Covid-19 pandemic response throughout 2021/22. Many IPH staff have been redeployed to support NHS services when needed and IPH facilities continue to be utilised for NHS patients. This has resulted in the reduction of capacity for private patient services and revenue; before the pandemic in 2019/20 IPH generated revenue of £55M, compared with £37.7M in 2021/22. The income from our private care is invested back into supporting all our services across the Trust, with a significant financial contribution to support NHS services at the Trust in 2021/22.

Making our hospitals easier to navigate

In 2021/22, we implemented our wayfinding system – to help patients and visitors navigate our complex hospital sites. This approach involves new signage, as well as consistent information on other systems such as website content, patient letters and other patient communications.

We also made additional improvements to navigating the physical environment, beyond signage, including decluttering our public spaces, to free walls of posters and notices and ensure visibility of the signs. We implemented AccessAble guides to provide users with landmarks to look out for, where to find wheelchair accessible entrances and the quickest routes to our units. User feedback initiated additional zoning at Hammersmith Hospital which also made the journey through the hospital even easier.

In 2022/23 we will roll out a process for maintaining the approach and system and continue to make updates to signs and other communications as services move and change.

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

Continuing to improve our understanding and treatment of Covid-19

Research teams across the Trust have worked tirelessly to understand Covid-19 and find and improve treatments. In 2021/22 this work ran alongside research in areas previously paused due to the pandemic. Teams worked collaboratively and at speed across our partnerships to share key insights that led to translational findings, supported by the NIHR Imperial Biomedical Research Centre (BRC).

Results from Imperial College's vaccine trial in July showed considerable promise for the new vaccine technology developed by Professor Robin Shattock's team. Supported in part by the NIHR Imperial BRC, the trial took place at Trust research facilities. The technology has now received a major investment from AstraZeneca through a new company, VaxEquity.

Studies with early origins in the pandemic have continued providing key breakthroughs. The Trust assisted with developing antibody testing and engaging with local populations for the REACT study, which has helped inform government policy, providing key information about population infection levels. The REACT-2 antibody surveillance study led by Imperial College London showed high levels of protection against Covid-19 in nearly 100 per cent of adults tested who received two doses of Pfizer/BioNTech or AstraZeneca vaccines.

The REMAP-CAP study, led by Professor Anthony Gordon, produced findings to improve treatments, such as blood thinners being found to reduce the need for vital organ support. The Trust has also supported the CATALYST trial, led at Imperial College by Professor Graham Cooke, which found a potential role in treatment for a new antibody therapy.

The MATIS trial, led by Dr Nichola Cooper, is investigating two drugs used for immune diseases to see if they can reduce blood clotting associated with severe Covid-19 due to inflammation.

Researchers also investigated treatments for paediatric inflammatory multi-symptom syndrome temporally associated with SARS-Cov-2 infection, a rare but serious condition identified by a joint team of clinicians and academics at the Trust and Imperial College London led by Dr Elizabeth Whittaker.

A study of data collected and analysed by the NIHR Imperial BRC during the pandemic has shown potential for a blood test allowing clinicians to identify at the point of care if infections are bacterial or viral, avoiding the need for a complex matrix of testing that can delay care. Researchers have also looked at vaccine responses in immunosuppressed populations – a paper led by Dr Nick Powell showed the benefit of a third primary vaccine dose in individuals taking medication for inflammatory bowel disease.

Since the first Covid-19 wave, a focus on longer-term impacts of Covid-19 has also been vital for protecting a population widely affected by severe disease. The OnCovid registry analysed data from thousands of cancer patients also affected by Covid-19 to understand the impact on this group of patients. Other studies have looked at long Covid and recovery, with findings from the PHOSP-COVID study showing limited recovery one year after hospitalisation, highlighting a need for ongoing support.

Research in nursing, midwifery and allied health professionals

In 2021/22 we made significant strides in developing and supporting our research delivery workforce, who played such an enormous part in Covid-19 research at Imperial. In June 2021 we appointed a new lead nurse for the clinical research workforce, Dr Helen Jones, and in November 2021, we appointed a dedicated research delivery team for Covid-19 research. This team has enabled our existing research workforce of over 200 nurses, midwives and practitioners to focus on re-establishing our non-Covid-19 research portfolio in priority areas such as cancer, diabetes, heart disease, dementia.

Our nurses, midwives, allied health professionals, pharmacy staff, psychologists and healthcare scientists (NMAHPPs) have published more than 140 journal and book publications this year. Many of them have been involved in developing guidelines and/or driving and supporting research of national and international significance. Sixteen clinical academic fellowships at pre-doctoral, doctoral and post-doctoral levels have been won by NMAHPP staff, bringing in £1.5 million in research income to the Trust and enabling our staff to develop knowledge and skills that will enhance practice and improve patient outcomes and experiences. Imperial BRC funding has enabled eight post-doctoral nurses, midwives and AHPs to have protected research time in their roles.

With the support of our clinical academic training office, we have held numerous research training and development events and courses for NMAHPPs, including a divisional "Windows into Research" day within Women's, children's and clinical support services. Our revised ward accreditation programme (WAP+) now includes an assessment of the research culture on our wards, so that we can identify ways of learning and developing research alongside practice.

Charity grant helps doctors utilise data to improve outcomes for patients with ovarian cancer

A team of doctors at the Trust, led by Dr Laura Tookman, are pioneering a new approach to data analysis that will provide key insights to help improve the diagnosis and treatment of patients with ovarian cancer.

Funded by Imperial Health Charity through the Innovate at Imperial grant, the project will use advanced data analysis techniques on anonymised patient data that is already contained within Trust systems. The analysis will then identify trends that may provide key information about how to improve patient care pathways and display this information to healthcare staff in near real time.

Artificial intelligence and remote monitoring could help improve care of patients with heart failure

Early diagnosis of heart failure is a key determinant of the effectiveness of treatments that improve symptoms, quality of life and reduce mortality. However, a lack of effective tools for GPs to confirm or rule-out heart failure leads to late diagnosis, substantially greater NHS cost and earlier death in 80 per cent of cases.

Through the first-ever NHS study to evaluate an artificial intelligence (AI) technology for point-of-care detection of heart failure, a team of researchers led by Professor Nicholas Peters, consultant cardiologist at the Trust, has demonstrated that the combination of technologies – AI coupled with 'smart stethoscopes' – provides a solution for an enormous unmet need for diagnosing heart failure earlier and helps doctors deliver better patient outcomes more cost effectively.

The Trust is also working with a remote healthcare provider to pilot an at-home monitoring system that it is hoped could provide additional support for patients with heart failure, improving outcomes and reducing the need to come to hospital.

The remote monitoring platform, provided by healthcare technology company Luscii, allows

patients to take charge of their healthcare and input important health data such as their weight, blood pressure and heart rate on a daily basis, providing their clinical team with instant access to this information. Doctors and heart failure nurses can monitor for any concerning changes, with the platform also flagging up early signs of patient deterioration using an AI-powered 'clinical engine'.

During the pilot, which has been supported by NHSX and also through Imperial College Health Partners' Discover-NOW hub, the Luscii platform is being offered to patients with heart failure who may have previously needed multiple, in-person hospital visits over the course of two to three months of their treatment. The pilot is the latest pathway in the Connected Care Programme – iCareConnect – in north west London. These co-ordinated pathways aim to deliver better care that is easier for the patient and more cost-effective.

Providing insights into social isolation in London to target and improve services

A new project, launched in January 2022, aims to map loneliness in London, highlight the scale of the issue and target existing services to those who need them most. It will be a collaboration between local councils, voluntary sector organisations and general practice to engage with a wide, diverse population and maximise the opportunities to tackle loneliness through meaningful community initiatives and improve mental health and wellbeing.

The project is the first of its kind and is led by the Trust, Imperial College London's School of Public Health, and Hammersmith & Fulham Council. The team will collect data from thousands of Londoners through a brief online survey to produce a visual snapshot of social isolation and loneliness across west London.

Responses and insights from the study will help build a clearer picture of how loneliness affects people in the borough and across the Capital to help target and improve services, as well as potentially providing a template that could be easily rolled out to provide insights at city, regional or national levels.

Trialling tools for quicker diagnosis of prostate cancer

Cases of prostate cancer are rising, with around 52,300 new cases diagnosed each year. It is the most common cancer in men in the UK, usually affecting men over 50. Black men are disproportionately impacted by the disease and deaths from prostate cancer have now overtaken those from breast cancer.

One of the main methods of diagnosis currently is a special type of magnetic resonance imaging (MRI) scan which helps doctors see if there is any cancer inside the prostate and how quickly the cancer is likely to grow. A team from the Trust and Imperial College London was awarded £1 million last year by Cancer Research UK to explore whether a new type of MRI can detect signs of prostate cancer more quickly, with less chance of side effects and at a lower cost.

The researchers, led by Professor Hashim Ahmed, consultant urological surgeon at Trust, will look at the effectiveness of using a shorter Bi-parametric MRI (bpMRI) to take images of the prostate and detect signs of cancer. It takes just 15 minutes and does not carry the same risk of side effects, which comes from a dye injection required by the current method, and it costs less.

The Trust is participating in another study that aims to improve the diagnosis of prostate cancer by using artificial intelligence to analyse prostate biopsies.

The technology, which has been developed by health tech company Ibex Medical Analytics, will be used by clinicians at the Trust and the results of the AI analysis will be compared to current diagnosis methods, where biopsies are meticulously reviewed by a pathologist.

The study will have two phases – the first will use historic biopsy samples to 'fine tune' the technology across the six study sites. The second phase, lasting a year or longer, will recruit around 600 patients referred for a biopsy who will be asked if the research team can also process their sample using the AI technology, as well as through examination by an expert pathologist. Patients who consent to their samples being used in the study will not experience any difference in their care as the research will be integrated with their NHS treatment.

Sepsis risk alerts can help to protect patients in hospitals

Research published in December 2021 found that a digital alert system used at the Trust to identify patients who are at risk of sepsis can reduce deaths and extended hospital stays.

The alert system monitors a range of infection responses in patients, such as body temperature changes and increased heart rate, and warns health workers if a patient is showing levels that indicate a potential sepsis reaction to allow for further investigation.

In addition to the alert, the Trust designed a multidisciplinary care plan which is launched in the electronic health record system when a clinician confirms a diagnosis of sepsis. The alert system was originally developed and implemented in 2016 and evaluated for the first time in 2019 in a study co-authored by Dr Anne Kindelerer, consultant rheumatologist and associate medical director at the Trust.

It is hoped that this work will lead to recommendations on the effectiveness of different alerts and the most effective method for implementing them.

Researchers investigate new weight loss treatment and aim to predict the success of weight loss interventions

This year researchers at Imperial College Healthcare were awarded £1.2 million to trial a new minimally invasive weight loss treatment in patients.

Researchers at the Trust and Imperial College London will assess whether a minimally invasive procedure called left gastric artery embolisation (LGAE) is more effective in reducing weight compared to receiving diet and exercise advice.

Another study has identified three types of brain responses which help to prevent weight regain following bariatric surgery.

In the small study, researchers looked at the brain activity of sixteen people with type 2 diabetes or pre-diabetes who underwent weight loss surgery. The brain activity was measured using magnetic resonance imaging (MRI) scans that detected the blood flow through different areas of the brain. They found that there were three distinct types of responses in areas of the brain that control hunger, appetite and food intake which were different from a separate group of people who had used a very low calorie diet to lose weight.

The researchers believe that these changes in brain activity after weight loss surgery can help explain why people who undergo this type of treatment have successful and long term weight loss, in comparison with those who have followed a very low calorie diet, where very often there is a regain of weight.

Researchers suggest that any weight loss programme aimed at helping people with type 2 diabetes could be assessed using similar scans to understand whether weight loss is sustainable in the long term.

AI-supported test can predict eye disease that leads to blindness

A new eye test can be used to predict a condition that can lead to blindness, according to a new study involving patients at Western Eye Hospital.

In a clinical trial of 113 patients, retinal imaging technology was able to identify areas of the eye that were showing signs of a common condition that causes reduced vision and blindness, known as geographic atrophy (GA).

The team believe that this technology could be used as a screening test for GA and help advance the development of new treatments for the disease. Currently it is difficult to identify GA early enough to avoid any vision loss and the condition is often diagnosed at a late stage. The new study found that the DARC technology was able to predict GA three years in advance.

Imperial Academic Health Science Centre seminars

The AHSC seminars are a programme of themed lectures designed to showcase the research work of the AHSC to staff, patients and other key stakeholders. Due to the Covid-19 pandemic, the AHSC seminars have taken place online and have been centred on the AHSC's work in responding to Covid-19 as well as other key health areas.

Over the last year, the AHSC has held nine seminars online, with over 400 participants for sessions on treating paediatric asthma in the hospital and community and protecting against Covid-vaccination approaches, and over 1,000 for understanding and treating long Covid.

Highlights and special recognition

Staff awards through 2021/22

We were delighted to see excellence across the Trust recognised nationally throughout 2021/22, with teams and individuals receiving 16 key awards over the year.

The first of the year, the chief nursing officer for England's Gold Award, was received by Winny Thomas, our matron for quality and Black, Asian and minority ethnic (BAME) nurses and midwives network chair. Thomas received the award for nursing excellence in recognition of her lifetime of achievement in nursing, a career which began in 1984 before joining Hammersmith Hospital in 1999.

In June 2021, non-executive director, Nick Ross; former director of infection prevention and control, Professor Alison Holmes; honorary consultant, Professor Paul Elliott; and Professor Azra Ghani, chair in infectious disease epidemiology in the school of public health at Imperial College London, were all recognised in the Queen's Birthday Honours list.

Later in the month, Miss Catherine Rennie, consultant ear, nose and throat (ENT) surgeon, was recognised in the Top 50 Women in Engineering list. The list is produced by the Women's Engineering Society to mark International Women in Engineering Day (23 June). Rennie led a team of clinicians at the Trust in developing and championing a device to protect staff and patients from exposure to Covid-19, also working in partnership with Imperial College London's aeronautics department and the Mercedes-AMG Petronas F1 team.

November 2021 was an extremely busy month in terms of recognition for the Trust. Firstly, our partnership programme with Royal Opera House, ENO Breathe, to help those suffering from symptoms of long Covid across the UK, was awarded the Royal Philharmonic Society's 2021 Impact award. Following this, we then swept the National Institute of Health Research's (NIHR) North West London Clinical Research Awards with a record six honours:

- **Outstanding collaborative working:** the Peart Rose research unit, surgery and oncology research team (PHOSP study team)
- **Excellence in patient and public involvement and engagement:** the boiled peanut immunotherapy for the treatment of peanut allergy (BOPI) study team
- **Outstanding research support:** Sobia Mustafa, paediatric research nurse
- **Outstanding team:** the children's clinical research facility
- **Rising star:** Caitlin Carr, clinical research nurse (Peart Rose research unit) and Kirupalini Mariampillai, paediatric staff nurse

On 11 November 2021, Noni Nyathi, a ward manager at St Mary's Hospital, was awarded the European Diversity Awards 'Hero of the Year' prize for pioneering innovative headwear for Black, Asian and minority ethnic colleagues; supporting them to wear PPE safely and leading to a permanent change in the Trust's dress code and uniform. Noni and the team behind the innovation; Winny Thomas, chair of the Nursing and midwifery BAME committee; Marcelle Tauber-Gilmore, lead nurse for clinical procurement; and Louisa Campbell, senior category manager, procurement, were then also recognised in the Best Diversity and Inclusion Practice category at the Nursing Times Workforce Awards on 17 November 2021.

As we approached the end of the calendar year, we were delighted to see Lloyd Nunag, team leader for the surgery and oncology research team become the first ever nurse to be awarded the prestigious Schwarzman Scholarship. A highly selective programme, Lloyd was granted one of 151 places on the programme, from an initial pool of over 3,000 applicants.

Finally, Dr Justin Roe, clinical service lead at the national centre for airway reconstruction at the Trust, was awarded an MBE in the New Year's Honours for services to speech and language therapy, particularly during Covid-19.

High profile visitors to Imperial College Healthcare

In October 2021, the Trust hosted a visit from Amanda Pritchard, chief executive officer of NHS England. She was accompanied by Duncan Burton, deputy chief nursing officer for England and met with newly qualified nurses, healthcare assistants and allied health professionals. During an interesting two-way discussion session, she thanked them for working through the pandemic and discussed their roles and aspirations.

The visit was in support of NHS England's "We Are the NHS" campaign, aiming to attract young people to a career in the NHS. It was an opportunity for staff to reflect on what led them to choose their professions and how they hope to grow their careers.

In November 2021, Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care, visited St Mary's Hospital for a first-hand look at the work of our staff and patient pathways. He began by visiting our site team for an operational overview and was impressed by the digital technology that helps us effectively respond to areas of pressure across our hospitals.

The Secretary of State then received a tour of the same day emergency care unit and spent some time shadowing consultants in emergency medicine. He travelled up to the major trauma ward and theatres, on the way hearing more about the patient care pathways and meeting staff. On the major trauma ward, he had an opportunity to shadow our therapists, before moving to the intensive care unit for a tour and discussion with a group of doctors and nurses involved in research and innovation.

The Secretary of State then received a short tour of the Mary Stanford wing and Lewis Loyd ward – an opportunity to highlight some key estates challenges – to see the excellent work of our elderly care teams. To end the visit, he met with members of the pharmacy department and officially opened a brand new robotic dispensing machine that is now in use to improve the process of dispensing medicines and speeding up patient discharge.

Imperial people and patients featured in two documentaries filmed at the Trust

Throughout 2021/22 the Trust was involved in the production of two new television series. Both series were broadcast in March 2022 and followed stories of our patients and staff.

"Emergency," a new series for Channel 4, was filmed across the major trauma network in London for two weeks, 24 hours a day, during the summer of 2021. The documentary told the stories of patients brought to St Mary's hospital with major injuries and the staff who saved their lives, providing a unique insight into the day-to-day running of the major trauma centre and its collaboration with trauma centres, trauma units and ambulance services across the capital.

"Your Body Uncovered," a new six-part factual series for BBC2, followed seven of our patients as they received treatment for their medical conditions. The series, presented by Kate Garraway and Dr Guddi Singh, helps patients understand more about their medical conditions by using state-of-the-art technology to see their scans in an immersive way, using augmented reality. The Trust featured in four of the six episodes and featured a range of medical conditions, including fibroids, Covid-19, gallstones and frozen shoulder.

Celebrating our staff with Gratitude Festival

As we emerged from the second wave of Covid-19, we wanted to publicly thank and recognise staff for their hard work and commitment at this point of the pandemic, as well as support their health and wellbeing.

We had already begun our appreciation response thanks to the launch of the reset and recovery day initiative, which gave all staff a recovery day and an additional day's leave for their birthday.

Building on this, our intention was to hold a week-long, light-hearted event that would focus on staff health and wellbeing – giving them an opportunity to rest, relax and recover.

Working with staff networks – and canvassing the opinions of staff across the organisation – led to the development of our first Gratitude week in July 2021, coinciding with the NHS birthday.

With equality, diversity and inclusion being at the heart of our approach, the week-long festival of fun, which was funded by the Trust and Imperial Health Charity involved a combination of online and offline events and activities including on-site food trucks with a range of cuisines, Deliveroo vouchers available for our offsite clinic staff, exclusive discounts from local suppliers and 'headliner' events including the long service awards, a celebrity quiz and a broadcasted staff talent show, Imperial's Got Talent.

5,400 meals and 8,000 commemorative thank you badges exclusively designed by artist Julian Opie were given out during the week. There was great staff engagement with our quality activities including 600 people joining panel talks and events, 90 teams in the running to win our online quiz, and over 4,300 views of Imperial's Got Talent. With such positive feedback from staff about the food offer, we incorporated food trucks and Deliveroo vouchers into our 2021/22 winter wellbeing approach for staff.

This scale and reach – when compared to our annual Make a Difference ceremony, which could only involve 300 staff – means that Gratitude week is firmly here to stay and will hopefully be seen by staff as a positive legacy from Covid-19.

Looking forward

Following a year in which many of our plans were once again overtaken by the continuing need to respond to Covid-19, we look forward to making more progress on our strategic goals in the year to come. We have 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 the last few 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.

There is still much to do but the hard work and expertise of our staff and partners across north west London has put us in a strong position for the year to come. As we build on recent improvements and work towards our goals, we will continue to adhere to the statutory reporting framework which underpins this report.

Sustainability report

Sustainability report

Inspiring, enabling and empowering our staff to act

In May 2021 we launched our green plan to inspire, enable and empower all staff at the Trust to act. It is rooted in continuous learning and innovation, and is our platform for staff 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.

Since then we have launched a green community network that enables staff to connect and share ways to reduce waste and improve sustainability. The network currently has 200 members – our ambition is for this to be over 500 within the next two years. Our co-designed sustainability education module for staff is set to launch in June 2022.

In February 2022, our green plan operating and advisory structure, which includes lay partners, will work towards producing a refreshed three-year action plan to ensure impactful, feasible sustainability improvements can be built into 2022/23 business planning.

Reducing our dependence on fossil fuels is a core strategy of our green plan. We have successfully delivered over £13m of retrofit and energy efficiency upgrades funded from a public sector decarbonisation fund (PSDF) grant. We expect to complete these works in the new financial year and have also secured additional funding to further decarbonise our estates in 2022/23.

Providing innovative care that is patient-centred, close to home where possible, and leveraging the benefits of digital care is another pillar of our green plan. Around 30 per cent of our outpatient care is now carried out virtually, broadly in line with national standards, and this has avoided an estimated 20.7 tonnes of carbon emissions normally associated with patient travel. We also continue to make progress on transforming our renal services with the number of dialysis patients receiving renal home therapies now at 17 percent, up two percentage points from last year.

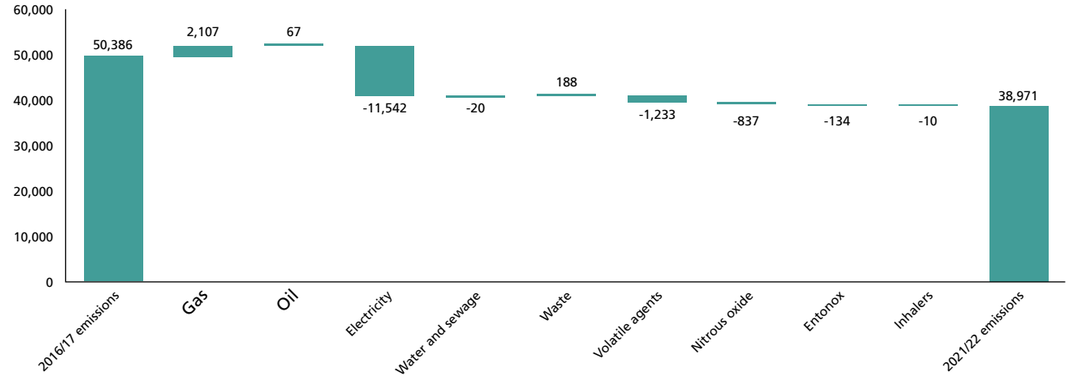
We are active partners in shaping a north west London integrated care system green plan that will support us to collaborate with other organisations to efficiently accelerate our progress to net-zero. And we have partnered with Imperial College, the Grantham Institute, the Institute of Global Health Innovation and the UK Alliance on Climate Change to publish '9 things you can do for your health and planet', a resource designed to encourage all citizens to help tackle climate change, improve their health and quality of life, and to support them to cope with the growing issue of eco-anxiety.

One year in, our green plan is also in line with our ambitions to deliver a net zero new St Mary's Hospital, in line with the Trust's wider redevelopment plans. This, alongside all of what we are doing to lower the carbon footprint of our other hospitals, will help the Trust become a net-zero exemplar and could contribute to the NHS meeting its net zero carbon target earlier than 2045.

Improving our understanding of environmental impact

Between 2016/17 and 2021/22 our directly controllable carbon footprint has fallen by 23 per cent (or 11,414 tonnes CO2e). This reduction has been largely driven by electricity grid decarbonisation and a downward trend in anaesthetics related emissions – although footprints from the last two years are likely to have been impacted by the global pandemic.

Our estimated directly controlled carbon footprint absolute change between 2016/17 and 2021/22 (tonnes CO2e)



In the context of our overall carbon footprint, fossil fuel and electricity related emissions represent the largest component of our directly controllable carbon footprint as of 2021/22 – standing at 53 per cent and 30 per cent respectively. However, we anticipate improvements in 2022/23 as we begin to reap the benefits of our public grant upgrades. Encouragingly, less than two percent of our waste goes to landfill, none of our waste is transported outside of the UK, and certain waste streams are used to produce fuel to generate grid electricity.

Decarbonising our estates

A large part of our directly controlled carbon footprint comes from fossil fuels and electricity. Reducing these through implementing cleaner energy solutions and energy efficiency is vital to reducing our carbon footprint. We have successfully invested over £13 million to complete the retrofit and upgrades from our 2021/22 £26.9 million public sector decarbonisation fund grant.

This includes the installation of an air source heat pump at Charing Cross Hospital, and implementation of a range of improved energy efficiency measures at both Charing Cross and Hammersmith hospitals, including lighting, pumping, heating, ventilation and air conditioning, alongside better energy controls. These upgrades will reduce our fossil fuel associated carbon footprint at our Charing Cross and Hammersmith sites by around 15 percent.

We have secured further funding from the public sector decarbonisation fund in 2022/23 for a range of further estate upgrades at Charing Cross and Hammersmith hospitals, including air source heat pumps, LED lighting and pipe insulation, that will lead to additional reductions in our fossil fuel related carbon footprint of between five and seven percent at the sites. In addition, we have implemented a PC power management solution at the Trust which will reduce our environmental impact from wasted electricity by around 1,343 tonnes of carbon over the next five years and will save at least £700,000 over this period.

Net-zero innovation

Creating a culture of innovation is key to delivering our green plan ambitions. Our green plan is galvanising staff to identify and bring innovation into the heart of what we do and how we do it. And since launching our green plan in May 2021 our groundwork has seen the spontaneous formation of a number of locally-led staff networks and groups that are now working collaboratively to explicitly embed environmental impact into care pathways and care settings, including our emergency department, our theatres, pharmacy, imaging and paediatrics.

Some of these carbon reduction innovations include:

- **use of reusable gowns in theatres:** This trial demonstrated a cost-neutral reduction of 1 tonne of carbon emissions and is being spread to other areas to better understand the potential to roll it out across the Trust.

- **reducing unnecessary cannulations:** This improvement project in the Charing Cross emergency department showed a safe reduction of around 40 unnecessary cannulations a day with a potential annual reduction in associated carbon of around 19 tonnes of carbon emissions with a cost saving of around £95,000. This project was showcased by the Greener NHS team as part of the UN's 2021 climate change conference, COP26.
- **use of remanufactured devices:** This trial, in our urology services, involves the collection, remanufacture and reuse of harmonic scalpels that are normally disposed of after a single use. This can halve the carbon emissions associated with their manufacture and can make cost savings through purchasing the cheaper remanufactured harmonic scalpels. We have seen the first small, but steady, environmental and monetary savings, and are working with surgeons to explore further spread and adoption.

We have also secured two Imperial Health Charity Innovate at Imperial grants, which will commence this year. One will explore the potential to reduce PPE waste through reusing the PPE material and the second is to trial, at all three of our sites, a volatile capture technology proof of concept in theatres which will capture harmful anaesthetic volatile agents rather than simply releasing them directly into the atmosphere.

Finally, we recognise that to become one of the most user-focused organisations in the NHS for patients, staff, citizens and local communities we need to innovate and learn how we can involve our patients and communities in co-producing environmental priorities and taking action. And this year we plan to begin a dialogue of discovery with our communities that consider practical ways that staff and the wider community and other more diverse stakeholders can collaborate in the design and delivery of our green plan.

Professor Tim Orchard, Chief executive officer
12 July 2022

Quality Account 2021/22

Chief executive officer's overview

This quality account is an opportunity for us to review our progress against key quality and safety improvement measures in 2021/22. It is impossible to do this without accounting for the massive challenge posed by further waves of Covid-19 infections, delivering the biggest vaccination programme in the history of the NHS, coping with returning demand in our emergency departments and managing the growth of waiting lists for planned care.

Despite these challenges, we continue to have among the lowest hospital mortality rates in the country, we are improving our incident reporting rates year-on-year and have improved the timeliness of our incident investigations. We have also improved our performance in our annual infection prevention and control practice audit and improved how we document informed consent through a new electronic consent programme.

Specifically in relation to the pandemic, we continued a range of services and programmes to respond to – and minimise the impact of – Covid-19. This included our clinical reference group, which provides clinical leadership and decision making, and our clinical harm review and prioritisation process, to provide a dynamic review of patients waiting for elective surgery to help prevent their health from deteriorating, as well as our staff and patient testing and vaccination programmes. We also introduced further measures to support the health and wellbeing of our staff. We will review these initiatives in the year to come as we continue our transition to living with Covid-19.

During 2022/23, we will also continue to progress our safety improvement programme priorities adding a focus on improving care for adult patients with swallowing problems and improving safety in blood transfusions and line insertion and care.

At the same time, as an organisation, we will be focused on reducing long waits and delays in our care, building a healthy, motivated workforce and progressing much-needed redevelopment of our estates. Improving the safety and quality of our services will need to underpin the achievement of all of these objectives. Likewise, our approach to quality and safety will need to be guided by organisation-wide improvements in how we work, in particular strengthening our focus on the needs of our patients and wider stakeholders, reducing health inequalities and joining up care across providers.

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 officer
12 July 2022

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

In 2022/23, we will focus on the implementation of our dosing model, which outlines what 'dose' of skill is required at each level of the organisation. Working closely with divisional and directorate leadership teams, this model will provide a more systematic focus of identifying who requires training and ensuring that improvement skills are directed towards Trust priority programmes, projects and focused improvements.

The Imperial management and improvement system

The Trust's strategy sets out our goals and the priority activities required to achieve them. This is guided by the Trust's strategic framework, which outlines our priority projects, programmes and focused improvements. The Imperial management and improvement system (IMIS) is the Trust's operational mechanism to help the organisation, our divisions, directorates, specialties, frontline and corporate teams deliver on their objectives. IMIS provides teams with a consistent and systematic approach to prioritising, monitoring and managing (i.e., improving and sustaining) strategic and operational change. This in turn enables teams to incorporate learning, improvement and innovation into everything they do, building a culture of continuous improvement.

To date, IMIS has predominantly been deployed at board and executive level, with aspects of the system implemented at division and directorate level. We have introduced core tools, including counter measure summaries and integrated performance scorecards. These scorecards are available at Trust, division, directorate and specialty level. This provides teams with their core measures and clear direction on which ones require improvement.

In 2022/23 we plan to employ best practice governance processes through the introduction of an integrated performance framework and toolkit. Additionally, we will expand IMIS to directorates and frontline teams as we roll out our 'delivering excellence' and 'tools for change' programmes.

2022/23 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 for 2022/23, which can be found on the following pages. The other strategic priorities are addressed and covered in our annual report.

This year, we have reframed our work in the context of the NHS patient safety strategy. This was published in 2019 by NHS England/Improvement. It focuses on how the NHS can continuously improve safety by building on two foundations: a patient safety culture and a patient safety system. It focuses on establishing a culture of psychological safety, sharing safety insight and empowering people – patients and staff – with the skills, confidence and mechanisms to improve safety. It sets out three strategic aims for the NHS as a whole (insight, involve, improve) with actions under each of these aims.

Due to the impact of the pandemic, implementation of many of the key elements of the national strategy was initially delayed e.g. the national patient safety syllabus, the framework for involving patients in patient safety and the new patient safety incident response framework. These are now starting to be launched and we will focus our efforts this year on implementing them, while continuing our work on priority improvement areas that we have identified as our key areas of risk internally.

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	**Rationale for selection**	**Progress metrics**
Deliver our safety improvement programme priority workstreams	We have had a quality and safety improvement programme in place since 2018. The programme is supported by three safety improvement leads, with steering groups in place for individual workstreams and overall reporting to our executive management board quality group. In May 2021, following consultation, we agreed six priority improvement areas for our quality and safety improvement programme for 2021/22 following a review of incidents (including serious incidents), structured judgment reviews, medical examiner outcomes, national reviews and national audits. These were identified as our key areas of risk internally. Recognising that owing to the impact of the pandemic we have more work to do to achieve the aims we set ourselves last year, we have chosen to continue our focus on these six improvement areas (N.B. one of these six – our 'improving incident reporting' work – is described under the incident reporting section in the following pages). We have also added two new priorities, which have been identified as risks through our incident reporting processes. Our 'improve' priorities for 2022/23 are: • improve hand hygiene practice, and the safe use of PPE in our clinical areas • improve how we agree and document appropriate treatment escalation plans, for our patients in an individualised, compassionate, and inclusive manner • improve how we document that our patients have provided informed consent prior to relevant procedures • reduce avoidable harm and improve performance and outcomes associated with invasive procedures • reduce the number of patient falls and associated harm levels • improve the checking of blood products prior to transfusion (new) • improve the identification and management of adult patients with dysphagia (new). The work we are undertaking for our ongoing priorities, and which will continue into 2022/23, is described in the next section. Our two 'new' priorities are set out below: **Improve the checking of blood products 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 rhesus positive blood rather than negative, which would have been avoided if the right checks had been carried out. Fortunately neither patient came to harm as a result of the incident. A large amount of work was undertaken in 2020 in response to previous blood administration incidents (two serious incidents and one never event) including the roll-out of an electronic bedside checklist. The group also introduced a new training module, which will relaunch in May 2022. This will be supported by simulation training in practice via a staged approach focusing first on high blood usage areas, which will provide additional support for staff and help us identify further improvements we can make. **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 have identified some gaps in our assurance around the recommendations of this inquiry. We therefore have some key improvement areas to focus on throughout 2022/23, which 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.	% of infection prevention and control incidents associated with nosocomial transmission % compliance with IPC training (level 2) % elective procedures consented for using our digital system % of audited compliance with the World Health Organization's five steps to safer surgery % of avoidable harm incidents associated with invasive procedures % of falls incidents causing harm % risk assessments completed on admission % compliance with falls prevention interventions Number of related blood transfusion incidents and near misses % compliance with the blood transfusion training module % compliance with recording of texture modified diets/fluids in our electronic patient record Audited compliance with Trust-wide dysphagia guideline

Insight: we will improve our understanding of safety		
Focus area	**Rationale for selection**	**Progress metrics**
Improve patient safety incident reporting rates across the Trust	High rates of incident reporting is a strong indicator that staff value safety, feel safe to raise safety concerns and can learn to continuously improve services. This is a key part of building our culture, being open and transparent and understanding what has happened when things go wrong, and supporting patients, staff and families. In 2022/23 we plan to continue with the focused improvement work we began this year. This will include continuing work with local areas to implement safety huddles focused on incident reporting and learning, as well as work to make our incident reporting system more user-friendly, to trial a web-based app to capture incidents, to improve access and quality of data insights around incident reporting and to use positive reporting to support learning from when things go right, as well as when things go wrong.	Patient safety incident reporting rate per 1,000 bed days – consistently in top quartile Incident reporting rate per whole time equivalent – 10% improvement (based on previously defined target)
Improve our approach to investigating patient safety incidents and implement the patient safety incident response framework (PSIRF)	Over the last two years, we have been working to improve our approach to investigating patient safety incidents, including: • Implementing a dedicated central investigations team • Using '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 • Providing additional training for clinical staff to become investigators. We still have work to do to ensure we are continuously improving and plan to focus in 2022/23 on how we can better involve patients, families and carers in our investigations. The patient safety incident response framework (PSIRF) will replace the current serious incident framework as the way the NHS investigates and learns from patient safety incidents from spring 2022. Once the framework is launched nationally, we will develop an implementation plan with our colleagues across the sector.	Targets will be defined once PSIRF is published

Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety		
Focus area	**Rationale for selection**	**Progress metrics**
Implement the framework for involving patients in patient safety	NHSE/I have published a new framework for involving patients in patient safety to support NHS organisations to do this successfully. While we have lots of good work across the Trust to involve patients and local communities in the business of the organisation through our strategic lay forum, and to help patients raise concerns and support them to take ownership of their care, the framework sets out specific actions we need to take related to patient safety. This year, we will therefore focus on developing a plan for implementation of the framework. Our initial action is to recruit our first two 'patient safety partners' in 2022, and we are currently working with our strategic lay partners to develop our policy, role profile and recruitment plan. We are aiming to ensure that patient safety partners are supported to become active partners in all elements of governance, monitoring and improvement related to patient safety, and that their contribution is recognised and valued by our staff.	Number of projects/ programmes in which we involve our patient safety partners
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 will be required for all staff across the NHS. The first two modules are now available and have been launched on our core skills system, LEARN. Our aim is to ensure that our staff have completed level 1: essentials for patient safety by April 2023, in line with national requirements. We will also focus on developing an implementation plan for the other modules.	90% of staff have completed level 1 patient safety training by April 2023

Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety		
Focus area	**Rationale for selection**	**Progress metrics**
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 strategy. We currently have one patient safety specialist, 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; developing this will be a focus for us in 2022/23. This is also an excellent development opportunity for our staff, providing a good learning platform and opportunity for sharing insights with other patient safety specialists nationally, which we want to open up to more people.	Targets to be defined once model developed

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

Progress against our 2021/22 improvement priorities

Last year we agreed six priority improvement areas for our quality and safety improvement programme for 2021/22. These were chosen following a review of our quality insights and in consultation with staff and our partners.

Improvement priority	What did we achieve?
1. Improve patient safety incident reporting rates across the Trust	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. Pre-pandemic, the numbers of incidents we reported were variable and during the first Covid-19 surge in spring 2020 reporting dropped across all divisions. This was partly due to reduced activity levels in particular parts of the organisation where 'business as usual' was paused and staff redeployed. In addition, clinical teams in areas which were under particular pressure e.g. critical care, did not have the capacity to report. Learning from this, we put in additional measures to support incident reporting during surge, including staff identified at each shift safety huddle as key reporters/investigators of incidents. As a result, although the numbers of incidents reported dropped slightly during the second and third surges, they remained higher than during the first surge (15.35 per 100 WTE in January 2022, compared to 13.45 in January 2021, and 10.44 in April 2020). Over the course of the year we have seen an overall improvement in our incident reporting rates, which is positive, particularly as our harm levels remain low (our percentage of incidents causing moderate or above harm is 1.34 per cent, below the national average of 2.67 per cent). Although we have not met our stretch targets, there have been 11 consecutive data points above the mean at whole time equivalent (WTE) level indicating a sustained change, and our patient safety incident reporting per 1,000 bed days is the highest it has been for over three years. Although the pandemic has inevitably delayed progress with our plans, our achievements in 2021/22 include: • focused improvement work to implement local safety huddles focusing on incident reporting and learning has begun with areas nominated by the divisions; a visual prompt has been designed with the teams involved to encourage discussion and sharing of learning, which we will continue to test and roll out to other areas as the work expands. • development of a communications campaign for all staff focused on the importance of reporting incidents and raising concerns, set to launch in summer 2022. • a quality improvement project to improve the experience of being involved in an incident of moderate or above harm for all junior doctors – a baseline survey has been completed and change ideas are being developed by the junior doctors leading the project. • an initial assessment of improvements we can make to our incident reporting system, Datix, to make it more user friendly. • continued work to improve our incident investigation processes. For this year, the focus has been on improving the timeliness of our investigations to ensure learning can be implemented more quickly and patients and families receive feedback earlier. By February 2022, we had no overdue serious incident investigations compared to a peak of 48 in April 2020. In 2022/23, we will focus on improving the quality of our investigations as part of the roll-out of PSIRF. This work will continue into next year, as described in the section 'Our improvement priorities for 2022/23'.

Improvement priority	What did we achieve?
2. Improve hand hygiene practice, and the safe use of PPE in our clinical areas	We know that hand hygiene is the single most important factor in the control of infection. The pandemic has increased the risks associated with hand hygiene further but has also increased the risk associated with the use of personal protective equipment (PPE). The correct use of PPE, alongside outstanding hand hygiene (HH) practice, is a key mechanism through which we can keep both our patients and staff safe, while reducing the risk of nosocomial infection, of Covid-19 and other pathogens. Throughout the year, we have continued to support staff through our HH/PPE 'helper' programme, which aims to improve compliance with infection control practices in a supportive manner. Our PPE helpers have delivered over 3,580 visits to clinical areas in 2021/22, an increase from 2,200 in 2020/21. Overall results in our Trust-wide annual IPC practice audit showed a small improvement compared to when it was last conducted, from 63 per cent in 2019 to 65 per cent in 2021; divisional action plans have been developed in response to areas of risk. Despite our work, we have continued to see an increase in infection related incidents. This is partly related to Covid-19, with our infection rates rising in line with community rates during the surges (see 'Covid-19 quality improvement activities' for more information). However, there has also been an increase in blood stream infections (BSIs), in particular MRSA BSIs. We reported 11 cases in 2021/22, seven of which were attributable to direct care at the Trust. The main contributing factor in six out of the seven cases was sub-optimal line care practices. Four of the cases occurred in paediatric haematology; targeted education and actions were led by our infection prevention and control team, and there have been no cases of MRSA BSIs in paediatric haematology since October 2021. As well as targeted local actions, a composite Trust-wide action plan is in place in response to the increase in line-associated infections which includes: • a Trust-wide point-prevalence survey • monthly multidisciplinary team meeting to review all healthcare-associated BSIs to identify themes and improvement areas • a gap analysis of national BSI reduction recommendations • ongoing observation and targeted education and assessment of aseptic non-touch techniques including vascular access device management such as decontamination and appropriate use of antiseptic patches • introduction of passive disinfecting cap to all unused lumens of all central venous access devices across the organisation. Following review of our infection-related data and feedback from our staff, throughout the last year we have been working to develop a new approach to infection prevention and control education, training and competency assessment, which will launch in June 2022. This approach has been informed by learning through our responses to Covid-19 surges, and by what similar organisations have in place. This new approach will involve an improved online training package, and quarterly observational practice audit and training as part of the new 'Better Together Thursday' initiative. This will be enhanced by a rolling programme of structured education and training visits across every area of the Trust by members of our infection prevention and control team with divisional colleagues. We will also continue to offer targeted support for areas with infection prevention and control-related issues, e.g. increases in infection, or issues with HH/PPE as identified through our audit.
3. Improve how we agree and document appropriate treatment escalation plans for our patients in an individualised, compassionate and inclusive manner	During the first pandemic surge, we increased the number of individual discussions with many patients with Covid-19 about what action to take if their heart stops. However, we continue to see instances where these conversations do not happen. At present, we do not have a systematic way to measure and improve how we agree and document treatment escalation plans. Intelligence from our medical examiners and from our structured judgement reviews show that this remains an issue. This feeds into end of life care planning but also into the care of patients when they are deteriorating. We know that proactive consideration of the actions that we will take when a patient deteriorates improves not only patient experience, but also outcomes where escalation is appropriate and should take place in a timely and agreed manner. Following a scoping exercise for this improvement priority in 2021, we identified that to improve the timeliness and quality of treatment escalation plans, we need to make wider improvements to how we care for patients who are at the end of their life, and their families. We have an end of life care steering group in place, who have led work including improvements to the CPR and treatment escalation form in our digital patient record, and development of an e-learning module. However, further progress has been delayed due to the impact of Covid-19. Following feedback from our patients and staff showing we need to do more, we have agreed to expand and improve our education and training and provide additional resource to support staff with advance care planning and other end of life skills. A business case is being developed as this will require additional resource. Once approved, this workstream will focus on implementation during 2022/23.

Improvement priority	What did we achieve?
4. 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. In 2021/22, we have focused on the implementation of an electronic consent process. Originally trialled in breast surgery with positive feedback from both patients and staff, the process allows patients to review clear information on their treatment, ask questions directly of the clinical team, and electronically consent to the procedure. This pilot was completed in early 2021 and evaluation showed that implementing electronic consent, Trust-wide, could significantly improve how both patients and staff experience the consent process and improve our documentation of it. A business case was approved and planning of the roll-out began in September 2021, including mapping of the digital consent workflow and engagement with surgical specialties. We have also collaborated with our partner, Chelsea and Westminster NHS Foundation Trust, to align our processes across the sector. All 19 of our elective surgical specialties have started to use the electronic process, with the early adopters now using it for the majority of their patients where appropriate. The aim for 2022/23 is to continue the roll out of the electronic consent process and have digital consent as the default method of consent for all elective surgical procedures by end of June 2022. We will also continue to work to improve the quality of the consent process. Our current focus area is patients who lack capacity to consent themselves; a recent audit has highlighted that we need to improve how we meaningfully involve patients' families and carers in this process.
5. 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 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, and the implementation of the Helping Our Teams Transform (HOTT) programme. HOTT provides simulation training, in situ coaching, 'conversation cafés,' and human factors training for those areas conducting invasive procedures. This work has continued to progress throughout 2021/22, though it has been interrupted by the pandemic. Our HOTT programme has delivered over 52 human factors training sessions over the year, with over 525 staff members trained, and conducted focused HOTT interventions with two areas nominated by their divisions (hepatobiliary surgery and thrombectomy), which has led to team-based development of local actions for improvement. Areas to participate in the programme in 2022/23 are currently being confirmed. We are pleased that operations and procedures incidents causing moderate or above harm have reduced from 7.3 per cent in October 2020 to 1.8 per cent by March 2022. Whilst we are not seeing repeats of the never events related to retained foreign objects or wrong site procedures which originally made this an improvement priority, we have had five never events in 2021/22, three of which occurred during an invasive procedure or in an area which routinely conducts them. Local actions were taken immediately where needed, and there was minimal harm to the patients involved. However as these never events showed some recurring issues related to key safety checks, we implemented some new Trust-wide actions in response, including: • use of team-based simulation to support the development of a single Trust-wide checklist for central line insertions. This will be launched in May 2022 alongside an accompanying training video, new standard operating procedure and a new e-learning module for central line insertion. • development of an options appraisal and business case for a bespoke competency assessment process for line insertion. This is being progressed through the routine Trust approvals process and will include how we provide training related to on-going management of lines for our staff following the increase in blood stream infections related to suboptimal line care practices (see the hand hygiene/PPE). • completion of a review of over 100 local safety standards for invasive procedures ('LocSSIPs'). The review will confirm which are required and will prioritise these for review, relaunch and audit. In 2022/23 we will progress work to make these electronic, rather than paper-based, and therefore easier for our teams to store, document and manage. • theatres and anaesthetics have also led on an action plan to specifically improve safety amongst their teams. Actions have included the relaunch of the 'stop before you block' campaign to reduce the risk of wrong-side anaesthetic blocks, a full review of medications storage and safety and implementation of an improved process for administration of blood through handheld checking devices.

Improvement priority	What did we achieve?
6. Reduce the number of patient falls and associated harm levels	This was introduced as a priority for 2021/22 as the number of falls causing harm to patients has increased, despite a reduction of falls overall. In 2021/22, the percentage of patient falls reported on our incident reporting system as causing moderate or above harm was 1.6 per cent. This is an increase compared to 2020/21 when it was 1.5 per cent. This is partly due to a change in how we report falls resulting in hip fracture in line with national audit recommendations. The recording of incidents is reliant on submissions in our incident reporting system, which means the overall numbers are not always aligned to the clinical records and the national audit data. Themes from incident reports continue to show an issue with consistent completion of risk assessments and implementation of the falls prevention policy. Due to the pandemic, we have not been able to progress work to improve in these areas as quickly as we would have liked in 2021/22, so this will continue as a priority area into 2022/23. Our achievements in 2021/22 include: • development of a falls improvement intervention toolkit to support local areas which is now starting to be rolled out across the Trust • benchmarking metrics to support local improvement included in ward dashboards (also known as 'harm-free care reports') • the relaunch of the safe mobility and prevention of falls steering group with redefined improvement intentions and scope • change in how we report falls with hip fracture; these are now reported as major/severe harm to bring us in line with national recommendations and investigated as serious incidents to ensure we are identifying any additional learning and implementing actions in response. The aim of the programme is to reduce falls with harm by 25 per cent in 2022 through: • understanding contributing factors as to why patients have fallen and what we did to prevent harm • taking proactive preventative actions to help patients mobilise safely in hospital to reduce the risk of a fall with harm • ensuring every clinical member of staff has the skills and knowledge to respond appropriately when a patient falls in hospital • sharing examples of best practice and emerging research to increase our awareness of potential areas of risk and possible innovative practices used in other services and organisations.

In addition to the work described previously, we also undertook quality and safety improvement work in response to other emerging risks and issues, including our response to the evolving Covid-19 pandemic, a summary of which is set out in the following summary. Other ongoing programmes of improvement work, including our response to the Ockenden report, are included in part 1.2.

Covid-19 quality improvement activities

For the second 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. In some cases, this has meant pausing some of our planned improvement work to refocus on work to promote and improve safety and quality as part of our Covid-19 response. As we enter the third year of the pandemic and continue our transition to 'living with Covid-19' in line with Government plans, 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.

Clinical oversight and support

In response to the overwhelming demands of the pandemic, we implemented several changes in 2020/21 to support our staff and the governance of safety and effectiveness. These changes – described in the following pages – have continued into 2021/22 and have been improved and adapted as our response to Covid-19 has evolved. They have helped us to provide a strengthened decision-making and clinical governance structure, deliver improved support for ethical decision-making and maximise the pace of assimilation of a rapidly evolving evidence base into practice in support of an effective organisational and clinical response to Covid-19.

Clinical reference group (CRG)

Established in March 2020, the CRG continued to meet several times a week throughout 2021/22, providing clinical leadership and decision-making to the Trust's response to the Covid-19 pandemic. The CRG is chaired by the Trust's medical director and has representation from a wide range of clinical and corporate areas, including our clinical divisions, clinical ethics, infection control, compliance, and nursing.

The CRG has several responsibilities, including:

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

This group has been instrumental in supporting the Covid-19 response and ensuring the Trust continues to follow changing standards and national guidelines. The group has reviewed over 600 items since March 2021, making evidence-based decisions to ensure that our patients and staff remain safe and receive the most up to date care for Covid-19, while continually reflecting on how to improve and adapt our clinical response to the pandemic.

Clinical decision support (CDS)

The CDS service continues to support our clinical teams as they make difficult decisions regarding treatment plans for our patients. It continues to provide clinicians with the opportunity to discuss patient care with colleagues, and to receive clinical ethics support where necessary. The CDS service can be triggered for any reason, but was predominantly set up for when:

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

There have been 17 CDS conversations convened since April 2021. These have included difficult conversations centred on family members disagreeing with proposed ceiling of treatments for their relatives and supporting staff to navigate through risk-based assessments related to Covid-19 isolation requirements.

The CDS service continues to provide support to consultants. Following a review of the service, this is now operational Monday to Friday, 09:00-17:00 and provided by site nurse practitioners, with clinical leadership provided by associate medical directors.

Infection prevention and control

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

Hospital-associated Covid-19 infection, transmission and deaths

One of the key areas of focus of the infection prevention and control (IPC) team in 2021/22 has been responding to the continued pressures associated with the Covid-19 pandemic. The latter quarter of the financial year saw the latest pandemic surge owing to the highly transmissible Omicron variant of SARS-CoV-2, leading to an increase in community prevalence of Covid-19 and patient admissions.

We continue to operate a robust Covid-19 surveillance platform, allowing for daily dissemination of reports on hospital-onset Covid-19 infections (HOCI) to clinical and epidemiology staff, which facilitates timely flagging of potential incidents and implementation of transmission mitigation measures. The surveillance platform employs 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).

The Trust recorded 478 HOCI in 2021/22, broken down as follows:

Hospital-onset indeterminate healthcare associated (HOIHA, positive test result three to seven days post admission)	185
Hospital-onset probable healthcare-associated (HOPHA, positive test result eight to 14 days post admission)	122
Hospital-onset definite healthcare-associated (HODHA, positive test result on or after 15 days post-admission)	171

Sadly, of these 478 cases, 61 patients (13 per cent) died within 30 days of a positive sample following either an indeterminate, probable, or definite hospital-onset Covid-19 infection.

The Trust's clinical incident management systems are used to investigate and learn from Covid-19 outbreaks and related incidents. All outbreaks are investigated as serious incidents, and an individual post-infection review undertaken for each case of hospital-onset Covid-19 infection in a patient more than eight days after their day of admission where the patient is not included as part of our outbreak management policy. For patients who have sadly died following hospital-onset Covid-19 infection, an independent clinical notes review or structured judgement review (SJR) is also undertaken. In 2021/22 we implemented a new process whereby once the structured judgement review, and the serious incident investigation/post infection review are complete, each case is reviewed at a panel chaired by the medical director to determine if there were any avoidable care or service delivery issues that may have contributed to the patient's infection. This process has helped to identify learning we can take forward as part of our response to the pandemic and has fed into the following actions described.

We continue with key actions to prevent, identify, and manage hospital-associated Covid-19 infection and transmission among staff and patients:

- frequently reviewing the IPC board assurance framework, which is updated monthly with an associated action plan that is reviewed regularly at our clinical reference group
- responding in an agile and coordinated manner to Covid-19 incidents and outbreaks, in partnership with divisional colleagues
- continuing to partner with occupational health in identifying and managing possible outbreaks of Covid-19 among staff
- managing Covid-19 incidents and outbreaks involving patients and staff across the Trust
- using the Trust's clinical incident management systems to investigate and learn from Covid-19 outbreaks and related incidents
- implementing changes in national guidance pertaining to management of Covid-19, including guidance around personal protective equipment (PPE)
- working closely with clinical specialities to implement these changes and developing clear messaging for our staff
- working closely with clinical specialities seeing an escalation of Covid-19 cases, particularly

in relation to challenging situations where patients tested negative on admission subsequently testing positive on 'low risk' pathways

- continuing to monitor ward, speciality, divisional and Trust level Covid-19 screening.

In response to updated UKHSA national guidelines for the prevention and management of seasonal respiratory viruses (including Covid-19), and in response to learning from our experience during the first wave of the pandemic, including our review of HOCI deaths as described above, we have also implemented the following changes:

- all contacts of patients diagnosed with Covid-19 are isolated in hospital and if they remain in hospital are then tested for 10 days
- all patients who test negative for Covid-19 at the point of admission to hospital are tested daily for the first seven days of their admission, and weekly thereafter should they remain in hospital
- we have updated guidance on managing elective and emergency admissions, including how best to care for patients that have recovered from a previous Covid-19 diagnosis, while identifying possible reinfection
- we have changed pre-procedure isolation protocols for elective procedures – balancing how we can support our patients to be safely admitted against the challenge of patients and their household isolating prior to admission.

Clinical harm review and prioritisation process

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 has been reviewed and updated for 2021/22 and is designed to ensure that treatments are prioritised for the most urgent patients. The clinical harm and prioritisation process enables assessment of the individual patient's actual or potential harm due to deferral and allows the clinician to modify the surgical priority relating to this, resulting in scheduling appropriate to clinical risk.

So far, no cases of harm have been confirmed through this process, although one case of potential harm is currently being investigated as a serious incident. We have however identified examples of harm through our incident reporting process for patients who have had their diagnostics or treatment delayed due to the pandemic (10 confirmed cases and three under investigation). These would not have been picked up through our current clinical harm process because this does not include review of potential or actual harm to delay for patients on a diagnostic or outpatient / non-admitted pathway. A process has now been developed across the north west London sector for patients in these categories which we are working to implement.

Health and wellbeing helpline

At the start of the pandemic, we opened a dedicated helpline for our staff and have continued to operate this throughout 2021/22. The helpline provides staff with a reference point for all queries relating to the rapidly evolving national and local Covid-19 guidance. This service provides quick advice to our staff regarding self-isolation and testing. Demand for the service has closely reflected the peaks and troughs of community infection rates and, also, the changes in government guidance. The helpline continues to be a valuable resource – providing support and guidance, as well as a listening ear, to colleagues across the organisation.

Pressure ulcers

Pressure ulcers are an injury affecting areas of the skin and underlying tissue – caused when the skin is placed under too much pressure. All people are potentially at risk of developing a pressure ulcer. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Category three, four and unstageable are the most serious types of pressure ulcers. We investigate each pressure ulcer and put in place a robust action plan for each serious incident.

During 2020/21 we reported 42 category three, four and unstageable Trust-acquired pressure ulcers, 22 of which were for patients with a diagnosis of Covid-19 who were being proned (proning is where a patient is moved to lie on their front – it is recommended for patients with severe hypoxemia).

We also took specific actions including implementation of facial protection guidance and a specialist trained proning team to assist with undertaking proning and de-proning as well as patient repositioning. As a result, of the 14 category three, four and unstageable Trust-acquired pressure ulcers reported in 2021/22, none were for patients being proned with Covid-19.

In 2021/22 we also implemented a new bed and mattress contract across all sites and continued with robust prevention and management training for our staff.

Testing

The Trust's Covid-19 testing programme has formed an integral part of our response to the pandemic since 2019. Designed to keep our patients, staff, and their household members safe the programme aims to reduce the risk of nosocomial infection, and to ensure that our staff and their household members can access symptomatic testing quickly when needed.

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

772,211 polymerase chain reaction (PCR) tests have been carried out for patients, staff and their household members since 1 April 2021, representing an increase from the previous year.

Patients

The testing team are responsible for the pre-admission screening of patients due to undergo procedures or admission to the Trust in line with Department of Health and Social Care guidance. Pre-elective screening is required between three and five days prior to admission and is provided in dedicated testing facilities across all three sites – designed to ensure that we understand a patient's Covid-19 infection status prior to admission so that we can take appropriate steps to keep the patient, other patients and staff safe. For those patients that are not able to easily travel to one of our testing facilities we have also designed a home courier testing service in partnership with our patient transport provider, Falck UK Ambulance Service.

From 1 April 2021 to 31 March 2022, the Trust performed 744,385 patient tests, prior to admission, at the point of admission and during inpatient stays, with a total of 19,027 positive results. We met our target of 90 per cent for three out of the five metrics for patient testing. For the remaining two metrics (testing within 12 hours of a non-elective admission and testing 72 hours before discharge to a care facility) performance was 89 per cent.

Staff and their household contacts

Since November 2020, all staff have had access to twice-weekly rapid lateral flow antigen testing. We continue to use lateral flow testing in line with national guidance and it remains an integral element of how we keep our patients and staff safe. Whilst we initially held local data on staff compliance with twice weekly testing, in 2021 we transitioned from locally distributed test kits and local reporting arrangements in line with national requirements.

Staff now order and report directly via the central government portal. Lateral flow testing has also proved to be a valuable tool in allowing us to maintain our workforce. We were able to use increased lateral flow testing for staff with contact exposures during recent surges due to the Omicron variant to allow them to continue working. We have also been able to use increased frequency of lateral flow testing in the cases of local outbreaks by providing an emergency supply of testing kits to staff as an enhanced safety response, minimising the disruption to services due to potential staff absence.

The Trust also provides access to testing for any staff with symptoms suggestive of Covid-19.

Staff can self-refer for a test, conducted either in our on-site testing hub, or if necessary, completed via home courier testing service. We also offer this option to household members of staff. This has been an incredibly helpful service in terms of offering rapid access to testing for our staff as well as reducing isolation periods for staff and household contacts where the test has been negative. This was especially evident in recent surges when community testing encountered capacity challenges. Over December 2021 and January 2022, we were also able to extend this offer of support to sector colleagues across north west London who were encountering challenges in accessing central testing resources.

From 1 April 2021 to 31 March 2022, we performed 27,826 tests for staff and their household members, with a total of 2,554 positive results identified.

Vaccination programme

The Trust vaccination programme has continued to remain a key component of our pandemic response through the ongoing 'evergreen' offer of Covid-19 vaccination to our staff and most vulnerable patients. In September 2021, we expanded this service to be able to co-administer annual flu vaccinations for these cohorts to increase immunity to seasonal influenza in the autumn and winter months of 2021/22.

We remain committed to improving uptake of vaccinations in our staff and patients and have worked with clinical services to minimise referral processes and wait times, often offering walk-in appointments for staff and patients who are in our hospitals for inpatient treatment or outpatient appointments. We have also improved access to vaccinations by operating a regular roaming vaccination service, with our trained vaccinators visiting areas of the hospital to provide vaccinations in other clinical settings. Pop-up 'mini hubs' have also been mobilised across our estate to further improve ease of access for eligible groups.

Through our commitment to the north west London vaccination effort, the Trust led on work with Brent Council and the north west London clinical commissioning group to provide pop-up mass vaccination events in June and July 2021. This included transforming a disused leisure and sports complex in Brent and our own W12 conference centre at Hammersmith Hospital into vaccination centres with capacity to deliver 3,000 appointments per day.

The commitment to our local communities continued with the extension of our regular vaccination efforts to all eligible members of the public by offering appointments in all of our main vaccination locations for the winter Covid-19 booster campaign via the NHS national booking system.

The vaccination programme responded to the national call by scaling up considerably during the Covid-19 booster campaign, increasing capacity from 3,500 appointments per week to 8,000 per week in December 2021. This contributed to the national effort to respond to the emerging threat of the Omicron variant. This effort was led by the medical director's office and outpatient departments with significant amounts of time, enthusiasm and effort invested from all professional groups from across the organisation.

In March 2022, we established a dedicated children's vaccination clinic for five- to 11-year-olds as this cohort became eligible to receive their vaccine. We also supported the national spring 2022 booster campaign by vaccinating over 75s and clinically extremely vulnerable over 12s when became eligible to receive their booster March 2022.

Between the first Covid-19 vaccination being given by the Trust on 20 December 2020 to 19 April 2022, we have:

- administered 85,000 doses of approved Covid-19 vaccines
- administered 49,000 doses to our staff and other health and social care workers
- vaccinated 92 per cent of our frontline staff with first and second doses, and 88 per cent of eligible frontline staff with their booster dose.

Our vaccination programme has continued to develop and adapt, responding to changing national requirements and using our expertise and resources in new and innovative ways to provide a service that meets the needs of the population.

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

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

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

1.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to the financial year 2021/22. 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 2021/22, the Trust provided services to combat the pandemic and endeavoured to provide its standard commissioned services. We have reviewed all the data available to us on the quality of care in these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2021/22 represents 95 per cent of the total income generated from the provision of Trust services in 2021/22. The income generated by patient care associated with these services in 2021/22 represents 85.3 per cent of the total income generated from the provision of services by the Trust for 2021/22.

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 2021/22, 41 national clinical audit programmes and three national confidential enquiries covered NHS services that we provide. During this period, we participated in 95 per cent of national clinical audits and 100 percent of national confidential enquiries in which we were eligible to participate.

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 division of medicine and integrated care review other relevant metrics to provide assurance through divisional governance processes and as part of the oversight of operational performance of emergency pathways. The second audit was management of the lower ureter in nephroureterectomy, which is part of the British Association of Urological Surgeons (BAUS) audit programme (BAUS Urology). Data was not submitted due to clinical pressures during the Covid-19 pandemic.

We partially participated in the national respiratory audit: we fully participated in the smoking cessation workstream but not the national outpatient management of pulmonary embolism workstream due to clinical pressures during the pandemic. The team are, however, working on the pulmonary embolism pathway from the British Thoracic Society and plan to carry out a local audit in lieu of this for assurance.

The national clinical audits and national confidential enquiries that we were eligible to participate in are included in a table at Annex 3. The number of cases submitted are presented as a percentage where available. Please note that percentages will be accurate up to February 2022 where host organisations were contacted, but some data collection was still ongoing.

National clinical audit

We reviewed the reports of 40 national clinical audits and confidential enquires in 2021/22. 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 included in the following pages to indicate the range of work and performance across the Trust.

National Joint Registry (NJR)

NJR collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery and monitors the performance of joint replacement implants. Hip, knee, ankle, elbow and shoulder joint replacements have become more common and are generally highly successful operations that bring many patients improved mobility and relief from pain. Overall the data quality provided by the Trust to the registry remains rated as good and above the national average. The main indicator of revision rate for hip replacements remains comparable to national standards. In previous reports, the revision rate for knee replacements had been higher than expected but this has now improved and we are no longer an outlier for standardised revision rate at 10 years. Revision rates for shoulder replacement surgery were

higher than the national average. Our shoulder surgeons have highlighted some possible inaccuracies in the data and are liaising with NJR to determine the reason for revision in this cohort of patients. The shoulder service has adopted the mass clinic model and all complex cases are discussed in a dedicated multidisciplinary team and during the mass clinic multi-consultant meeting. We hope this approach will continue to support delivery of improved outcomes.

Royal College of Emergency Medicine (RCEM) mental health in emergency departments

The number of patients attending our emergency departments has increased over the years, and this audit examined those who have self-harmed and whether they received appropriate assessments in a timely manner. Charing Cross Hospital emergency department performed well (the report for St Mary's Hospital is under review). We were above average in our initial assessment times and risk assessments. We rated average for continuing mental health observations due to only having registered mental health nurse cover from 10:00 to 22:00. Since the audit, we have taken a number of actions to address these, and other issues we have identified including long waits in our emergency department for patients waiting for mental health beds in the community. We have worked to improve the facilities and resources within our emergency departments to manage patients with mental health issues and are delivering a plan to increase our employment, retention and training of registered mental health nurses. We now have in place better documentation forms on Cerner regarding physical health clearance and assessment of mental capacity. We are also supporting delivery of the system wide action plan to improve access for patients with mental health needs which will in turn reduce the time patients wait in our emergency departments.

Saving lives, improving mothers' care rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK

Key learning and recommendations to care and services for pregnant and postpartum women were identified from the first wave of the pandemic in this report. Our Trust was compliant with all the relevant recommendations in the report, including having a pathway in place with a decision tree for assessment and monitoring of pregnant women with Covid-19, taking into account the risk factor for severe disease. The report advises that face-to-face treatment may be preferable when the patient has complex needs and therefore, we perform a risk assessment for each patient to ascertain whether they are suitable for remote consultation. We also have a missed appointments pathway to help ensure that women understand the importance of attendance.

National Vascular Registry (NVR) 2021 annual report

NVR measures the quality of care outcomes for adult patients who undergo major vascular procedures. From April 2021, Imperial College Healthcare NHS Trust became the regional unit for all aortic cases, taking on work from London North West University Healthcare NHS Trust. In line with the report's recommendations, we have access to a hybrid theatre and 24/7 endovascular aneurysm repair for ruptured aneurysms. Sixty per cent of inpatients with chronic limb-threatening ischemia are meeting the target of receiving revascularisation within five days of admission (as compared to a national average of 58 per cent). The Trust's amputation care pathway has now been implemented and is delivering improvements in pathways and care for this patient group.

National diabetes audit (NDA) 2019, Type 1 Diabetes Report

The national diabetes audit measures diabetes care in England and Wales against NICE guidelines and quality standards. This is the first report from NDA specific to patients with type 1 diabetes. The Trust meets two out of the three recommendations including contributing to future national diabetes audits and insulin pump treatment being in line with NICE guidelines, however we do not fully meet the third recommendation (provision of, and access to, expert diet and lifestyle guidance and support for people with type 1 diabetes, though associated obesity is on a par with the rest of the population), due to difficulties in recruiting to a long-term specialist diabetes dietitian vacancy. The team are working to make the vacant role more attractive and will continue to try to recruit. In the meantime, the diabetic specialist nurses in the service are providing dietary support and glucose monitoring.

National Early Inflammatory Arthritis Audit (NEIA)

NEIA audit aims to improve the quality of care for people living with inflammatory arthritis. Data collection analysed in the report includes all patients over the age of 16 in specialist rheumatology departments. The identified issues related to low levels of submission to the audit, and to poor compliance with standards around referral to appointment times and follow-ups. This audit covers the period May 2019 to May 2020 and therefore includes the first wave of Covid-19. Prior to this period, we had made good progress on the EIA pathway, introducing a dedicated clinic, bringing time to first appointment down from a median of 100 days to 15 days, and introducing a nurse-led EIA intensive treatment titration pathway. However, issues related to staffing and capacity have resulted in a decline in our performance with the standards of this audit. We expect our performance to improve as the staffing issues have now been addressed, with gaps in the consultant and administration team being recruited to, two locum consultants joining in March 2022 and a new band 4 nurse associate role who will support patient enrolment to the audit.

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. Throughout 2021/22, this was primarily focused on audits which supported our pandemic response. See some examples in the table below.

Audit title	Audit findings
Assessing reasons for patient bed moves during the Covid-19 pandemic	This snapshot audit reviewed bed moves for patients who tested positive for Covid-19 to determine whether these moves were essential or non-essential. The audit found that the majority of Covid-19-positive patient transfers during the second wave of the pandemic were clinical transfers, and therefore essential. Additionally, all patients that were transferred had the reasons for their transfer documented, in line with Trust policy.
Monitoring of inpatient compliance with wearing face masks during the Covid-19 pandemic	This audit formed part of the infection prevention and control board assurance framework action plan. It assessed inpatient compliance with wearing face masks (if clinically acceptable to do so), particularly when patients were moving around the wards. The audit demonstrated that there was no assurance at the time of the audit that patients were routinely wearing masks on the ward. Much recent improvement work has taken place in this area, with clinical staff and infection prevention and control reminding patients during their hospital admission that mask-wearing is Trust policy and providing encouragement and support with compliance.
Steroid prescribing (dexamethasone) in Covid-19 patients attending A&E at St Mary's Hospital	Patients who are Covid-19 positive should be prescribed with a corticosteroid on attendance in an emergency department, as evidence shows that corticosteroids mitigate hyper inflammation and acute respiratory distress syndrome in Covid-19 patients. This audit found that most patients who attended St Mary's Hospital's emergency department were prescribed dexamethasone but it identified variable compliance amongst medical staff with these guidelines and identified reasons/limitations for non-compliance. We now review monthly data for ongoing assurance to determine whether dexamethasone is being considered for all eligible patients, in accordance with Trust guidelines.

Some examples of relevant local audits which have been used to inform our safety improvement programme include:

Audit title	Audit findings
Audit of digital consent form 4	In April 2021, Concentric (digital consent platform) went live in pilot form, with the digital consent group leading the roll out for elective procedures in 19 specialties. The audit evaluated the completeness of consent form 4 (this is used in situations where treatment is being considered for an adult who does not have capacity to consent to the treatment themselves) on Concentric and to assess whether the appropriateness of use was in line with Trust policy. Additionally, it examined whether a mental capacity assessment was completed and a best interest assessment was documented in patient notes for those patients who were deemed to lack capacity prior to being consented for investigation or treatment. The audit showed substantial assurance that clinical staff who were completing consent form 4 on Concentric were doing so in line with Trust policy. However, the audit highlighted three key areas for improvement in the assessment of patients who are deemed to lack capacity: involvement of family and friends; documentation in support of the details of this discussion; and the requirement of a mental capacity and best interest assessment to be completed prior to patients being consented for investigation or treatment. Delivering improvement in these areas is a key part of our safety improvement programme for 2022/23.
Consultant ward round audits	Trust priority audits were completed in neurology, orthopaedics, elderly medicine, cancer and antenatal wards during 2021/22. The Trust has substantial assurance that ward rounds had taken place on each day of inpatient stays, but this dropped to acceptable assurance for documentation that a consultant was present. There was also limited assurance that inpatients had been seen by a consultant within 14 hours of emergency admission. The improvement team are now working on board rounds as a focused improvement. Observations of board rounds on all wards were conducted in November and December 2021, which reinforced many of the themes identified in the board round audit conducted by the discharge team in July 2021. These showed inconsistency across several areas, such as multidisciplinary presence (including consultant leadership) and documentation of key information in the patient record. A number of improvement measures are currently being implemented, including guidance for effective board rounds and a new power form in our electronic patient record to allow measurement of whether board rounds have taken place and to enable better documentation of board rounds by clinical teams. The improvement team conducted coaching for board round improvement on six wards during February and March 2022 and the number of wards will be increased during 2022/23. Several wards have demonstrated improvements in the recording of key information in the patient record, number of discharges before noon and use of the discharge lounge.

In addition to the Trust-wide audit work described in the previous pages, specialties within directorates conduct local audit activities which provide information on how their services are performing. Throughout 2021/22 there were 298 local audits registered in the Trust. These reports, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

The Ockenden report

This year we have continued to implement our action plan in response to the findings of the Ockenden report (emerging findings and recommendations from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust) published in December 2020.

In the summer of 2017, following a letter from bereaved families raising concerns where babies and mothers died or potentially suffered significant harm while receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

We conducted an initial self-assessment and subsequently were asked to provide evidence to NHS England to demonstrate compliance with the immediate and essential actions. The Trust was informed we achieved 100 per cent compliance with the evidence requirements. This is an excellent result and is a testament to the hard work of our teams. We completed audits as part of this process and have since compiled an action plan to address areas which required further developments to improve performance. Ongoing assessments are in place and will be monitored through the divisional governance pathway.

The final Ockenden report was published on 30 March 2022. We are currently reviewing our response to this and identifying any additional actions we need to take.

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 Translational Research Centre (PSTRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). Our CRF has recently been awarded funding for a further five years from 2022 onwards, and we are awaiting the outcome of applications for other infrastructure awards.

The BRC focuses on experimental medicine – early phase discovery science trialled in the clinic for the first time. BRC highlights from the past year include a deeper understanding of how certain cells malfunction in lupus (a life-long autoimmune disease that disproportionately affects young women from ethnic minority communities), how participation in elite adult rugby may be associated with changes in brain structure, and how the identification of certain bacteria in pregnant women is associated with an increased risk of preterm birth.

As well as new drugs, devices and diagnostics, the BRC is funding the development of new research programmes to utilise health data for patient benefit in a safe and secure manner, and to take advantage of new tools based on artificial intelligence (AI) technology to assist in clinical decision-making. For example, we have been using AI to predict Covid-19 patients' pathways through intensive care.

Currently there are some sectors of our population who are underrepresented or underserved in terms of their involvement and inclusion in clinical research. We are therefore focusing intently on initiatives which will 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.

Covid-19 has had a very significant impact on the portfolio of research we have undertaken over the past year, as well as on the way this research is delivered. The Trust's response to the pandemic continues to be of national and international relevance – the REACT study continues to inform policy, and other trials are providing deeper insights into the fundamental mechanisms of the disease and its effect on the respiratory, cardiovascular and neurological systems – crucial to identifying effective new therapies.

We continue to work in close partnership with Imperial Health Charity to complement the research we undertake, particularly around training and development of staff. The Trust and Charity co-fund the academic career development of many 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 2020/21 that were recruited to participate in research approved by a research ethics committee was 14,029. 10,439 patients were recruited into 346 NIHR portfolio studies in 2021/22 – this includes 1,574 patients recruited into 16 Covid-19 urgent public health studies. 390 patients were recruited into 77 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. A proportion of the Trust's income is conditional on achieving goals through the framework. Although initially we agreed to implement ten CQUIN schemes for 2021/22, national guidance from NHS England stated that the 2021/22 CQUIN targets would remain suspended due to the Covid-19 pandemic. Trusts were therefore not required to gather or submit performance data for the period 1 April 2021 until 31 March 2022.

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 2021/22 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'.

Following the CQC's suspension of all its routine activity (including inspections) during 2020/21, it began to resume some routine work from April 2021, although no routine inspections of NHS trusts were carried out this year. The CQC continued to carry out urgent inspections for serious concerns, but the Trust was not subject to an urgent inspection. We participated in routine engagement meetings with the CQC this year (monthly by telephone and quarterly via Microsoft Teams), 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).

The Trust did not participate in any special reviews or investigations by the CQC this year, nor was it 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. Following suspension of some surveys during the pandemic, the outcomes of four surveys were published this year:

- 2020 urgent and emergency care survey, published September 2021
- 2020 adult inpatient survey, published October 2021
- 2020 children and young people's survey, published December 2021
- 2021 maternity survey, published February 2022.

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 2021/22, the Trust participated in the 2021 national cancer patient experience survey, 2021 adult inpatient survey, and 2022 maternity survey with outcomes expected to be published during 2022/23.

Our data

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

NHS number and general medical practice code validity

The Trust submitted records during 2021/22 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data. The percentage of records in the published data (current to February 2022), which included the patient's valid NHS number, was:

1 98.3 per cent for admitted patient care

2 99.4 per cent for outpatient care

3 96.5 per cent for accident and emergency care.

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

1 99.9 per cent for admitted patient care

2 99.9 per cent for outpatient care

3 100 per cent for accident and emergency care.

Data security and protection toolkit

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

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

Clinical coding quality

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

The Trust was not subject to any clinical coding audits by NHS commissioners in 2021/22.

Data quality

In 2021/22, the Trust continued to manage data quality via the Covid-19 elective care waiting list data quality and reporting framework, which was developed in response to Covid-19 impacting operational processes from March 2020. The performance support team continued to report data quality to the Trust executive on a bi-monthly basis to provide a comprehensive overview of data quality across the Trust and to update on performance across the current data quality metrics and internal audit of 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.

Throughout the last year, a number of key data quality issues have been identified as having a particular impact on referral to treatment (RTT) performance. In response to this, the performance support team have commenced an RTT data quality improvement task and finish group to provide specialist expertise on root cause investigation and to deliver recommended solutions.

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 which is regularly reported to the board. In line with national guidance our medical examiner (ME) service was fully operational prior to the 1 April 2020 deadline. Medical examiners independently review every death that occurs within the Trust to ensure that the cause of death is accurate and explained to the bereaved and that they are provided with the opportunity to raise any concerns about the quality of care or treatment that the deceased patient received.

Sadly, the Covid-19 pandemic led to an increase in the number of deaths across the Trust during pandemic peaks. With the medical examiner service review of clinical notes and, most importantly, a discussion with the bereaved for all deaths occurring in our hospitals, we have ensured that a) the proposed cause of death is accurate, b) there is appropriate and consistent referral to the coroner, c) the bereaved understand the cause of death and have an opportunity to raise any concerns, and d) cases are appropriately referred for structured judgement review (SJR) when the criteria are met.

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 the areas for learning and implementation of appropriate actions to address these.

Patient deaths: April 2021 – March 2022

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	359	475	524	441	1,799
Number of deaths referred for SJR – based on date of death	36	48	63	27	174

Deaths which occurred in 2021/22

Of the 1,799 deaths that occurred during 2021/22, all deaths were subject to ME review, and 174 were referred for structured judgement review. Of the 169 deaths which have had these reviews completed, there were 16 for which some issues were identified in the overall care delivered. The themes for these were: earlier discussion of ceiling of care; the timing of input from the palliative care team; and improved family communication. Where concerns were raised following the structured judgement review these cases were managed via our serious incident framework.

We have reintroduced a regular review meeting, chaired by the medical director to review any complex cases and triangulate all associated reviews and investigations. Recently, this meeting has been predominately used to review hospital-onset Covid-19 infection (HOCI) deaths, however, we are now re-starting review of other cases. Of the non-HOCI deaths reviewed, there was one in which care and service delivery issues were identified that may have contributed to a patient's death (confirmed as moderate harm) and another where it was confirmed that they did contribute to the death (extreme harm). In response to this, and another similar incident, a new safety improvement priority has been agreed for 2022/23 to improve the identification and management of adult patients with dysphagia.

The perinatal mortality review tool (PMRT) is used to review all cases of stillbirths, late fetal losses and neonatal deaths. Of the 19 reviews completed in 2021/22, there were no cases where care or service delivery issues were identified which may have changed the outcome.

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. 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 summer 2020, we implemented improvements to our learning from deaths process, appointing six consultants across different specialties as new reviewers who have dedicated time to undertake structured judgement reviews. This has reduced our average completion time from the date of referral from 30.2 days between April and September 2021 to 9.8 days between October 2021 and March 2022. This allows us to implement any learning and action required more responsively. This dedicated resource is also facilitating increased consistency and opportunity for consolidation of learning from both good practice and areas for improvement to be cascaded through the Trust, including via a quarterly newsletter which we introduced in February 2022.

Seven-day hospital services

From 2018, all NHS trusts have been required to report their activity and progress towards delivering high quality and consistent levels of service and care seven days a week. There are 10 defined standards for seven-day services, of which NHS England/Improvement (NHSE/I) classify four as key standards. Through our rolling audit programme we continue to be able to report substantial levels of assurance against the four priority standards, and full or partial compliance with all other standards.

Standard two – Early consultant review: While our policies, procedures and staffing models comply with this standard, our rolling audit programme has identified that timely consultant reviews are not always being clearly recorded. This year we have been focusing on improving the quality, documentation and timeliness of multidisciplinary ward and 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 future so we can identify any further areas for improvement.

Standard five – Access to diagnostic services: While we can report full compliance with this standard, we have identified some areas for improvement. Our imaging and diagnostic services are under considerable pressure due to large patient waiting lists as a result of the pandemic. New ways of working, including the potential to outsource routine reporting of some results, are being considered to address this issue.

Standard six – Access to interventions: We can 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 improvement is needed, the work described above is supporting areas to undertake ward and board rounds in a consistent, timely and high-quality manner. The workload in our acute respiratory units and our downstream acute medicine wards changed during the pandemic and currently they do not provide daily consultant-led review over the weekend. We are reviewing the acute medicine care model and our rotas/staffing to resolve this issue.

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

Rota gaps

We have 806 doctors in training working at the Trust, with 52 gaps on the rota. Thirty-two of these gaps have been filled by locally employed doctors. We have 20 unfilled posts, 13 of which are being recruited to. The remaining seven are going through the approval to recruit process. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan targeted campaigns for 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 in the following section, 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, 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 2021/22*			Trust performance				
	Mean	Lowest	Highest	2021/22	2020/21	2019/20	2018/19	2017/18
SHMI	100	71.93	118.6	76.78	77.02	70.24	73.21	74.13
Banding**	2	3	1	3	3	3	3	3
% deaths with palliative care coding	39.00%	11.00%	64.00%	58.00%	56.00%	58.10%	57.70%	56.70%

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

HSMR

	Trust performance				
	2021/22*	2020/21	2019/20	2018/19	2017/18
HSMR	68.9	75.9	67.6	64	67.37
National performance	Seventh lowest HSMR of all acute non-specialist providers	Third lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers	Second lowest HSMR of all acute non-specialist providers

*National and Trust data currently only available to December 2021
Source: Dr. Foster

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

- it is drawn from nationally reported data
- our mortality rates remain statistically significantly low
- 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 fifth lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (November 2020 through October 2021)
- we have the seventh lowest HSMR of all acute non-specialist providers across the last available year of data (November 2020 through December 2021).

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

- continuing to work to eliminate avoidable harm and improve outcomes
- reviewing every death which occurs in our Trust and implementing learning as a result, as described above in the 'learning from deaths' section
- undertaking an in-depth review of our mortality rates following our small regression in ranking for HSMR from third lowest in 2020/21 to seventh lowest based on the most recent data.

Our mortality rates remain statistically significantly low, and amongst the best in the country. Analysis has emphasised that our HSMR is improving, but not as quickly as some other providers, which is affecting our ranking. We are therefore reviewing our data to identify any additional areas for improvement.

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

	National performance*			Trust performance			
	Mean	Best	Worst	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. Currently provisional.

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

- we have a process in place to collect, collate and calculate this information monthly, which is then sent to NHS Digital.
- data is compared to peers, highest and lowest performers, and our own previous performance.
- we are performing above the mean for both hip and knee replacement surgery. We will continue to focus on improving our performance in these areas.
- elective surgery was disrupted during the pandemic and this may be reflected in insufficiently modelled records.

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*	2021/22**	2020/21	2019/20	2018/19	2017/18
28-day readmission rate (Patients aged 0-15)	9.87%	5.22%	4.80%	4.78%	4.88%	4.92%
28-day readmission rate (Patients aged 16+)	9.16%	6.33%	6.18%	7.45%	6.75%	6.92%

*National data only available up to August 2021

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.

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2021	2020	2019
Percentage of staff who would recommend the Trust to friends and family needing care	66.9%	89.5%	43.6%	74.3%	79%	75.8%

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2021	2020	2019
Percentage of staff who would recommend the Trust as a place to work	58.4%	77.6%	38.5%	64.5%	71.4%	67.5%

Another key measure in the NHS staff survey is the overall measure of engagement and morale. Overall engagement measures motivation, involvement and advocacy. In 2021, our overall score for engagement dropped from 7.2 to 7.0, though this trend held across all acute trusts. Our score therefore remains above the average score of 6.8 for all acute trusts. The same trend is seen in the overall score for morale, where our score dropped from 6.1 in 2020 to 5.8 in 2021. We remain above the average of 5.7 for acute trusts.

During 2021 our staff engagement focus was on supporting staff wellbeing in response to the pandemic. The Trust delivered a significant programme of work in response to the 2020 staff survey results which included three priority people programmes:

- Equality, diversity and inclusion: progress in delivering on our equality agenda has 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, commitment from six senior leaders to build a better, anti-racist workplace, 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, and the relaunch of our equality impact assessment process which helps us to consider the impact of our policies on all groups of people.
- Improvement through people management: a significant Trust-wide programme in response to the immediate manager theme of the staff survey including how we recruit, develop, and support our managers.
- Health, safety and wellbeing: this has included the expansion of our health and wellbeing services to include a permanently-funded expanded counselling service, staff physio services, long Covid clinics, a winter wellbeing plan including breakroom supplies, free food carts and Christmas vouchers for staff, completion of the first wave of 'rest nest' and staff room renovations, new physical activity offers, a new benefits portal, financial wellbeing support and guidance, and the launch of wellbeing champions.

We also continued to roll out of our values and behaviours programme, and work on conflict resolution and teamworking.

We are currently reviewing the 2021 staff survey results in detail and will determine the priority people programmes for 2022/23 based on these results.

Patient recommendation to friends and family

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

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

The key changes included the timing and frequency of FFT completion and the FFT question itself. Patients can now complete the FFT at any point in their patient journey and as many times as they want to. This is now referred to as the participation rate not the response rate; it does not measure the total number of patients who complete the survey but rather the number of surveys patients complete.

The core question changed to 'overall how was your experience of our services?' This new FFT score cannot be directly compared to the previous FFT 'likely to recommend' question, given the different wording of the question.

The new Trust scorecard reports one composite measure that incorporates the four FFT pathways (inpatient, outpatients, emergency department, and maternity services). Over the past year, the average overall rating of care score has been 88 percent, with the inpatient average at 96 percent and the emergency department at 80 per cent. These trends are comparable or better than the England national average.

The net sentiment score looks at all free text comments and identifies positive, negative and neutral comments from which a score is derived. Over the past year, this has averaged at 50 (on a scale from -100 to +100) indicating the Trust receives significantly more positive comments than negative.

A&E Friends and Family Test

The average participation rate over the past year has been eight per cent (over 1,300 responses per month). This is an improvement from 2020/21 (an average of 850 respondents per month), although still lower than our pre-Covid-19 response numbers.

Since the introduction of the new FFT question we have noted the England average for this new core question score averages at 80 percent per month. This is approximately five percent lower than the previous 'likely to recommend' FFT question. This national trend is mirrored in our data, though the Trust performs better or the same when compared to national England data.

It is difficult to know whether this is a 'real' reduction in patients' overall experience of care or whether it is due to the new wording of the question itself.

	National performance 2021/22			Trust performance				
	Mean	Best	Worst	2021/22**	2020/21*	2019/20	2018/19	2017/18
Score	81%	100%	56%	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:

- we have maintained consistently good standards of care in our emergency departments at a time of extreme and competing demands due to the ongoing impact of Covid-19 and extended 'winter pressures'. The Trust has worked to redevelop our urgent care pathways to ensure patients are nursed in appropriate environments based upon their Covid-19 status and risk.
- our staff are kind to our patients as evidenced through the feedback we receive.

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

- embedding the new FFT survey into practice
- continuing to work towards reinstating the services following the pandemic
- introducing patient liaison volunteers into the emergency department to support patients in accessing drinks and snacks in the department.

Inpatient Friends and Family Test

	National performance 2021/22			Trust performance				
	Mean	Best	Worst	2021/22**	2020/21*	2019/20	2018/19	2017/18
Score	94%	100%	69%	95%	N/A	97%	97%	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 throughout the Covid-19 pandemic, as evidenced by the overall rating of care
- our staff deliver consistently good care, even when they have been redeployed to areas in which they do not normally work. This is a positive reflection of strong local leadership and support throughout this exceptional year.

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

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

- building upon our deaf awareness work, as we launch a programme of deaf awareness and British Sign Language (BSL) training for staff
- reintroducing patient liaison volunteers into clinical areas
- reinstating visiting, as Covid-19 restrictions allow
- reviewing and relaunching the 'eat, drink, move and sleep' project to help improve patient experience on our wards.

Responsiveness to inpatients' personal needs

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

	National performance 2020/21*			Trust performance				
	Mean	Best	Worst	2020/21**	2019/20*	2018/19	2017/18	2016/17
Score	68.6	86.0	57.6	70.8	N/A	65.2	68.8	67.3

*There was no national inpatient survey published in 2019/20
**The most recent data is from the national survey which was published in 2021 for data from 2020

Our performance reflects that:

- this data is drawn from the nationally reported results of the national inpatient survey, which was published in October 2021 for data collected from patients who were discharged in November 2020
- 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 take action to improve patient experience as described above
- embedding a culture of continuous quality improvement on our wards through our refreshed ward accreditation programme (WAP+). The WAP+ combines data from three methodologies to provide a dashboard of performance: digital data automatically populated from the electronic patient record, an unannounced observational visit and an evidence portfolio designed to allow wards to showcase their performance in other areas, such as research culture and wellbeing initiatives. The accreditation report provides a basis from which ward managers can identify and track priority areas for improvement, with each ward matched with a coach to support local improvement work.

In addition to our ongoing work to improve patient experience, we are also continuing to focus on improving our services for our most vulnerable patients. This includes:

- our safeguarding service, which provides expert safeguarding advice and support to staff, patients and their families. During the year we appointed a domestic abuse nurse specialist in response to a rise in domestic abuse disclosures from patients. Following a fall in compliance during the pandemic, we implemented a change to our approach for Level 3 safeguarding training for staff working with children to make it easier to complete.
- we have a service level agreement with Central and North West London NHS Foundation Trust to oversee the application of the Mental Health Act. No breaches of the Act were reported during the year. The agreement also includes a training component and during the year a number of Mental Capacity Act (MCA) masterclasses were provided to staff, which were positively evaluated. We have added additional guidance, resources and training for our staff.

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 more than 95 per cent of all inpatients. Data is provided on a continuous basis via the Trust dashboard.

	National performance**			Trust performance				
	Mean	Best	Worst	2021/22*	2020/21	2019/20	2018/19	2017/18
Percentage of patients risk assessed for VTE	95.47%	100%	71.83%	96.4%	96.62%	95.90%	95.39%	93.87%

Source: Trust data – suspended reporting to NHS England/Improvement
*2021/22 data – provisional figures based on Trust data.
**National performance data not available for 2020/21 – figures reflect performance from 2019/20 national data.

Our performance reflects that:

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

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

- working with the areas that are below target to support staff to complete the assessment. However, we are satisfied from the review of patient level data that the three to four per cent of patients seemingly not assessed are not at high risk for VTE.
- reviewing our compliance with national guidance and are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of root cause analysis into VTE cases
- initiating audits to ensure compliance with the NICE quality statements and guidance relevant for VTE.

Clostridium difficile

	Trust performance					
	Mean*	**2021/22#**	**2020/21**	**2019/20****	**2018/19**	**2017/18**
Rate of Clostridium difficile per 100,000 bed days	31.2	27.6	16.5	28.6	14.3	17.6
Number of cases		71	59	101	51	63

*National performance figures are based on UK Health Security Agency (UKHSA) epidemiological data for the period April through January financial year 2021/22. The complete financial year 2021/22 data will be available in May 2022.
**Change to Public Health England C.*diff* definitions
Based on April through February financial year 2021/22 cases

Our performance reflects that:

- submissions to UKHSA's mandatory infection portal are carried out monthly and signed off by the chief executive's office.
- incidence and rate of C.difficile infection are monitored regularly through a weekly meeting with assurance provided through quarterly Trust infection control committee meetings.
- in 2021/22, we reported 71 cases of C. difficile attributed to the Trust. This is below our target of no more than 99 cases. Two of these cases were related to lapses in care, the same number as last year.

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

- continuing to work on reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates 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**	**2021/22*****	**2020/21***	**2019/20**	**2018/19**	**2017/18**
Patient safety incident reporting rate per 1,000 bed days	58.4	118.7	27.2	54.9	52.1	Apr-Sep 19: 50.7 Oct 19 – March 20: 50.4	Apr-Sep 18: 50.4 Oct 18 – March 19: 45.8	Apr-Sep 17: 47.96 Oct 17 – March 18: 51.26

*Data is now released yearly, not every six months, so there will now only be one figure for the year as opposed to two.
**National performance data is as of 2020/21
*** 2021/22 data is provisional and is calculated from our Trust figures.

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
- Our incident reporting rate has improved year on year, however where previously we have been in the top quartile compared to other acute non-specialist trusts, we are now below the mean. This is based on the most recent national data available, which is for 2020/21. During this period, incident reporting rates increased across the country, although the number of incidents reported actually decreased. This reflects the impact of the pandemic with reduced activity affecting the bed day denominator. In 2020/21 our incident reporting rate was tenth highest out of 18 London trusts.

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

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

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

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

	National performance**			Trust performance				
	Mean	**Best**	**Worst**	**2021/22*****	**2020/21***	**2019/20**	**2018/19**	**2017/18**
Percentage of severe/ major harm incidents (# of incidents)	0.2%	0.00%	1.00%	0.13% (24)	0.12% (18)	Apr-Sep 19: 0.03% (2) Oct 19 – Mar 20: 0.04% (3)	Apr-Sep 18: 0.05% (4) Oct 18 – Mar 19: 0.04% (3)	Apr – Sep 17: 0.06% (5) Oct 17 – Mar 18: 0.12% (9)
Percentage of extreme harm/death incidents (# of incidents)	0.2%	0.00%	1.8%	0.04% (7)	0.06% (9)	Apr-Sep 19: 0.06% (5) Oct 19 – Mar 20: 0.06% (5)	Apr-Sep 18: 0.05% (4) Oct 18 – Mar 19: 0.01% (1)	Apr – Sep 17: 0.09% (7) Oct 17 – Mar 18: 0.05% (4)

*Since 2020/21 data has been released yearly, not every six months, so there will now only be one figure for the year as opposed to two.
**National performance data is as of 2020/21
*** 2021/22 data is provisional and is calculated from our Trust figures.

Our performance reflects that:

- we utilise nationally reported and verified data from the NRLS
- between April 2020 and March 2021 (most recent national data available), we reported 0.12 per cent severe/major harm incidents (18 incidents) compared to a national average of 0.2 per cent and 0.06 per cent extreme/death incidents (nine incidents) compared to a national average of 0.2 per cent.
- between April 2021 and March 2022, based on our provisional internal data, we reported 0.13 per cent severe/major harm incidents (24 incidents) and 0.04 per cent extreme/death incidents (seven incidents). Ten of these remain under investigation so the final harm level may change.
- we now report all falls with hip fractures as severe/major harm in line with national recommendations which has led to an increase in the percentage of these incidents.

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 2022/23 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 Improvement single oversight framework indicators

NHS Improvement uses several national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues. We report on most of these monthly to our Trust board through our performance scorecards.

Key performance indicators

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

		Performance		Quarterly trend			
		Annual	Target	Q1	Q2	Q3	Q4
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	68.7%	70.4%	71.2%	68.6%	5.1%
Diagnostics	Maximum six-week wait for diagnostic procedures	1%	26.1%	36.6%	30.3%	21.9%	14.3%
Cancer access initial treatments	Two-week wait	93%	85.1%	93.9%	92.9%	80.0%	73.4%
Cancer access initial treatments	Breast symptom two week wait	93%	66.3%	93.8%	95.9%	58.8%	16.8%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	70.8%	77.7%	76.8%	68.2%	60.3%
Cancer access initial treatments	% patients treated within 62 days from screening referral	90%	60.6%	76.1%	55.6%	55.5%	55%
Cancer access initial treatments	% patients treated within 62 days (upgrade standard)	85%	85.2%	87.7%	85.8%	82.5%	84.8%
Cancer access initial treatments	% patients treated within 31 days of decision to treat	96%	95.7%	97.6%	95.8%	95.0%	94.3%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91.5%	94.5%	90.8%	89.2%	91.4%
Cancer access subsequent treatments	Chemotherapy treatments within 31 days	98%	99.8%	100.0%	99.4%	100.0%	99.8%
Cancer access subsequent treatments	Radiotherapy treatments within 31 days	94%	97.2%	96.6%	96.8%	97.5%	97.9%
Infection control	C. difficile acquisitions	99	71	16	20	13	22

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

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

NHS North West London Collaboration of Clinical Commissioning Group (NW London CCG)

The NHS North West London Collaboration of Clinical Commissioning Group (NW London CCG) has welcomed the opportunity to respond to the Trust's Quality Account for the year 2021/22, which we received on 6th May 2022. We acknowledge the impact COVID-19 has had on the Trust and the progress made against the Trust priorities. We note the good work the Trust has made over the year to ensure the health and wellbeing of staff was critical to the delivery of safe care to patients.

We are delighted that the Trust is committed to developing and supporting safety improvement programmes which prioritise safety issues. We note that it will employ consistent measurement and improvement methods to monitor progress.

We have reviewed the progress made against the six priorities for 2021/22.

We are pleased with the progress that the Trust has made in incident reporting and that there has been an overall improvement, which is important for quality improvement developments and better outcomes for patients. This will certainly support the Trust in the transition to the Patient Safety Incident Response Framework (PSIRF). We note harm levels have remained low and look forward to hearing more on the progress that is being made in this area.

We acknowledge that further work is required to improve hand hygiene practice, safe use of Personal Protective Equipment (PPE) in clinical areas and reducing blood streams infections. We fully support the continuation of this priority for 2022/23.

We recognise that further work is required in documenting appropriate escalation plans for patients and the impact this will have on those who are on the end of life pathway. We support the continuation of this priority for 2022/23.

We look forward to hearing about the continued roll out of the electronic consent process and digital consent for all elective surgical procedures. We note the progress made and support the continuation of this priority for 2022/23.

We note the good work around "Helping Our Teams Transforms" to improve performance and outcomes associated with invasive procedures and the continued work into 2022/23.

We acknowledge the work on patients falls and the Trust's ambition to reduce harm from falls by 25 per cent. We acknowledge that there is further work to be done and support the continuation of this priority for 2022/23.

We acknowledge the contributions and results from the Trust participation in the national audits and the successes in performance as well as areas identified. We note the Trust compliance against NHS England initial assessment on the Ockendon Report.

We recognise some patients lack mental capacity as highlighted in the account and the Trust has identified this as one of your focus areas, we look forward to seeing the progress made in this area of improvement.

The openness and transparency which has been articulated in this reporting year is notable, demonstrating a clear approach to learning from deaths. We also note appropriate dissemination of identified learning across the Trust.

The CCG fully supports the Trust in continuing with the six priorities from 2021/22 into 2022/23, in addition to the two new priorities. It is acknowledged that this Quality Account complies with national guidance and demonstrates areas where there has been achievement as well as areas where improvement is required.

On behalf of NHS NW London CCG, we look forward to continuing to work closely with the Trust over the coming year to further improve the quality of services to our patients.

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

Thank you for the chance to comment on your quality accounts, received 6 May 2022. On behalf of the London Borough of Hounslow's Overview and Scrutiny Committee, please find our response statement for inclusion in the Imperial College Healthcare NHS Trust Quality Account 2021-22 report.

The London Borough of Hounslow's Overview and Scrutiny Committee (the 'Committee') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust (the 'Trust') Quality Account 2021-22 which provides a report on progress made and identifies future priorities.

The Committee would like to thank the Trust and its staff for continuing to provide services through the Covid-19 pandemic and for preparing the Quality Account for comment.

Statement

Thank you for sharing your improvement priorities, for this and next year. We note the work done on the 2021/22 improvement priorities, and we are pleased to see 'Improve patient safety incident reporting rates' as the first priority as we noted last year the importance of keeping this under review. We note the positive change in numbers and hope to see this sustained. We note the other priorities for the year. In the future, it would also be useful to see the continued progress on last year's priorities.

We note the continued Covid-19 improvement work and appreciate the ongoing importance of this. However, we would want to reiterate the importance of mitigating the impact of Covid on wider health and progress on other priorities, as we had stressed last year.

We note the review of services and are happy to see the continued research activities of the trust. We also commend the focus on ensuring equal participation in clinical research. We note the continued work with the CQC and the work done on mortality rates. We also note the changes to the Friends and Family Test and hope to see trend data in the future when comparable numbers are available.

We commend that national benchmark data is provided on some measures, and would like to suggest that this should be done for all measures, including monitoring trends over time. The data could, however, be presented in a clearer way and we would like to reiterate what we noted last year: that a more succinct report and an executive summary would be helpful.

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

Healthwatch Hammersmith and Fulham Statement

Healthwatch Hammersmith and Fulham is pleased to be able to respond to the Imperial College Healthcare NHS Trust (ICT) Quality Account for 2021/22. We welcome the continued working relationship we have with the Trust and give our full support to its efforts to involve Healthwatch and wider patients in its work.

We note the progress and limitations on achievements for 2021/22 and further congratulate the Trust and staff for their hard work and dedication during another extremely challenging and demanding year dealing with the Covid-19 pandemic.

Placing particular importance on patient feedback and the patient voice, Healthwatch Hammersmith and Fulham is exceptionally pleased to note the following achievements of the Trust against their 2021/22 improvement priorities and other focus areas:

- Increase in initiatives and opportunities for underrepresented communities to join clinical studies and collect better demographic data that is reflective and of current patients and service users.
- Achieved over 10,000 pieces of patient feedback from the Friends and Family Test. Our patient experience data generally corroborates the largely positive feedback received by the Trust from the FFT and Trust scorecards.
- Establishment of the Equality, diversity, and inclusion programmes for staff. Including the introduction of 19 BAME ambassadors to provide a safe and supportive space for BAME staff, the Calibre Leadership Programme and team-based race equity training for managers. All of which will ultimately impact better representation, understanding and care that patients receive.
- The unprecedented developments and changes that took place, to promote and improve safety and quality as part of the Covid-19 pandemic response and commitment to caring for patients and staff members. Patients have commented on the high standards of hygiene and covid-19 safety procedures.

In addition, we note and understand the rationale for the Quality Priorities chosen for 2022/23 and offer our ongoing support to the Trust to help make progress in these areas.

During 2021/22 Healthwatch Hammersmith and Fulham gathered 477 patient experience comments, 64% positive, 22% negative, 14% neutral in sentiment.

Overall the Trust scored an average star rating of 4 out of 5.

Our findings show that service users in our sample experienced a very high level of satisfaction with the quality of treatment and care and the staff involved in this delivery with an average star rating of 4.5*.

Patient experience data regarding access to services and aspects of the administrative function indicated a lower level of satisfaction, principally in relation to waiting times and the booking/availability of appointments. These issues have likely been exacerbated by the increased pressures on resources as result of the Covid-19 pandemic.

However, given the low levels of feedback on ICT healthcare services overall, we would welcome some strong partnership work with the Trust to support and develop Healthwatch opportunities for obtaining independent feedback on services. We look forward to developing these discussions and a more concerted approach to partnership work in 2022/23.

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

Healthwatch Central West London (CWL) Response to The Imperial College Healthcare (ICH) NHS Trust Quality Accounts 2021/22

We welcome the opportunity to comment on the Imperial College Healthcare NHS Trust Quality Accounts (QA), and to comment on the quality of the services commissioned locally to meet the health needs of Westminster and Kensington and Chelsea residents.

Our members acknowledge the challenges that the Trust had to deal with during the Covid-19 pandemic: caring for patients with Covid-19, dealing with a greater than usual demand on emergency departments and delayed planned care. And alongside that, taking part in the biggest vaccination programme in the history of NHS.

We commend the Trust for its commitment to supporting its staff by strengthening the leadership and decision making, as well as, offering support with difficult conversations. We applaud the Trust for smoothly operating the dedicated helpline that provided information related to the rapidly evolving national and local Covid-19 guidance.

We commend the Trust for the high number of front-line staff (92%) vaccinated with first and second doses of the Covid-19 vaccine.

Our members welcome the Trust's focus on reducing hospital-associated Covid-19 infections and transmissions, and recognise huge challenges in the early identification, isolation, and treatment of patients with Covid-19, alongside non-Covid patients.

We acknowledge that engaging with patients during the Covid-19 pandemic was difficult and we are pleased to know that in the next year, the Trust will focus its efforts on implementing patients' participation strategy.

Comments on Quality Accounts (QA) 2021/2022

QA Presentation & Layout

Overall accessibility of QA

Our members commend the Trust for the clear narrative of the report as well as the lack of acronyms which makes it easier for a lay members to understand it.

Our members welcome a detailed account of Covid-19 quality improvement activities, service reviews and national audit data.

We suggest that the analysis of complaints and lessons learned, would be a welcome addition to the Quality Account.

As the trust operates from various locations, our members would have liked to see a more detailed account of each location, cross-referencing the data might help to make the document more relevant for the reader.

Use of graphs and tables

Our members welcome the use of tables to present key information across the QA.

Quotes

Our members would like to encourage the Trust's use of quotes to represent qualitative data, especially when talking about patient feedback and the Friends and Family Test.

Patient Engagement

Friends and Family Test (FFT)

We noted that the FFT has been changed to: 'overall how was your experience of our services?' and welcome this change. There also were changes to how this survey is collected, allowing for it to be completed at any point of a patient journey.

We commend the Trust on relatively high positive scores which range from 80% for the emergency department to 96% for the inpatient department.

However, we do not know what the response rate is, nor do we know the Hospitals it corresponds to. It would be useful to break this down by the Hospital and the department or service area.

Our members would encourage the Trust to carry out further engagement with patients, families, and carers to explore how services could be improved, and we would suggest focusing on the low scoring areas and using focus groups, workshops or consultations to listen to people views.

We would encourage the Trust to use quotes to illustrate qualitative data of FFT.

Our members noted that the staff survey FFT results were low – only 74% of staff would be happy to recommend ICH as a place of treatment, and even lower – 65%, would recommend the Trust as a place of work. It would be useful to understand what reasons were given by staff and what steps the Trust will take to further explore how to improve staff satisfaction.

Other patient engagement initiatives

We commend the Trust for undertaking a variety of initiatives to improve health outcomes for their patients. However, more detail is needed to understand how patients will be involved in decision making and improvement planning. For example, it is not clear if the End of life care steering group includes a lay member or a patient representative.

Our members would have liked to see how the Trust will follow up on a recent audit which highlighted the need to involve patients, families and carers in the improvement of electronic consent for patients who lack the capacity to consent themselves.

Our members have noted that there were missed opportunities to engage with patients in every key priority area and there is no detail about who are your community partners.

Our members commend the decision to introduce volunteers specifically, the patient liaison volunteers into the emergency departments to support patients in accessing drinks and snacks.

Targets

Our members commend the Trust for prioritising fall prevention and aiming for an ambitious target to reduce falls with harm by 25%. Our members would have liked to have more detailed actions on how the Trust will achieve this target. We would encourage the Trust to engage with patients and carers in conversations about what would help them to feel safer and reduce the risks of falls.

We commend the Trust for putting emphasis on staff training. Our members would like to know how training packages are evaluated against participants' satisfaction and effectiveness.

Our members noted that the results in incident reporting are encouraging, and harm levels are virtually half the national average. This demonstrates the culture of trust and transparency and is the key element in encouraging staff and managers to strive for improvement.

Conclusion

We welcome the decision to relaunch patient involvement and patients' safety strategy.

We commend the Trust for taking part in innovative research with the National Institute of Health Research which will allow our residents to benefit from cutting-edge treatments.

To improve decision making, we encourage the Trust to introduce the roles of patient representatives and to think about how these are recruited.

Healthwatch CWL and our members would like to congratulate the Imperial College Healthcare NHS Trust for such a comprehensive document which informs all levels of interest in knowledge and enquiries.

We look forward to continuing work with the Imperial College Healthcare NHS Trust in improving the care and support of patients.

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.

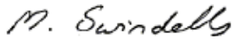
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality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

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

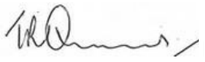
- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the quality report is not inconsistent with internal and external sources of information including:
  1. board minutes and papers for the period April 2021 to May 2022
  2. papers relating to quality reported to the board over the period April 2021 to May 2022
  3. feedback from clinical commissioning groups
  4. the annual governance statement May 2022
  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 2021
  8. the head of internal audit's annual opinion of the Trust's control environment May 2022
  9. Mortality rates provided by external agencies (NHS Digital and Dr. Foster).
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our audit, risk and governance committee held in May 2022, where the authority of signing the final quality accounts document was delegated to the chief executive and chair.

By order of the board



Matthew Swindells, Chair, 12 July 2022



Professor Tim Orchard, Chief executive officer, 12 July 2022

Annex 3: Participation in national clinical audits and confidential enquiries 2021/22

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
Case Mix Programme	Intensive Care National Audit and Research Centre	√	Ongoing data collection
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	100%
Chronic Kidney Disease Registry	The Renal Association/The UK Renal Registry	√	Ongoing data collection
Elective Surgery (National PROMS)	NHS Digital	√	Ongoing data collection
Emergency Medicine QIPs	Royal College of Emergency Medicine	√	Ongoing data collection
Falls and Fragility Fracture Audit Programme	Royal College of Physicians	√	Ongoing data collection
Inflammatory Bowel Disease Audit	IBD Registry	√	Four records submitted
Learning Disabilities Mortality Review Programme	NHS England	√	100% submitted to NHSE/I audit of learning disability standards
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative	√	Ongoing data collection
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	100%
National Adult Diabetes Audit	NHS Digital	√	Ongoing data collection
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Royal College of Physicians	√	Ongoing data collection
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	√	N/A – Data not collected directly from hospitals
National Audit of Cardiac Rehabilitation	University of York	√	Ongoing data collection
National Audit of Care at the End of Life	NHS Benchmarking Network	√	100% – Ongoing data collection
National Audit of Dementia	Royal College of Psychiatrists	√	N/A – no nationally mandated data collection
National Audit of Pulmonary Hypertension	NHS Digital	√	Ongoing data collection. Data not reported yet due to pandemic
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health	√	Ongoing data collection
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	√	100% – Ongoing data collection.
National Cardiac Audit Programme	Barts Health NHS Trust	√	Ongoing data collection
National Child Mortality Database	University of Bristol	√	N/A – Data does not come directly from hospitals
National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	√	100% – ongoing data collection
National Early Inflammatory Arthritis Audit	British Society of Rheumatology	√	Ongoing data collection. 11 cases submitted, no ascertainment available
National Emergency Laparotomy Audit	Royal College of Anaesthetists	√	100% Charing Cross Hospital, 12.5% St Mary's Hospital – ongoing data collection, not final
National Gastro-intestinal Cancer Programme	NHS Digital	√	90% – ongoing data collection
National Joint Registry	Healthcare Quality Improvement Partnership	√	Ongoing data collection
National Lung Cancer Audit	Royal College of Physicians	√	Ongoing data collection. 161 surgical resections
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	√	Ongoing data collection
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	√	100% – ongoing data collection
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	√	Ongoing data collection
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	√	Ongoing data collection
National Prostate Cancer Audit	Royal College of Surgeons	√	Ongoing data collection
National Vascular Registry	Royal College of Surgeons	√	Ongoing data collection. 478 total cases
Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	√	N/A – data collected from HES data
Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	√	N/A – data not collected from hospitals
Paediatric Intensive Care Audit	University of Leeds / University of Leicester	√	Ongoing data collection
Respiratory Audits	British Thoracic Society	√	100% (Smoking Cessation). Pulmonary Embolism – not participated
Sentinel Stroke National Audit Programme	King's College London	√	90% – Ongoing data collection
Serious Hazards of Transfusion	Serious Hazards of Transfusion	√	Ongoing data collection. 38 total reports
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	X	Non participation
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	√	Ongoing data collection. 20 total cases
Trauma Audit and Research Network	The Trauma Audit and Research Network	√	91% – data collection ongoing
Urology Audits	British Association of Urological Surgeons	X	Non participation

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 Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board at 31 March 2022 consisted of the 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 two additional non-voting non-executive directors who provide additional expertise to the board. Both participated in the NHS England and Improvement NExT Director programme, which gives participants experience of the role and responsibilities of being a non-executive director.

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

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

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

The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for executive directors, by the chief executive; for non-executive directors and the chief executive by the chair; and for the chair usually via a process managed by NHS England and Improvement. For 2021/22, the chair role was fulfilled by one of the non-executive directors acting as chair.

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.

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

- Bob Alexander became acting chair on 1 April 2021, following Paula Vennell's departure on 31 March 2021. Bob was previously a non-executive director of the Trust.
- Claire Hook became chief operating officer on 1 July 2021.

The Trust board at 31 March 2022 was as follows:

Bob Alexander	Acting Trust chair
Professor Andrew Bush	Non-executive director
Dr Andreas Raffel	Non-executive director

Peter Goldsbrough	Non-executive director
Kay Boycott	Non-executive director
Nick Ross	Non-executive director
Sim Scavazza	Non-executive director
Dr Ben Maruthappu	Associate non-executive director (non-voting)
Rev. Beverley Ejimofo	Associate non-executive director (non-voting)
Professor Tim Orchard	Chief executive officer
Professor Julian Redhead	Medical director
Professor Janice Sigsworth	Chief nurse
Jasbir Kaur (Jazz) Thind	Chief financial officer
Claire Hook	Chief operating officer

Governance 'lite' during Covid-19 pandemic

From December 2021 to January 2022 in response to the Covid-19 pandemic surge period, the Trust implemented governance 'lite' arrangements to allow the Trust to focus on operational and system pressures. This meant pausing all non-critical meetings, including Trust board and board committees and, if held, these were held virtually to discuss pressing matters and those that required decisions. Two such meetings were held during the reporting period. Governance 'lite' arrangements were eased between the Covid-19 surge periods with normal business meeting agendas resuming in virtual mode.

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

Attendance at Trust board meetings: 1 April 2021 – 31 March 2022

The Trust board met six times in regular session; five board seminars were held during the reporting period. Attendance at the Trust board and attendance at the board committees is described below:

Trust board member	Attendance (actual/possible)
Non-executive directors	
Bob Alexander, Trust chair (from 1 April 2021)	6/6
Professor Andrew Bush, non-executive director	4/6
Peter Goldsbrough, non-executive director	4/6
Dr Andreas Raffel, non-executive director	6/6
Kay Boycott, non-executive director	6/6
Sim Scavazza, non-executive director	6/6
Nick Ross, non-executive director	6/6
Dr Ben Maruthappu, associate non-executive director (non-voting member)	6/6
Rev. Beverley Ejimofo, associate non-executive director (non-voting member) (from 1 October 2021)	6/6
Executive directors	
Professor Tim Orchard, chief executive officer	6/6
Professor Julian Redhead, medical director	6/6
Jazz Thind, chief financial officer	6/6
Professor Janice Sigsworth, chief nurse	6/6
Claire Hook, chief operating officer (from 1 July 2021)	6/6

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

Audit, risk and governance committee

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

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

The committee met four times in regular session during the reporting period, and also held two 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)	6/6
Professor Andrew Bush, non-executive director	3/6
Dr Andreas Raffel, non-executive director	3/6
Sim Scavazza, non-executive director	4/6
Jazz Thind, chief financial officer	6/6
Professor Julian Redhead, medical director	5/6
Professor Janice Sigsworth, chief nurse	6/6

The chief executive and acting chair are also regular attendees.

Deloitte LLP acted as the Trust's external auditors in 2021/22, having been appointed in April 2017 for an initial three-year period that was extended. PricewaterhouseCoopers LLP (PwC) continued as the Trust's internal auditors, having been appointed for an initial period of three years from April 2018.

Outlined below is a summary of the key business conducted by the committee during 2021/22, in accordance with its terms of reference.

- 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:

• use of HealthRoster • Covid-19 reset and recovery • data quality • management of SARs • capital development • key financial systems • estates and facilities; hotel services • cost improvement programme	• contract management follow up • data reporting • 'well-led' toolkit for clinical directorates • baselining the Green Plan • discharges into mental health • planned maintenance of estates • workforce recruitment and retention • patient and public engagement.

The committee also 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.
- During 2021/22 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. During 2021/22, these included health and safety, redevelopment and ICT.
- The corporate risk register is also reviewed regularly, together with themes from key divisional risk registers and the key divisional risks profile. These give the committee visibility of the overall Trust risk exposure and how effectively risks are managed at the Trust.
- The committee 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 ICT disaster recovery and regularly received the Trust cyber security dashboard.
- The committee received a report on the risks associated with the EU exit, following assurance discussions during 2020/21 on the preparations that the Trust were making alongside NHSE/I and the Department of Health and Social Care to plan for EU exit.
- The committee received an update on contract management in relation to management actions following an internal audit completed in September 2020, with findings and actions agreed in January 2021.
- 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 2021/22 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 the performance of external audit, internal audit and counter fraud services and approved an extension to Deloitte's appointment as external auditors and awarded the contract for the provision of internal audit and counter fraud services for the next three years to KPMG.

- The committee also reviewed its terms of reference and discussed its annual review of effectiveness self-assessment for 2020/21.

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
Kay Boycott, non-executive director	4/5
Dr Ben Maruthappu, associate non-executive director (member until November 2021)	1/3
Bob Alexander, acting Trust chair (interim member from November 2021)	2/2
Sim Scavazza, non-executive director	5/5
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 committee during 2021/22, in accordance with its terms of reference.

- The committee discussed the risk and assurance deep dives into: failure of estates critical equipment and facilities that prejudices Trust operations and increases clinical and safety risks; national patient safety strategy; intensive treatment unit; outpatients transformation; and waiting lists.
- The committee received the annual complaints and PALS report which was also the subject of a deep dive.
- 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 St Mary's Hospital strategic outline case, strategic business case and quality account.
- The committee received oral updates on key divisional risks until November 2021; since then 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. A final response was received from NHS England following the Ockenden evidence submission which confirmed 100 per cent compliance.
- On a quarterly basis the committee received the learning from deaths report, research report and North West London Pathology report.

- 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; end of life report and cost improvement plans quality impact assessment.
- Other reports received by the committee were: serious and incident monitoring report; water management issues; learning and improvement and innovation report; transformation update; ward accreditation programme; and update on medical devices strategy.
- The committee also reviewed its terms of reference and discussed its annual report and review of effectiveness self-assessment for 2020/21.

Finance, investment and operations committee

The committee is responsible for receiving assurance that the Trust achieves financial performance targets set by the Trust board and also for ensuring the Trust's investment decisions support achievement of its strategic objectives. We also focus our operations and transformation activities as we have on finance; to monitor progress, add support and understand risks and opportunities in these areas which are important in achieving our strategic goals.

The committee met six times during the reporting period:

Finance, investment and operations committee member	Attendance (actual/possible)
Dr Andreas Raffel, non-executive director (committee chair)	5/6
Peter Goldsbrough, non-executive director	5/6
Dr Ben Maruthappu, associate non-executive director	5/6
Professor Tim Orchard, chief executive officer	5/6
Jazz Thind, chief financial officer	6/6
Claire Hook, chief operating officer (from 1 July 2021)	4/5

The chair also attends on a regular basis.

Outlined below is a summary of the key business conducted by the committee during 2021/22, in accordance with its terms of reference.

- The committee discussed the risk and assurance deep dives into: business planning and financial budget for 2021/22 (revenue plan and capital plan); debt; cost improvement plans; planning for the latter half of the financial year (H2)/business planning/winter plan; and business planning 2022/23.
- The committee reviewed and approved the following business cases and contracts: the St Mary's Hospital strategic outline case re-submission of the economic and finance case; procurement; St Mary's redevelopment business case for Paddington Square; North West London Pathology's molecular business case; replacement of one linear accelerator for radiotherapy business case; West London children's healthcare business case; facilities management contract extension; approach to the community diagnostic centres (CDCs) programme business case; and the hotel services food supply contract.
- The committee discussed the delivery of the operating plan and the winter plan 2021/22.
- The committee received regular finance reports; and particular financial reports such as intra-system financial framework; costing updates (national cost collection submission, patient-level information and costing systems); national cost collection update; revised capital budget; productivity and efficiency programme board update; payroll consolidation update; and redevelopment financials.
- The committee received regular reports on transformation update; North West London Pathology finance report; summary of business cases approved by the executive.
- Other reports received by the committee were: an updated annual review of the financial benefits of business cases approved by the executive; outsourced service contracts; Imperial Private Healthcare's international affiliate network report; Imperial Private Healthcare performance and strategy review; and managed maintenance post-project evaluation.
- The committee discussed and recommended approval by audit, risk and governance committee of the scheme of delegated financial authorities.
- The committee also reviewed its terms of reference and discussed its annual report and review of effectiveness self-assessment for 2020/21.

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	5/5
Peter Goldsbrough, non-executive director	4/5
Nick Ross, non-executive director	5/5
Sim Scavazza, non-executive director	5/5
Professor Tim Orchard, chief executive officer	5/5
Jazz Thind, chief financial officer	4/5
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 2021/22, in accordance with its terms of reference.

- Over 2021/22, the committee discussed the programme director's report on key activities which included updates on the St Mary's programme plan, strategic outline case re-submission, St Mary's site options, planning, Paddington Square, Charing Cross and Hammersmith redevelopment, J-block, communications, stakeholder engagement, life sciences, patients' pathways and population update, and finance update.
- The committee discussed the risk and assurance deep dive into contingency planning / estate management risks.
- The committee discussed and agreed the redevelopment governance framework; and agreed the appointment of the design team; and agreed the heads of terms for Project Juniper were agreed (J-block).
- The committee discussed designing and defining the care pathways that will deliver the Trust's vision for care.
- The committee discussed the Fleming Centre for Clinical Infection.

- Due to time constraints, the ReFit energy performance contract was agreed by the chair of the committee outside of the meeting and recorded at the next committee.
- Other reports and oral updates received by the committee were: contingency planning; Samaritan Hospital and Western Eye Hospital site; decarbonisation project and 'our green plan'.
- The committee also reviewed its terms of reference and discussed its annual report and review of effectiveness self-assessment for 2020/21.

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 once during the reporting period:

Remuneration and appointments committee member	Attendance (actual/possible)
Peter Goldsbrough, non-executive director (committee chair)	1/1
Bob Alexander, Trust chair (from 1 April 2021)	1/1
Nick Ross, non-executive director	1/1
Professor Tim Orchard, chief executive officer (attendee)	1/1
Kevin Croft, chief people officer (attendee)	1/1
Julian Redhead, medical director (attendee)	1/1

Outlined below is a summary of the key business conducted by the committee during 2021/22, 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 update 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 2020/21.

People committee

The committee monitors, reviews and provides assurance to the board on the cultural and organisational development of the Trust including 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)	4/5
Kay Boycott, non-executive director	5/5
Dr Ben Maruthappu, associate non-executive director	5/5
Rev. Beverley Ejimofo, associate non-executive director (from 1 October 2021)	5/5
Professor Tim Orchard, chief executive officer	5/5
Professor Julian Redhead, medical director	4/5
Professor Janice Sigsworth, chief nurse	4/5
Kevin Croft, chief people officer	5/5
Bob Alexander, acting Trust chair	1/1

Outlined below is a summary of the key business conducted by the committee during 2021/22, in accordance with its terms of reference:

- The committee discussed the risk and assurance deep dives into: risk of staff developing Covid-19 infection as a result of exposure at work and the subsequent impact on their health; risk of staff experiencing poor mental/psychological health as a result of the Covid-19 pandemic; failure to deliver appropriately skilled and competent nursing care in hard-to-recruit areas; people and organisation development risk appetite; and nursing and midwifery workforce.
- The committee regularly received an update on the people strategy and priority objectives which were agreed at the start of the establishment of the committee. The priority objectives were reviewed individually during the year, covering: improvement through people management; managing our values, behaviours and conflict resolution; equality, diversity and inclusion (work programme 2021/22); and assessing impact of race equality interventions.
- The committee had a focused session on equality, diversity and inclusion covering 'disability' as the topic which included a related staff story followed by insight from the I-CAN staff network chair and update on the Calibre Programme.
- The committee received a regular workforce performance report which was refined later in the year to bring into line with Imperial management and improvement system reporting.
- The committee regularly received the health and safety report which for the first half of the year predominately focused on the Covid-19 response from a health and safety perspective.
- 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 2020/21;
- The committee received the mid-year review on safe, sustainable and productive nursing and midwifery staffing.
- The committee agreed the proposal for the use of staff stories at board. Two stories were heard at the people committee and one at the Trust board.
- The committee reviewed the risk register for people and organisational development.
- Other reports received by the committee were: direction of travel for the Freedom to Speak Up report; and an update on staff networks.
- The people assurance report was developed towards the end of the year and the one report included 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 results. Current issues included an update on the vaccination as a condition of deployment (VCOD) and integrated care systems workforce update. 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.

Governance 'lite' committees

Two meetings were held during the Covid-19 surge period between December 2021 and February 2022. These replaced the committees that would usually have taken place during this period and included key business items over two committees chaired by the Trust chair and all board members invited.

Meeting 1: Quality and people committee governance 'lite' committee **Meeting 2: Audit, risk and governance; finance, investment and operations; and redevelopment committee governance 'lite' committee**	**Attendance (actual/possible)**
Bob Alexander, acting Trust chair	2/2
Kay Boycott, non-executive director	2/2
Dr Andreas Raffel, non-executive director	2/2
Sim Scavazza, non-executive director	2/2
Peter Goldsbrough, non-executive director	2/2
Professor Andrew Bush, non-executive director	1/2
Nick Ross, non-executive director	2/2
Dr Ben Maruthappu, associate non-executive director	2/2
Rev. Beverley Ejimofo, associate non-executive director	1/2
Professor Tim Orchard, chief executive officer	2/2
Professor Janice Sigsworth, chief nurse	2/2
Professor Julian Redhead, medical director	2/2
Jazz Thind, chief finance officer	1/2
Claire Hook, chief operating officer (from 1 July 2021)	2/2

- The quality and people governance 'lite' committee received an update on the operational situation report (sitrep) including Covid-19 and vaccine update, and received an assurance update on the ongoing care for patients on waiting lists.
- The committee received the quality performance report and reviewed the maternity quality assurance oversight report to receive the mandatory assurance setting out compliance against the clinical negligence scheme for trusts.
- The committee received the infection prevention and control board assurance framework for Covid-19 self-assessment which set out the mandatory assurance compliance against the elements of the infection prevention and control board assurance framework for Covid-19.
- The committee noted the update on workforce performance and plans in response to the current Covid-19 response/surge and update on vaccination as a condition of deployment (in full).
- The audit, risk and governance; finance, investment and operations; and redevelopment committee governance 'lite' committee received an update on the operational situation report including Covid-19 and vaccine update.
- The committee reviewed the approach to developing contingency plans and actions to mitigate the potential estate risks prior to completion of St Mary's Hospital redevelopment; and the committee noted the Western Eye Hospital update.
- The committee received an update on progress against the 2021/22 internal audit plan and an update on the procurement of the Trust's external audit service (including a summary of the current market conditions and the impact this had had on the process and final decision making).
- The committee received an update and recommendation for the preferred bidder for the Trust's internal audit service and received an update on the provision of the Trust's local counter fraud service
- The committee noted the update on risk management at the Trust, which provided an update on the corporate risk register and profile.
- The committee received the finance report update on the first nine months of 2021/22.
- The committee noted the update on business planning 2022/23.
- The committee received an update on the progress of the payroll consolidation project.

Hammersmith & Fulham integrated care partnership (ICP) board

The Hammersmith & Fulham integrated care partnership (ICP) board was formally established in 2018 and is made up of nine organisations, who signed up to a partnership alliance agreement to work towards an integrated care model. The purpose of the board is to agree shared objectives, work on joint challenges, and to support places and organisations that comprise the system in the interests of communities, with primary care networks at its heart and a clear link to the emerging north west London integrated care system (ICS). This included setting up a 'committees in common' and establishing governance mechanism to provide local strategic leadership and oversight of the integrated care partnership.

In addition to the formal board structure, two further meeting structures were established; namely the integrated care partnership executive leadership group and operational delivery group, and convene fortnightly to progress the partnership's priorities, and to facilitate closer system partnership working.

The Hammersmith & Fulham integrated care partnership board convened four times over the past year, in May, July and September 2021 and February 2022. The Trust has been represented at each board meeting by the integrated care divisional director, along with other colleagues:

Member	Attendance (actual/possible)
Anna Bokobza, integrated care programme director	4/4

The past year saw a number of significant changes to the Hammersmith & Fulham integrated care partnership leadership arrangements; and work programme, reflecting the continual impact of the pandemic on local communities and in line with the direction of travel of the north west London integrated care system. The integrated care partnership board co-chairing arrangements between the London Borough of Hammersmith & Fulham Council and Central London Community Health Care Trust, continues the renewed commitment to working together to improve the health and wellbeing of residents through the delivery of integrated care.

The integrated care partnership continued to support the Covid-19 vaccination and booster programme rolled out across north west London and to address hesitancy; one of its key priorities, vaccinating tens of thousands in the fight against Covid-19 and building on the early success of the campaign at the end of 2020/21. To address the health and wellbeing challenges in the borough, intensified by the pandemic and to build on the learning from increased collaborative working between health, social care and community and voluntary sector and lay partners during the last year. It continues to tackle health inequalities and placing the resident at the centre of care, delivering this through our joint north west London strategy and plan for digital inclusion and to improve quality of life, through a grassroots approach of engagement with residents and holding virtual workshops within primary care networks and with wider stakeholder groups across the system partnership. To have an understanding from a patient and resident perspective on integrated care, to inform renewed areas of focus, and to co-design and co-produce services with patients and neighbourhoods at the forefront.

Some of the key integrated care programme areas progressed over the past year include: Covid-19 vaccination and booster programme; developing the four integrated care partnership campaign areas, scope, aims and priorities; organisational development and engagement plan (development plan, 100-day plan, identity and co-production); population health management programme; dementia strategy; winter plans for 2021/22; better care fund plan; dashboard; strategic estates; suicide prevention needs assessment 2021-2024; integrated care system potential values and behaviours; and place development programme.

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 2021/22.

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 February 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 undertakes periodic self-assessments against the CQC well-led framework and has regular peer observers at board meetings to inform our development, as well as representatives from CQC joining 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 and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance and strategy.

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 officer
12 July 2022

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:

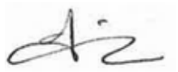
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgments and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and 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 officer
12 July 2022



Jazz Thind, Chief financial officer
12 July 2022

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 2021/22 follows the format required by NHS England and NHS Improvement.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure. 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 2022 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 takes collective responsibility for setting out the strategic direction of the Trust, including setting the risk appetite.

The Trust board 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 oversees 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/Improvement.

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) is the executive decision-making body in the Trust. It meets monthly to review progress against strategic objectives, setting and deploying strategy, managing performance, prioritising initiatives against organisational capacity, ensuring it supports the Trust's overall promise of 'Better health, for life', and aligns with our clinical and corporate strategies and the north west London sustainability and transformation plan. The EMB also acts as the Trust executive risk committee.
- The EMB provides assurance to the Trust board that 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 risk and assurance deep dives, provides a high-level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.
- The audit, risk and governance committee oversees and monitors 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.

The following have been identified as the significant risks facing the Trust through 2021/2022 and as it enters 2022/23;

Estates and redevelopment

The Trust's capital plan for 2022/23 is once again extremely challenging due to the level of backlog maintenance, ICT infrastructure, and medical equipment replacements required to mitigate Trust level risks. This is in addition to divisional capital projects which are essential for the 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 2022/23 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 2022/23 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 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.

St Mary's 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, ICT, equipment and minor works. In addition, the replacement of Linac and PET CT devices have been prioritised.

The £24 million strategic investment pot is dependent on the Trust receiving transformation funding from NHS England/Improvement for the Western Eye Hospital, cardiology and redevelopment which will then allow the Trust 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 Improvement 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 hospitals programme, which was announced in Autumn 2020. St Mary's, Charing Cross and Hammersmith hospitals were part of this announcement. The new hospitals 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 site."

The Trust is identifying the feasibility of delivering a new hospital within the context of a wider redevelopment and regeneration of the Paddington Basin area. The Trust re-submitted the strategic outline case to NHS England and the new hospitals programme in September

2021. The Trust expect this to be reviewed once the new hospitals programme has had their programme business case approved in summer 2022. Business cases will commence for Hammersmith and Charing Cross hospitals during 2022/23.

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 2021/22.

In response to the first wave of the Covid-19 pandemic, the CQC suspended most of its routine activities, including routine inspections, for most of 2021/22. Two routine CQC activities were intermittently undertaken with the Trust during 2021/22. The first was engagement meetings, of which five were held (April, June, September and November 2021 and March 2022), along with requests for incident reports as part of the CQC's mandate for learning from deaths, of which two requests were made (April 2021 and January 2022). Although the CQC continued to carry out urgent inspections and to use its temporary regulatory framework, the transitional regulatory approach (TRA) for virtual assessments, the Trust did not have any virtual assessments or urgent inspections during 2021/22.

The Trust has not participated in any special reviews or investigations by the CQC during the year. All trusts are captured in CQC patient surveys, these outcomes were published this year from surveys that ran in 2020/21 as set out below. All surveys carried out during 2021/22 capture peoples' experiences of care during the pandemic; given the Trust's positive performance in all surveys, there is reasonable assurance not only about services generally, but how services managed during Covid-19.

- The 2020 urgent and emergency care survey was published in September 2021.
  - Overall, Trust performance was comparable with tier 1 patient services (A&E departments, of which there are 126 in England).
  - For the majority of questions, the Trust's performance was positive (a score of 8/10 or greater). There were four areas where the Trust's performance was about the same as other trusts, but which could be improved:
    - information and arrangements for transport home
    - information on waiting times and delays
    - information about possible medication side effects
    - total length of time spent in the A&E during their visit.
- The 2020 adult inpatient survey was published in October 2021.
  - This survey captures the views of patients aged 16 years and older who spent at least one night in hospital; within the Trust this means patients within two clinical divisions: medicine and integrated care, and surgery, cancer and cardiovascular.
  - The Trust was not an outlier in any category, meaning it did not perform differently than expected.
  - Overall, compared to its performance in the previous survey in 2019 the Trust improved on all questions except for one, which related to long waits for admission.
  - There was no significantly worse performance relating to any question at any of the sites including (St Mary's, Charing Cross and Hammersmith hospitals), compared to site performance in the previous survey.
  - St Mary's, Charing Cross and Hammersmith hospitals performed about the same as each other for the majority of questions.
- The 2020 children's and young people survey was published in December 2021; this survey captures the views of both patients and their parents / carers.
  - Overall, the Trust performed about the same or better than other trusts.
  - Performance was better than other trusts in relation to:
    - choice of admission dates
    - overnight facilities for parents and carers
    - feeling listened to
    - parents and carers being able to accompany their child.
  - Performance was less favourable when compared to other trusts for two questions:
    - changing admission dates
    - access to hot drinks.
- The 2021 maternity survey was published in February 2022.
  - Overall, the Trust performed about the same or better than other trusts.
  - Performance was better than other trusts in relation to:
    - provision of information about labour induction prior to being induced
    - being involved in decisions to induce
    - skin to skin contact shortly after birth.
  - Performance was less favourable when compared to other trusts for taking account of women's personal circumstances when midwives provided advice.

Patient surveys continued to be undertaken on a modified schedule during 2021/22. The 2021 adult inpatient, 2021 maternity, and 2021 national cancer patient experience (NCPES) surveys are due for publication in 2022/23.

Integrated performance management

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

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

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

External oversight

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

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

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

The approach to system-based performance 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.

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. Due to the Covid-19 pandemic, most of these reviews were suspended in 2021/22, however the Trust did maintain internal controls to ensure efficiency and effectiveness, including executive approval of business cases which were reviewed by the finance, investment and operations committee for oversight at board level.

Data security and protection structure

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.

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

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.

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.

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 ICO 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.

Due to the continued impact of the Covid-19 pandemic, the submission period for the data security and protection toolkit for 2021/22 now runs from 1 July 2021 to 30 June 2022.

The Trust data security and protection toolkit return was subject to an independent audit provisioned by NHS Digital and operated by KPMG, which returned an overall rating of high assurance / substantial confidence, with eight areas of good practice highlighted and only one minor recommendation made. On this basis, the Trust can be assured that a robust plan is in place to deliver all 110 mandatory evidence items to support a "standards met" status for the data security and protection toolkit for 2021/22.

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 on 18 June 2021 for the purposes of the 2020/21 data security and protection toolkit return. There is a plan in place to achieve the annual mandatory training target for the 2021/22 data security and protection toolkit return by 30 June 2022.

Data security and protection incidents 2020/21

The Trust is mandated to report all incidents via the data security and protection toolkit. In cases where there is a risk to the rights and freedoms of data subjects the incident reporting tool will automatically notify the Information Commissioners Office and Department of Health and Social Care.

Due to the unprecedented impact of the Covid-19 pandemic the reporting term for 2020/21 was provided for the period of 1 April 2020 to 30 June 2021. However, in order to allow timely reporting of data security and protection toolkit incidents in line with the annual governance statement, the 2021/2022 incident reporting period has been captured for 1 July 2021 to 31 March 2022. Future case monitoring will cover the 12-month period between 1 April and 31 March for the respective years.

Table of data security and protection incidents 2021/22

Table 1: Incidents reported 1 July 2021 – 31 March 2022

Grade of incident	Number
Incident reported to the ICO and Department of Health	4
Trust level incident	35
Incidents under investigation yet to be classified	29
Total *+	68

*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.

+ Nine-month reporting window: As the case index for 2020/21 covered an extended 15-month period, the above reporting index covers only Q2-Q4 of the 2021/22 financial year. In order to return to financial year reporting, a new case index has been set up to record incidents for the period 1 April 2022 to 31 March 2023, and this reporting period will be maintained prospectively.

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. Thirteen separate process reviews have been initiated in the 2021/2022 period to manage these outputs.

Category of incident	Number
Email	19
Patient held record	9
Paperwork	8
Subject access request	6
Abuse of authorised access	5
Incorrect upload	4
Hacking	3
Postal	2
Counter fraud	1
Loss / theft	1

Incidents reported to the ICO and Department of Health (*Total = 4)

- upload of patient identifiable image to social media by bank employee
- police request – alleged fraud
- alleged unauthorised disclosure
- Potential national immunisation and vaccination system (NIVS) data breach involving Trust staff account

Details of each of these four incidents are provided below:

Summary of incident	Upload of patient identifiable image to social media by bank employee
Incident details	An agency nurse working within the Trust photographed and filmed Trust patient records whilst on shift and then uploaded these images to a personal Instagram account which was potentially visible to other users. The Trust commissioned a formal investigation. This case was assessed by the DPO and Caldicott Guardian and found to constitute a significant risk to the rights and freedoms of our patients.
Actions taken by the ICO	This case was forwarded to the ICO criminal investigations team. No further action has been taken by the ICO and the DPO has recorded this case as closed.

Summary of incident	Police request – alleged fraud
Incident details	The Trust's fraud response service alerted the DPO that they had received a disclosure request from the City of London Police seeking information related to an investigation into a Trust employee as part of potential fraudulent activity. The disclosure request form supplied stated that they had identified that a current employee of the Trust had leaked the personal data of patients to aid courier fraud. This is the subject of an ongoing police investigation and the Trust is seeking advice as to whether further investigations are required.
Actions taken by the ICO	As this incident is under police investigation, the ICO have indicated that they shall not run a parallel investigation and this matter is now closed in respect to the ICO.

Summary of incident	Alleged unauthorised disclosure
Incident details	A patient raised a complaint alleging that a Trust staff member disclosed information to a member of the employee's family.
Actions taken by the ICO	The ICO confirmed that no further action would be taken following the Trust's full investigation.

Summary of incident	Potential NIVS data breach involving Trust staff account
Incident details	The Trust were notified of a potential incident relating to suspicious activity on the NIVS. It has been identified that individual records have been updated to include vaccination records which have not been provided
Actions taken by the ICO	The ICO confirmed that no further action would be taken following the Trust's full investigation

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.

We continued to focus on data quality in 2021/22 through our waiting list data quality and reporting framework, which is led by our chief operating officer and reported regularly to the executive management board. The risk scoring for poor waiting list data quality, which is monitored via our corporate risk register, has varied over time and has increased during the pandemic and remains high due to operational pressures. The benefit of the waiting list data quality and reporting framework is that patients are highlighted to operational services who would otherwise be lost to follow up due to the data quality of those patient pathways.

A comprehensive number of indicators are available digitally to all staff to track data quality across a range of patient pathways and our clinical and operational teams are supported by a small central team of data quality experts who undertake audit and training. The long-term goal is to improve data quality at source – to ensure data recording is accurate, complete and timely and that our systems make that easy for our people.

An important component of the data quality framework is a quality assurance and 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. The Trust has experienced a deterioration in data quality across multiple waiting lists and operational processes during the pandemic. 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. In the interim the Covid-19 elective care waiting list data quality and reporting framework provides mitigation by highlighting key risk cohorts of patients via data quality metrics and sample audits.

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/who-we-are/our-board. The Trust board considers that all its non-executive directors are independent in character and judgment. 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 1,946 staff, 60 per cent, had been returned at the end of March 2022.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. Of these 125 staff, 77 per cent had declared at the end of March 2022.

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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.

Sustainability

The Trust has undertaken risk assessments and the Trust has a board approved green plan with a named director to lead on its implementation. The Trust ensures that its obligations under the Climate Change Act, the Delivering a Net Zero NHS and adaption reporting requirements will be complied with.

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 2015. The Trust participates in the annual EPRR assurance process carried out by NHS England and Improvement; 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our audit, risk and governance committee and quality committee held in May 2022, 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, which continued during the pandemic, have provided a range of levels of assurance, including one report rated as high risk relating to subject access request management. Audit reports have identified three high, 12 medium and 21 low risk findings. Following the audit reports, 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 have rated the framework as providing substantial assurance.
- The audit, risk and governance committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate.
- The 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.

To the best of my knowledge, no significant internal control issues have been identified within 2021/22.

Professor Tim Orchard, Chief executive officer
12 July 2022

Remuneration and staff report 2021/22

Remuneration report

Remuneration for the Trust's executive directors is determined by the remuneration committee of the board.

Remuneration consists mainly of salary, which is inclusive of high-cost area supplement, and pension benefits in the form of contributions to the NHS pension fund.

Annual salary increases are ordinarily in line with increases for the wider NHS workforce but may be higher where there is a significant change to an individual's responsibilities.

In order to attract high quality candidates to senior posts and to support retention we:

- make decisions in the context of the current market
- take into account independently sourced benchmark data and analysis of pay within relevant NHS, private health and non-healthcare markets
- compare pay with other staff on nationally agreed agenda for change and medical consultant terms and conditions.

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based. Salary levels 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 29 senior managers who are not executive directors. These salaries are set by the relevant executive director with approval from the director of people and organisation development.

Non-executive directors are normally appointed on fixed term contracts of between two and four years. Non-executive directors are not generally members of the pension scheme. Remuneration for non-executive directors is set by NHS Improvement based on a national framework.

The remuneration of all other members of staff is determined by national terms and conditions such as the agenda for change and medical consultant terms and conditions.

Pay multiples (subject to audit)

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The Trust is required to disclose the relationship between the remuneration of 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.

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	2021/22	2020/21	Change (%)
Total remuneration (£)	292,500	287,500	1.7%
Salary component of total remuneration (£)	272,500	272,500	Nil (See below)
Performance pay and bonuses component of total information	17,500	17,500	Nil (See below)

Please note that using the mid-point of the applicable £5k bands means that, while total remuneration has moved up by one increment, individual components have remained at the same value, i.e. different points within a band, but still the same band.

The following tables compare the banded remuneration of the highest paid director:

2021/22	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

2020/21	Median
Total remuneration (£)	41,633
Salary component of total remuneration (£)	41,633
Pay ratio information	6.91

The change in the median ratio from 6.91 (2020/21) to 7.34 is not primarily caused by any one factor. The median salary in the organisation can fluctuate due to relatively small changes in the composition of staff grades, including the level and cost of agency staff utilised. In addition, the prescribed method of calculation for this ratio has driven a small level of increase in the year, though the highest paid director did receive an increase in remuneration that was consistent with other staff groups.

Please note that prior years only required disclosures against the median remuneration, a definition which was expanded in 2021/22 to include the other quartiles.

In both 2020/21 and 2021/22 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £20,199 to £292,500 in 2021/22 (£16,069 to £287,500 in 2020/21).

Remuneration tables

Salary and pension disclosure tables: information subject to audit

Remuneration report 2021/22

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	**Salary (bands of £5,000)**	**Expense payments (taxable) (total to nearest £100)**	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension related benefits[6] (bands of £2,500)**	**Total remuneration (bands of £5,000)**
Name and title	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Non-executive directors						
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
Dr Ben Maruthappu, associate non-executive director	10 - 15	-	-	-	-	10 - 15
Beverley Ejimofo, associate non-executive director[2]	5 - 10	-	-	-	-	5 - 10
Executive directors						
Professor Tim Orchard, chief executive officer[3]	270 - 275	-	15 - 20	-	192.5 - 195.0	480 - 485
Professor Julian Redhead, medical director[4]	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[5]	160 - 165	-	-	-	107.5 - 110.0	270 - 275

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Remuneration report 2021-22 (pension)	**Real increase at pension age (bands of £2,500) £000s**	**Real increase in lump sum at pension age (bands of £2,500) £000s**	**Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000s**	**Lump sum at pension age relating to accrued pension at 31 March 2022 (bands of £5,000) £000s**	**Cash equivalent transfer value at 1 April 2021 (nearest £1k) £000s**	**Real increase in cash equivalent transfer value (nearest £1k)[7] £000s**	**Cash equivalent transfer value at 1 April 2022 (nearest £1k) £000s**	**Employer's contribu-tion to stakehold-er pension (nearest £1k) £000s**
Professor Tim Orchard, chief executive officer[3]	10.0 - 12.5	10.0 - 12.5	115 - 120	165 - 170	1,685	167	1,897	–
Professor Julian Redhead, medical director[4]	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[5]	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. Beverley Ejimofo joined the board as an associate non-executive director on 1 October 2021, having previously undertaken a 12-month placement at the Trust as part of the NExT Director scheme.
3. Prof Tim Orchard: £35-40k of his salary relates to payment for his clinical role.
4. Prof Julian Redhead: £55-60k of his salary relates to payment for his clinical role.
5. Claire Hook was appointed to the board as chief operating officer on 1 July 2021, having previously occupied other senior roles within the Trust.
6. 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.
7. 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).

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

Remuneration report 2020/21

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	**Salary (bands of £5,000)**	**Expense payments (taxable) (total to nearest £100)**	**Perfor-mance pay and bonuses (bands of £5,000)**	**Long term perfor-mance pay and bonuses (bands of £5,000)**	**All pension related benefits 1 (bands of £2,500)**	**Total remunera-tion (bands of £5,000)**
Name and title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Non-executive directors						
Paula Vennells, chairz[2]	55 - 60	-	-	-	-	55 - 60
Sir Gerald Acher, deputy chair[3]	10 - 15	-	-	-	-	10 - 15
Bob Alexander, acting chair / non-executive director[4]	5 - 10	-	-	-	-	5 - 10
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
Nick Ross, non-executive director	10 - 15	-	-	-	-	10 - 15
Kay Boycott, non-executive director	10 - 15	-	-	-	-	10 - 15
Sim Scavazza, non-executive director[5]	5 - 10	-	-	-	-	5 - 10
Dr Ben Maruthappu, associate non-executive director	10 - 15	-	-	-	-	10 - 15
Executive directors						
Professor Tim Orchard, chief executive officer[6]	270 - 275	-	15 -20	-	60 - 62.5	345 - 350
Professor Julian Redhead, medical director[7]	250 - 255	-	-	-	-	250 - 255
Professor Janice Sigsworth, director of nursing	185 - 190	-	-	-	40 - 42.5	225 - 230
Jazz Thind, interim chief financial officer[8]	155 - 160	-	-	-	105 - 107.5	260 - 265
Richard Alexander, chief financial officer[9]	20 - 25	-	-	-	-	20 - 25

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Remuneration report 2020-21 (pension)	**Real increase at pension age (bands of £2,500)**	**Real increase in lump sum at pension age (bands of £2,500)**	**Total accrued pension at pension age at 31 March 2021 (bands of £5,000)**	**Lump sum at pension age relating to accrued pension at 31 March 2021 (bands of £5,000)**	**Cash equiva-lent transfer value at 1 April 2020 (nearest £1k)**	**Real increase in cash equiva-lent transfer value (nearest £1k)[10]**	**Cash equiva-lent transfer value at 1 April 2021 (nearest £1k)**	**Employ-er's contri-bution to stake-holder pension (nearest £1k)**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Professor Tim Orchard, chief executive officer[6]	2.5 - 5	-	105 -110	155 -160	1,558	63	1,685	-
Professor Julian Redhead, medical director[7]	0	-	70 - 75	180 - 185	1,413	0	1,435	-
Professor Janice Sigsworth, director of nursing	2.5 - 5	7.5 - 10	90 - 95	280 - 285	2,118	98	2,277	-
Jazz Thind, chief financial officer[8]	5 - 7.5	5 - 7.5	55 - 60	75 - 80	777	87	900	-
Richard Alexander, chief financial officer[9]	-	-	-	-	-	-	-	-

1. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
2. Paula Vennells left the board on 31 March 2021.
3. Sir Gerald Acher left the board on 20 November 2020.
4. Bob Alexander joined the board on 1 October 2020.
5. Sim Scavazza joined the board on 1 October 2020.
6. Prof Tim Orchard: £50-55k of his salary relates to payments for his clinical role.
7. Prof Julian Redhead: £55-60k of his salary relates to payment for his clinical role.
8. Jazz Thind became the chief financial officer on 1 February 2021, prior to which time she was interim chief financial officer on secondment from Oxleas NHS Foundation Trust. The figures disclosed for her cover remuneration for the whole year including time on secondment and time as chief financial officer.

Staff report

The headcount data is as of 31 March 2022 and is for clinical and corporate divisions and research and development (excluding hosted and contracted services).

Workforce composition by staff group

At the end of 2021/22 the Trust employed 14,531 staff. Approximately 64 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in table titled 'headcount by Trust staff group' below.

Headcount by Trust staff group*	Headcount
Admin and clerical	2,040
Allied health professional (qualified)	762
Allied health professional (support)	126
Ancillary	993
Doctor (career grade)	37
Doctor (consultant)	1,284
Doctor (Trust and training grade)	1,812
Nursing and midwifery (qualified)	4,140
Nursing and midwifery (support)	1,157
Pharmacist	153
Physician associate	6
Scientific and technical (qualified)	851
Scientific and technical (support)	416
Senior manager	754
Trust Total	**14,531**

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 2021/22 women accounted for 57 per cent of senior managers, 37 per cent of executive directors and 38 per cent of board directors. There are four directors who are defined both as executive team members and as board directors.

Gender – all *	**Headcount**
Female	10,037
Male	4,494
Trust total	**14,531**
Gender – senior managers*	**Headcount**
Female	424
Male	321
Trust total	**745**
Gender – board of directors*	**Headcount**
Female	6
Male	10
Trust total	**16**
Gender – executive team*	**Headcount**
Female	7
Male	12
Trust total	**19**

Workforce composition by age and ethnicity

Age group*	**Headcount**
16-19 years	12
20-29 years	2,713
30-39 years	4,398
40-49 years	3,290
50-59 years	2,896
60 years and over	1,222
Trust total	**14,531**

Ethnic origin*	Headcount
White - British	3,366
White - Irish	385
White - Any other White background	1,755
Mixed - White and Black Caribbean	117

Ethnic origin*	Headcount
Mixed - White and Black African	95
Mixed - White and Asian	137
Mixed - Any other mixed background	240
Asian or Asian British - Indian	1,234
Asian or Asian British - Pakistani	325
Asian or Asian British - Bangladeshi	195
Asian or Asian British - Any other Asian background	1,541
Black or Black British - Caribbean	592
Black or Black British - African	1,784
Black or Black British - Any other Black background	416
Chinese	219
Any other ethnic group	1,275
Undefined	442
Not Stated	413
Trust total	**14,531**

Average staff numbers (subject to audit)

This table represents the average staff numbers through the year and so presents a different figure than the analysis tables above, which relate to the number of staff employed as of 31 March 2022.

	2021/22			2020/21		
Average staff numbers	**Total**	**Perma-nently employed**	**Other**	**Total**	**Perma-nently employed**	**Other**
Medical and dental	2,275	2,262	13	2,262	2,258	4
Ambulance staff	0	0	0	0	0	0
Administration and estates	3,789	3,712	76	3,749	3,665	84
Healthcare assistants and other support staff	1,898	1,810	88	1,883	1,841	42
Nursing, midwifery and health visiting staff	4,457	4,323	133	4,321	4,241	80
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	1,123	1,047	76	1,109	1,033	76
Social care staff	0	0	0	621	621	0
Healthcare science staff	617	617	0	0	0	0
Other	4	4	0	6	6	0
TOTAL	**14,162**	**13,776**	**386**	**13,951**	**13,665**	**286**
Staff engaged on capital projects (included above)	24	24	0	30	30	0

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

	2021/22			2020/21		
	Permanent	**Other**	**Total**	**Permanent**	**Other**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Salaries and wages	623,667	65,317	688,984	629,891	57,614	687,505
Social security costs	65,958	7,536	73,494	63,265	6,424	69,689
Apprenticeship Levy	2,896	382	3,278	2,794	335	3,129
Employer Contributions to NHS BSA	97,273	7,557	104,830	94,759	7,096	101,855
Other pension costs	122	51	173	72	3,240	3,312
Termination benefits	0	0	0	0	0	0
Total employee benefits	**789,716**	**80,943**	**870,759**	**790,781**	**74,709**	**865,490**
Employee costs capitalised	**3,627**	**7**	**3,634**	**2,269**	**0**	**2,269**
Gross Employee Benefits excluding capitalised costs	786,289	8,836	867,125	788,512	74,709	863,221

Sickness absence

Low sickness absence is an indicator of effective leadership, good people management and staff wellbeing and as such this an important key performance indicator for the Trust. Due to the extraordinary events of the Covid-19 pandemic, sickness absence data was not available across the sector in the usual way in 2020/21.

In 2021/22, we continued to see some impact of the pandemic on our sickness absence rates. The Trust achieved a sickness absence rate of 9.7 average sick days per full-time equivalent; comparing favourably to the average of 11.6 days reported nationally across the NHS. This is markedly higher than the figures for 2018/19, when the Trust achieved a sickness absence rate of 6.6 average sick days per full-time equivalent; compared to the average of 9.81. Staff health and wellbeing is a key focus for the Trust and will remain so in the year to come – more information is available in the chief executive's overview of the performance report.

Employment of staff with disabilities

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

Staff with disabilities*	**Headcount**
No	11,463
Not declared	2,073
Prefer not to answer	99
Unspecified	561
Yes	335
Trust total	**14,531**

Trade union facility time publication requirements report: 2021/22

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 2021-31 March 2022.

Trade union representatives – the total number of employees who were trade union representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	FTE employee number
56	52.46

Percentage of time spent on facility time – How many employees who were trade union representative officials employed during the relevant period spent a) zero per cent, b) one per cent to 50 per cent, c) 51 per cent to 99 per cent or d) 100 per cent of their working hours on facility time.

Percentage of time	Number of employees
0%	48
1-50%	8
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 trade union representatives for facility time during the relevant period.

First column	Figures
Provide the total cost of facility time	£39,826.47
Provide the total pay bill	£868,978,848.92 = total figure for 2021/2022 including apprenticeship levy (£3,584,462) £865,394,386.92 = 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**	0.005%

Paid trade union activities – As a percentage of total paid facility time hours, how many hours were spent by employees who were trade union representatives during the relevant period on paid trade union 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**	54%

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 trade union 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.

Term	Definition
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 22, for more than £245 per day:

	Number
Number of existing engagements as of 31st March 2021	4
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	2
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 2021 and 31 March 2022, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	12
Of which:	
Number not subject to off-payroll legislation	1
Subject to off-payroll legislation and determined as in-scope of IR35	8
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 2021 and 31 March 2022

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	20

Exit packages (subject to audit)

In 2021/22 the Trust approved severance payments to eight staff (2020/21: 20 staff).

Exit packages

2021/22								
Exit package cost band (including any special payment element)	**Number of compul-sory redund-ancies**	**Cost of compul-sory redund-ancies**	**Number of other depar-tures agreed**	**Cost of other depar-tures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of depa-rtures 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**

2020/21								
Exit package cost band (including any special payment element)	**Number of compul-sory redund-ancies**	**Cost of compul-sory redund-ancies**	**Number of other depar-tures agreed**	**Cost of other depar-tures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of depa-rtures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	4	17,205	1	905	5	18,110	0	0
£10,000-£25,000	1	15,500	1	21,551	2	37,051	0	0
£25,001-£50,000	1	29,884	1	38,056	2	67,940	0	0
£50,001-£100,000	1	71,028	0	0	1	71,028	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0

2020/21								
Exit package cost band (including any special payment element)	**Number of compul-sory redund-ancies**	**Cost of compul-sory redund-ancies**	**Number of other depar-tures agreed**	**Cost of other depar-tures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of depa-rtures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
£150,001 - £200,000	0	0	0	0	0	0	0	0
Total	**7**	**133,617**	**3**	**60,512**	**10**	**194,129**	**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.

	2021/22		2020/21	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000s**	**Number**	**£000s**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	7	145	3	61
Total	**7**	**145**	**3**	**61**

Professor Tim Orchard, Chief executive officer
12 July 2022

Chief financial officer's report

Introduction and overview

As was the case in 2020/21 financial year, 2021/22 was a year of two halves in terms of differing financial regimes for each six-month period. The Trust continued to be governed by block contracts, and whilst funding was still available to support continued response to the Covid-19 pandemic, this was reduced and efficiencies were required to ensure the Trust achieved financial balance. The two most notable changes related to the way in which elective recovery funding (ERF) could be accessed (with in-year changes to the methodology); and the receipt of additional funding relating to additional intensive care capacity for the second half of the year. The Trust reported a surplus of £30.6m, and an adjusted financial performance of £0.1m.

Financial review of 2021/22

The Trust planned to achieve a breakeven position for the financial year, in line with sector funding assumptions including: an efficiency target of 2.5 per cent for the year as well as a challenging elective recovery plan. Overall the Trust reported a small adjusted financial performance surplus of £0.1m which was favourable to the breakeven plan and successfully remained within both the external financing (EFL) and capital resource (CRL) limits.

The year-end capital resource limit was however significantly higher than that planned for as of 1 April 2021 due mainly to additional funding allocations becoming available during the year providing an injection of cash that enabled the Trust to make further capital investments.

Although the position as of 31 March 2022 represents a resilient view for the year, there remain two key ongoing risks, primarily: 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) and delivering the level of year-on-year efficiencies required to maintain medium term financial sustainability.

The table below sets out the actual income and expenditure performance as at the 31 March 2022, including comparative information for 2020/21 and tracks this against the Trust agreed plan:

Statement of comprehensive income	2021/22 £'m	2020/21 £'m
Income	1,483.1	1,422.8
Expenditure	(1,440.6)	(1,422.5)
Net financing costs	(0.4)	(0.5)
Public dividend capital payable	(11.6)	(10.3)
Surplus/(deficit) for the year	30.6	(10.6)
Adjustments for revaluations and impairments	18.5	(0.1)
Total comprehensive income/(expense)	**49.1**	**(10.7)**

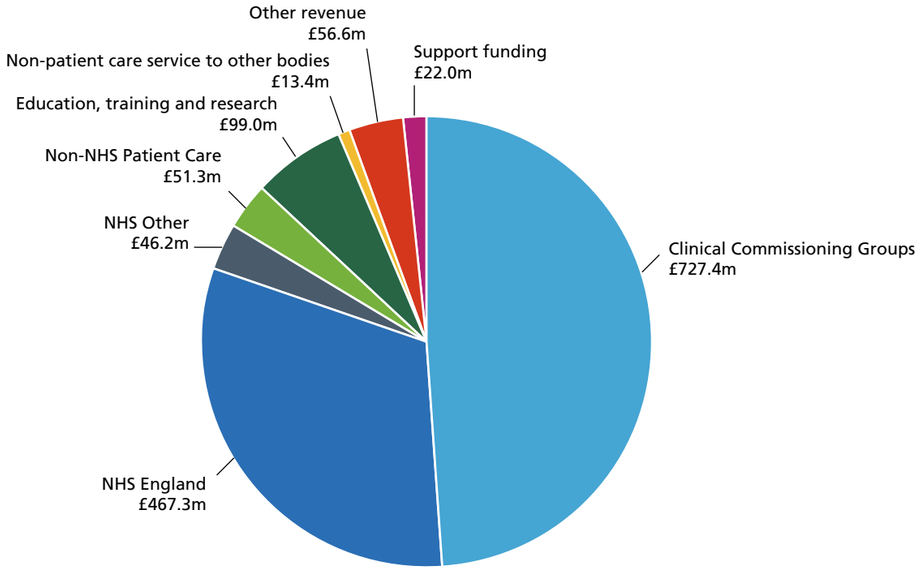
Performance Against Plan	2021/22 £'m	2020/21 £'m
Total Comprehensive Income/(Expense) for the year as per Annual Accounts	**49.1**	**(10.7)**
Donated asset adjustment	(12.9)	(7.2)
Adjust for revaluation and impairment	(36.1)	17.9
Adjusted financial performance surplus	**0.1**	**0.0**
Planned breakeven position	0.0	0.0
Performance Against Plan	**0.1**	**0.0**

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.

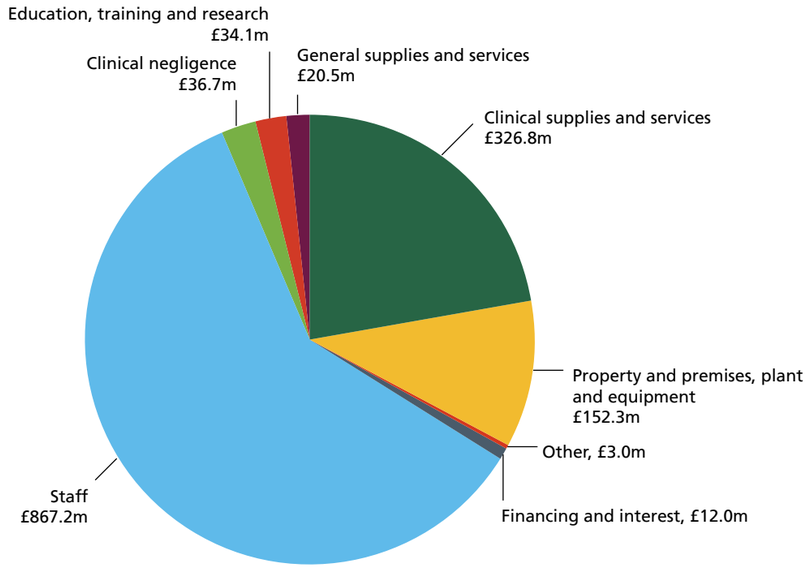
Our total income amounted to £1,483m for 2021/22 (2020/21 £1,423m). The majority of this related to NHS patient care income for the provision of clinical services. During 2021/22 the financial regime continued to be governed by block contracts, and whilst funding was still available to support continued response to the Covid-19 pandemic, this was reduced and efficiencies were required to ensure the Trust achieved financial balance. Under these arrangements the Trust was able to access additional income via the elective recovery funding totalling £33m, in recognition of the additional activity delivered across the year to meet the planned recovery of services to our patients.

In addition there are a number of other income sources the Trust receives, including: education and training 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; research and development income of £51m in 2021/22.



Expenditure

Excluding financing and interest costs total Trust expenditure for 2021/22 was £1,441m (2020/21 £1,423m). 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 costs with the other expenditure category in the chart below accounting for several smaller cost elements including legal fees, consultancy, operating lease, bad debts and inventories write downs.



To achieve the breakeven plan, £31.5m 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 in the integrated care system. However given the overarching need to focus on operational performance and manage the Omicron variant any slippage in savings plans was able to be mitigated by the contribution from elective recovery funding secured by the Trust ensuring it was well placed to deliver the financial plan.

Cash

The Trust continued to successfully manage its cash throughout 2021/22 thereby remaining within its external financing limit (EFL), ending the year with a cash balance of £237.5m at 31 March 2022 (£88m higher than the same point in 2020/21). This position was higher than plan due primarily to the variation in timing between receipts of cash and payments to suppliers, particularly around capital expenditure incurred in the final month of the year. Although our cash holdings are expected to decrease in 2022/23 as liabilities are settled, this will not impact on the payment of our staff and creditors with the cash balance expected to remain higher than historic levels.

Capital investment programme

By 31 March 2022 the Trust invested £94.9m in capital expenditure (including £16m of grant and charity funding, and other donated assets). A summary of the key themes of the capital programme is provided below:

Source of Funds	**£m**
Internal Financing (NWL allocation)	51.7
Confirmed external funding inc. PDC	29.2
Charitable Funds & Grants	16.0
Total	**96.9**
Income & Donation	-16.0
Capital Resource Limit (CRL) funding	80.9
Use of funds	**Actual £m**
Backlog Maintenance	18.3
ICT	10.2
Replacement of Medical Equipment	14.0
Other Capital Projects	13.1
Redevelopment	36.8
Covid-19	2.4
Gross Expenditure	**94.9**
Income & Donation	**-16.0**
Expenditure against CRL	**78.8**
Expenditure as a % of funding	**97%**

Included in the total above is £1.1m of Imperial Health Charity money. We remain grateful to the Charity for its ongoing fundraising efforts and the financial support it provides to the Trust in respect of the capital programme. Both these additional funds and donated assets make a huge contribution enabling the Trust to continue to improve the quality of care it provides, including funding for redevelopment of the breast clinic at Charing Cross and investment in hybrid theatre capacity.

Against the capital resource limit of £80.9m, the Trust achieved expenditure of £78.8m (97 per cent of plan), an underspend of £2.1m. In the context of the delivery challenges posed by both the later than anticipated award of £22.5m funding and the wider economic and public health environment in the second half of the year, the final results represent a considerable achievement.

Other notable capital projects include investment in linear accelerator radiology equipment (£4.8m), completion of the PET CT scanning project (£2.2m) new multidisciplinary team rooms (£1.5m), preparatory work around the development of Hammersmith Hospital A block and acute imaging capacity at St Mary's and Charing Cross, and ICT projects around digitisation and automation supported by the DHSC's targeted investment fund.

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.

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 PwC during 2021/22 to provide us with our specialist counter-fraud services.

In spite of the impact of the pandemic, we have continued to publish our policies and procedures for staff to report any concern about potential fraud and this has been reinforced by sharing of fraud notices and general awareness raising by the local counter fraud specialist. Any concerns are investigated by our local counter fraud specialist or the NHSCFA as appropriate with all investigations reported to the audit risk and governance assurance committee.

At the time of writing the report, so far as all directors are aware, there is no relevant audit information of which the Trust's auditor is unaware, and they have taken all the steps that are necessary as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury, has met the income disclosures as required by section 43(2A) of the NHS Act 2006 and did not make any political donations during 2021/22. Within the provisions of the better payment practice code (BPPC) the Trust is required to pay 95 per cent of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later and the Trust has met this requirement in year. During 2021/22 95.4 per cent of invoices by value and 98.4 per cent by volume of total payables were paid within the required standard, this was broadly in line with the value performance and an improvement in the volume performance against 2020/21; 95.8 per cent and 97.8 per cent respectively.

Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a 'going concern'.

The Trust board has considered the advice in the Department of Health and Social Care's general 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.

The Trust has the reasonable expectation that it will continue to have access to adequate cash resources to service its operational activities in cash terms for at least the next 12 months.

Block contract values have been issued to providers for the 2022/23 financial year which represent a roll forward of the 2021/22 second half of the year (H2) envelope extrapolated to a full year. All sector funding, including initial elective recovery funding has been allocated, although this funding will be subject to achieving targets. It is expected that the funding envelope agreed with the sector will ensure a level of cash resilience for the Trust.

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 hospitals programme and two tranches of seed funding have been received over 2020/21 and 2021/22 to progress the strategic outline case for the St Mary's site. At least a further £1m has been allocated in 2022/23 at the time of writing. However, no commitment to cover any unexpected estates failures has been provided at the point of writing this report.

2022/23 looking ahead

- **2022/23 financial planning:** confirmation of the funding regime has been received for the financial year. The north west London integrated care system will receive similar funding levels as those in the second half of 2021/22 adjusted up / down to reflect national guidance. Providers have been allocated settlements, adjusted for a three per cent efficiency requirement, with an agreement that any higher than funded inflationary pressure remains an unmitigated cost pressure across the integrated care system. In addition to the baseline envelope, there is again the ability to earn additional income linked to performance targets, and with indicative allocations made to providers. However these are subject to targets being achieved, and where performance falls below thresholds income could be clawed back. As with all other NHS organisations we will continue to face the year-on-year challenge of balancing the delivery of high-quality care with rising demand, rising acuity, paying due attention to staff wellbeing and the need to increase both productivity and efficiency.
- **Operational focus:** providers have been issued with fixed activity trajectory targets for the year. Based on the latest activity plan from services, the Trust is on track to, as a minimum, meet the trajectories set. As stated above, an initial allocation has been awarded to the integrated care system to achieve the minimum activity targets, with further funding available to providers who exceed these targets. The Trust has however set an internal aspiration to exceed the minimum targets in order to ensure as many patients as possible have their clinical need met and waiting lists for care are reduced.
- **Redevelopment programme:** as noted above, further funding of at least £1m has been awarded to continue work on the redevelopment business case in 2022/23. A draft strategic outline case has been prepared and shared for review with NHS England and Improvement, with initial positive feedback received. The new hospital programme team are producing a national programme business case which is expected to progress by the summer of 2022. 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.
- **Integrated care systems:** the Trust continues to be actively engaged in the development of the integrated care system in line with national requirements. For 2022/23 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.

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 back-office processes for possible economies of scale, and collaborative capital schemes to leverage best value from the limited resources available. The Trust continues to review and evolve its governance processes to ensure grip and control is maintained whilst ensuring it has the necessary agility to respond to challenges.

Statement of the Chief executive officer's responsibilities as the Accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive 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 officer
12 July 2022

Independent auditors' 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 2022 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 33.

The financial reporting framework that has been applied in their preparation is applicable law and the 'Accounts Direction'.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice, the Local Audit and Accountability Act 2014 (the 'Act') and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

The going concern basis of accounting for the trust is adopted in consideration of the requirements set out in the Accounts Direction, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it 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 and internal audit and local counter fraud about their own identification and assessment of the risks of noncompliance 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 valuations, 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 area, 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.

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; 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.

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

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

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the trust's resources.

We are required under the Code of Audit Practice and section 21(3)(c) 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 guidance, published by the Comptroller & Auditor General in December 2021, as to whether the trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, 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 2022 by the time of the issue of our audit report. Other findings from our work, including our commentary on the trust's arrangements, will be reported in our separate Auditor's Annual Report.

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

We are also required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Trust Development Authority (NHS Improvement);
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

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

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
13 July 2022

Audit certificate issued subsequent to opinion on financial statements

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2022 issued on 13 July 2022 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of the trust as at 31 March 2022 and of its expenditure and income for the year then ended; and
- had been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

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

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2022 on 13 July 2022, we had not completed our work on the trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2022 issued on 13 July 2022, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this areas.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Imperial College Healthcare NHS Trust in accordance with requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Jonathan Gooding (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
26 August 2022

Financial statements

Statement of Comprehensive Income

For the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	1,292,126	1,182,827
Other operating income	4	190,995	239,962
Operating expenses	6, 8	(1,440,556)	(1,422,521)
Operating surplus from continuing operations		**42,565**	**268**
Finance income	11	110	14
Finance expenses	12	(517)	(539)
PDC dividends payable		(11,580)	(10,332)
Net finance costs		**(11,987)**	**(10,857)**
Surplus / (deficit) for the year		**30,578**	**(10,589)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(39)	(85)
Revaluations	13	18,540	-
Total comprehensive income / (expense) for the period		**49,079**	**(10,674)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		30,578	(10,589)
Remove net impairments not scoring to the Departmental expenditure limit		(17,564)	17,862
Remove I&E impact of capital grants and donations		(13,982)	(5,882)
Remove net impact of inventories received from DHSC group bodies for COVID response		1,051	(1,344)
Adjusted financial performance surplus		**83**	**47**

An NHS trust's financial performance is derived from its surplus/(deficit), but is adjusted for impairments and reversal of prior year impairments to property, plant, equipment and elimination of income and expenditure arising from donations and donated assets, as these are not considered to be part of the organisation's operating position.

Statement of Financial Position

As at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	13	18,984	14,089
Property, plant and equipment	13	622,858	550,562
Receivables	17	3,215	3,200
Total non-current assets		**645,057**	**567,851**
Current assets			
Inventories	15	17,401	17,065
Receivables	17	63,682	90,596
Cash and cash equivalents	16	237,469	149,055
Total current assets		**318,552**	**256,716**
Current liabilities			
Trade and other payables	18	(272,703)	(217,456)
Borrowings	20	(3,267)	(2,492)
Provisions	22	(40,586)	(33,607)
Other liabilities	19	(30,900)	(27,932)
Total current liabilities		**(347,456)**	**(281,487)**
Total assets less current liabilities		**616,153**	**543,080**
Non-current liabilities			
Borrowings	20	(15,910)	(15,924)
Provisions	22	(3,965)	(3,200)
Other liabilities	19	(2,058)	(2,058)
Total non-current liabilities		**(21,933)**	**(21,182)**
Total assets employed		**594,220**	**521,898**
Financed by			
Public dividend capital		797,116	773,873
Revaluation reserve		20,914	2,413
Income and expenditure reserve		(223,810)	(254,388)
Total taxpayers' equity		**594,220**	**521,898**

The notes on pages 145 to 181 form part of these accounts.

Name: Professor Tim Orchard
Position: Chief executive officer
Date: 12 July 2022

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
Taxpayers' and others' equity at 31 March 2022	**797,116**	**20,914**	**(223,810)**	**594,220**

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 2020 - brought forward	**720,787**	**2,498**	**(243,799)**	**479,486**
Surplus/(deficit) for the year	-	-	(10,589)	(10,589)
Impairments	-	(85)	-	(85)
Revaluations	-	-	-	-
Public dividend capital received	53,086	-	-	53,086
Taxpayers' and others' equity at 31 March 2021	**773,873**	**2,413**	**(254,388)**	**521,898**

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 as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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

Statement of Cash Flows

For the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		42,565	268
Non-cash income and expense:			
Depreciation and amortisation	6	48,813	45,772
Net impairments	7	(12,642)	17,862
Income recognised in respect of capital donations	4	(16,036)	(7,716)
Decrease in receivables and other assets		26,227	32,330
Increase in inventories		(336)	(1,795)
Increase in payables and other liabilities		42,585	60,185
Increase in provisions		7,744	3,352
Other movements in operating cash flows		1,356	36
Net cash flows used in operating activities		**140,276**	**150,294**
Cash flows from investing activities			
Interest received		110	14
Purchase of PPE and investment property		(76,158)	(71,583)
Receipt of cash donations to purchase assets		14,802	1,871
Net cash flows used in investing activities		**(61,246)**	**(69,698)**
Cash flows from financing activities			
Public dividend capital received		23,243	53,086
Movement on loans from DHSC		(1,226)	(17,031)
Movement on other loans		(446)	631
Capital element of finance lease rental payments		(828)	(275)
Interest on loans		(477)	(519)
Interest paid on finance lease liabilities		(35)	(22)
PDC dividend paid		(10,847)	(11,355)
Net cash flows from financing activities		**9,384**	**24,515**
Increase in cash and cash equivalents		**88,414**	**105,111**
Cash and cash equivalents at 1 April - brought forward		**149,055**	**43,944**
Cash and cash equivalents at 31 March	**16**	**237,469**	**149,055**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a 'going concern'.

The Trust board has considered the advice in the DHSC's GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

The Trust has the reasonable expectation that it will continue to have access to adequate cash resources to service its operational activities in cash terms for the next 12 months.

Block contract values have been in force throughout the 2021/22 financial year. For 2022/23, all sector funding has been distributed within agreed parameters, with additional access to Elective Recovery funding available based on performance against targets. The Trust has set a plan that should allow access to this additional funding, which will provide a level of cash resilience.

Note 1.2 Critical judgements and key sources of estimation uncertainty in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see 1.2.2) that management have made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.1.1 Land and buildings valuation

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.7 for further details.

Land and building assets are valued using the modern equivalent asset (MEA) approach. oth 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 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.

Note 1.2.2 Key sources of estimation uncertainty

The following are the estimations that management have made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.2.1 Provisions

Where the Trust is subject to challenge or outcome on as yet undetermined matters e.g. employment tribunal, redundancy claim, pay claims, etc. the Trust takes a prudent view and provides for such claims within the accounting period in which they arose. See Note 1.13 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 22 to these accounts.

Note 1.2.2.2 Allowance for credit losses

The provision for impairment of receivables is based on assumptions concerning the future and other sources of information about the age and recoverability of the debt. Management provides for the potential of impaired receivables according to its classification, age and status (i.e. disputed or otherwise). Management uses its judgement to decide when to provide against other specific debts which are considered at risk of impairment other than the risk generated by classification, age and status.

The carrying amounts of the Trust's provisions for credit losses are detailed in Note 17.1 to these accounts.

Note 1.3 Interests in other entities

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its full share of the assets, liabilities, income and expenses for North West London Pathology (NWLP), of which it is a joint operator, with a corresponding debtor or creditor with the other joint operators for their share of operational performance.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also received additional income outside of the block payments to reimburse specific costs incurred, and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as a variable consideration.

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.

Note 1.4.2 Revenue grants and other contributions to expenditure

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 grants 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 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

Past and present employees are covered by the provisions of the 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 the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40, or IFRS 5.

For land and buildings assets, current values in existing use are determined as follows:

- land and non-specialised buildings – market value for existing use basis
- specialised buildings – depreciated replacement cost based on a Modern Equivalent Asset (MEA)

The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA, the Trust has to make assumptions that are practically achievable. However, the Trust is not required to have any plans to make such changes.

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.

Revaluation gains and losses

Revaluations of property, plant and equipment are performed with sufficient frequency (annually) to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

The valuation carried out as at 31 March 2022 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 indes 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 13 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

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.

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

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

Impairments

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year-end.

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset,
  - an active programme has begun to find a buyer and complete the sale,
  - the asset is being actively marketed at a reasonable price,
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale', and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation or amortisation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Assets which are to be scrapped or demolished do not qualify for recognition as 'held for sale' and instead are retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 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 where the cost is more than £5,000.

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 is not capitalised. It is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value-in-use where the asset is income generating.

Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40, or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful 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	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in, first-out' cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

In 2020/21 and 2021/22, 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 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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.

Classification and measurement

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

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

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income".

When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a credit loss provision.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are recognised where the probability of a transfer of economic benefits is not probably but neither is it 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 1.15 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, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

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 1.16 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 1.17 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 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95 per cent. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	34,407
Additional lease obligations recognised for existing operating leases	(33,889)
Changes to other statement of financial position line items	(261)
Net impact on net assets on 1 April 2022	**257**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(3,789)
Additional finance costs on lease liabilities	(298)
Lease rentals no longer charged to operating expenditure	3,911
Estimated impact on surplus / deficit in 2022/23	**(176)**
Estimated increase in capital additions for new leases commencing in 2022/23	**18,900**

The Trust has applied judgements in estimating the underlying duration of lease commitments where the contractual documentation is not clear - it has applied the principle of economic substance over legal form.

The Trust's estimate of the future increase in capital additions is an estimated figure for management information purposes and is subject to revision and change.

Note 2 Operating Segments

The Trust Board led by the Chief Executive Officer is the 'chief operating decision maker' within the Trust. It is the duty of the chief operating decision maker to consider classes of activities, services or locations that constitute discrete operating segments meriting separate disclosure within the accounts.

The Trust provides a range of healthcare services which are reported internally in five divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and children's, and clinical support services; private health; and, corporate services. The Trust is also party to a joint arrangement for the North West London Pathology Hub.

However, having considered the requirements, the Trust Board considers that for the purpose of statutory reporting the Trust's activities fall under the single heading of healthcare. Consequently, there are no additional disclosures to be made as regards the statutory accounts with regard to operating segments.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	1,010,034	927,719
High cost drugs income from commissioners (excluding pass-through costs)	126,881	121,955
Other NHS clinical income	15,997	14,832
Community services		
Block contract / system envelope income	10,119	10,956
Income from other sources (e.g. local authorities)	154	95
All services		
Private patient income	38,184	28,082
Elective recovery fund	32,931	-
Additional pension contribution central funding*	31,965	31,021
Other clinical income	25,861	48,167
Total income from activities	**1,292,126**	**1,182,827**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2021/22 £000	2020/21 £000
Income from patient care activities received from:		
NHS England	467,271	470,802
Clinical commissioning groups	727,380	627,761
Department of Health and Social Care	19	99
Other NHS providers	43,962	46,341
NHS other	2,227	566
Local authorities	203	76
Non-NHS: private patients	38,184	28,082
Non-NHS: overseas patients (chargeable to patient)	4,358	2,092
Injury cost recovery scheme	1,806	2,218
Non NHS: other	6,716	4,790
Total income from activities	**1,292,126**	**1,182,827**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22 £000	2020/21 £000
Income recognised this year	4,358	2,092
Cash payments received in-year	4,923	2,396
Amounts added to provision for impairment of receivables	2,453	2,019
Amounts written off in-year	2,108	1,323

Note 4 Other operating income

	2021/22 £000	2020/21 £000
Research and development	51,276	40,327
Education and training	47,689	53,920
Non-patient care services to other bodies	13,413	14,761
Reimbursement and top up funding	22,030	84,247
Income in respect of employee benefits accounted on a gross basis	9,774	8,672
Receipt of capital grants and donations	16,036	7,716
Charitable and other contributions to expenditure	4,653	16,820
Rental revenue from operating leases	1,827	1,667
Other income	24,297	11,832
Total other operating income	**190,995**	**239,962**

All income relates to continuing operations - the Trust has not discontinued any operations in 2021/22 or 2020/21.

Other income includes income relating to goods, services or other items which are outside of the Trust's core activity of delivery of healthcare.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	14,351	8,162
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	3,216

Note 5.1 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Operating expenses

	2021/22 £000	2020/21 £000
Purchase of healthcare from NHS and DHSC bodies	11,410	17,278
Purchase of healthcare from non-NHS and non-DHSC bodies	12,174	12,753
Staff and executive directors costs	867,111	863,115
Remuneration of non-executive directors	135	137
Supplies and services - clinical (excluding drugs costs)	169,088	140,388
Supplies and services - general	20,458	22,708
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	134,096	117,362
Inventories written down	520	1,870
Consultancy costs	430	1,265
Establishment	10,300	8,879
Premises	73,574	62,016
Transport (including patient travel)	19,635	19,218
Depreciation on property, plant and equipment	44,418	42,884
Amortisation on intangible assets	4,395	2,888
Net impairment / reversal of previous impairments	(12,642)	17,862
Movement in credit loss allowance: contract receivables / contract assets	2,557	2,045
Audit services- statutory audit	248	159
Internal audit costs	279	189
Clinical negligence	36,651	37,545
Legal fees	924	1,241
Insurance	617	539
Research and development	31,157	29,378
Education and training	2,985	2,537
Rentals under operating leases	4,766	3,860
Redundancy	14	106
Hospitality	44	2,814
Other	5,212	11,485
Total	**1,440,556**	**1,422,521**

Note 6.1 Remuneration paid to the external auditor

	2021/22 £000	2020/21 £000
Other auditor remuneration paid to the external auditor:		
Statutory external audit fee	248	159
All other services	-	-
Total	**248**	**159**

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets

	2021/22 £000	2020/21 £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	3,418	-
Changes in market price	(17,564)	17,862
Total net impairments charged to operating surplus / deficit	**(12,642)**	**17,862**
Impairments charged to the revaluation reserve	39	85
Total net impairments	**(12,603)**	**17,947**

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	663,983	672,710
Social security costs	73,494	69,689
Apprenticeship levy	3,278	3,129
Employer's contributions to NHS pensions	104,830	101,855
Pension cost - other	173	3,312
Temporary staff (including agency)	25,001	14,795
Total staff costs	**870,759**	**865,490**
Of which		
Costs capitalised as part of assets	3,634	2,269
Redundancy	14	106

Note 8.1 Retirements due to ill-health

During 2021/22 there were two early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £102k (£115k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2021, updated to 31 March 2022 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, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 Imperial College Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Imperial College Healthcare NHS Trust is the lessor.

The Trust is the lessor for a number of arrangements including the use of space in Trust sites by other parties for purposed including retail and healthcare activities, as well as the use of Trust buildings to site telecommunications equipment. The Trust also owns residential accommodation which is let on a long term agreement for the use of key workers.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	1,827	1,667
Total	**1,827**	**1,667**
Future minimum lease receipts due:		
- not later than one year;	1,324	1,350
- later than one year and not later than five years;	4,495	4,924
- later than five years.	18,163	19,058
Total	**23,982**	**25,332**

Note 10.2 Imperial College Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Imperial College Healthcare NHS Trust is the lessee.

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.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	4,766	3,860
Total	**4,766**	**3,860**
Future minimum lease payments due:		
- not later than one year;	2,502	2,442
- later than one year and not later than five years;	4,939	6,043
- later than five years.	1,459	1,883
Total	**8,900**	**10,368**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2021/22 £000	2020/21 £000
Interest on bank accounts	110	14
Total finance income	**110**	**14**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2021/22 £000	2020/21 £000
Interest expense:		
Loans from the Department of Health and Social Care	482	517
Finance leases	35	22
Total interest expense	**517**	**539**

Note 13 Intangible Assets, Property, Plant and Equipment

Note 13.1 Intangible assets - 2021/22

	Information technology £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	**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 - brought forward	**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 13.2 Intangible assets - 2020/21

	Information technology £000	Total £000
Valuation / gross cost at 1 April 2020 - as previously stated	**15,093**	**15,093**
Reclassifications	12,717	12,717
Disposals / derecognition	(2,344)	(2,344)
Valuation / gross cost at 31 March 2021	**25,466**	**25,466**
Amortisation at 1 April 2020 - as previously stated	**10,833**	**10,833**
Provided during the year	2,888	2,888
Disposals / derecognition	(2,344)	(2,344)
Amortisation at 31 March 2021	**11,377**	**11,377**
Net book value at 31 March 2021	**14,089**	**14,089**
Net book value at 1 April 2020	**4,260**	**4,260**

Note 13.3 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plants & machinery	Information technology	Furniture fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 – brought forward	**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 - brought forward	**-**	**-**	**-**	**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)
Reclassifications	-	-	-	-	-	-	-
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**

	Land	Buildings excluding dwellings	Assets under construction	Plants & machinery	Information technology	Furniture fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**84,168**	**339,331**	**55,114**	**178,734**	**63,892**	**1,611**	**722,850**
Additions	-	-	80,074	5,845	-	-	85,919
Impairments	-	(64,372)	-	-	-	-	(64,372)
Reversals of impairments	20,756	(1,443)	-	-	-	-	19,313
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	61,767	(116,146)	24,920	15,977	765	(12,717)
Disposals / derecognition	-	-	-	(5,011)	(11,695)	(103)	(16,809)
Valuation/gross cost at 31 March 2021	**104,924**	**335,283**	**19,042**	**204,488**	**68,174**	**2,273**	**734,184**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**-**	**-**	**137,170**	**46,509**	**980**	**184,659**
Provided during the year	-	27,112	-	8,102	7,437	233	42,884
Impairments	-	(23,245)	-	-	-	-	(23,245)
Reversals of impairments	-	(3,867)	-	-	-	-	(3,867)
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(5,011)	(11,695)	(103)	(16,809)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**140,261**	**42,251**	**1,110**	**183,622**
Net book value at 31 March 2021	**104,924**	**335,283**	**19,042**	**64,227**	**25,923**	**1,163**	**550,562**
Net book value at 1 April 2020	**84,168**	**339,331**	**55,114**	**41,564**	**17,383**	**631**	**538,191**

	Land	Buildings excluding dwellings	Assets under construction	Plants & machinery	Information technology	Furniture fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	151,121	339,521	23,655	46,239	26,409	1,016	587,961
Finance leased	-	3,788	-	811	2,654	-	7,253
Owned - donated/granted	-	-	-	27,644	-	-	27,644
NBV total at 31 March 2022	**151,121**	**343,309**	**23,655**	**74,694**	**29,063**	**1,016**	**622,858**

Note 13.6 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plants & machinery	Information technology	Furniture fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	104,924	312,686	19,042	53,995	23,751	1,163	515,561
Finance leased	-	-	-	-	2,172	-	2,172
Owned - donated/granted	-	22,597	-	10,232	-	-	32,829
NBV total at 31 March 2021	**104,924**	**335,283**	**19,042**	**64,227**	**25,923**	**1,163**	**550,562**

Note 14 Donations of property, plant and equipment

The Trust received £1.8m of donated equipment from DHSC of which £1.2m meets the definition of capitalisable assets and is included within the notes above.

This equipment was recognised at deemed cost with the corresponding benefit recognised in income.

Note 15 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	6,921	7,305
Consumables	10,129	9,470
Energy	351	290
Total inventories	**17,401**	**17,065**

Inventories recognised in expenses for the year were £205,822k (2020/21: £180,939k). Write-down of inventories recognised as expenses for the year were £520k (2020/21: £1,870k).

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 2021/22 the Trust received £3,152k of items purchased by DHSC (2020/21: £14,854k).

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 16 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.

	2021/22 £000	2020/21 £000
At 1 April	**149,055**	**43,944**
Net change in year	88,414	105,111
At 31 March	**237,469**	**149,055**
Broken down into:		
Cash at commercial banks and in hand	200	144
Cash with the Government Banking Service	237,269	148,911
Total cash and cash equivalents as in SoFP	**237,469**	**149,055**
Total cash and cash equivalents as in SoCF	**237,469**	**149,055**

Note 16.1 Third party assets held by the Trust

Imperial College Healthcare NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2022 £000	2021 £000
Monies on deposit	72	77
Total third party assets	**72**	**77**

Note 17 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	58,933	81,481
Allowance for impaired contract receivables / assets	(9,233)	(8,842)
Prepayments (non-PFI)	6,723	9,384
PDC dividend receivable	-	672
VAT receivable	4,818	5,389
Other receivables	2,441	2,512
Total current receivables	**63,682**	**90,596**
Non-current		
Other receivables	3,215	3,200
Total non-current receivables	**3,215**	**3,200**
Of which receivable from NHS and DHSC group bodies:		
Current	60,310	80,935
Non-current	3,215	3,200

Note 17.1 Allowances for credit losses

	2021/22 Contract receivables and contract assets	2020/21 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**8,842**	**8,238**
New allowances arising	2,557	3,182
Reversals of allowances	-	(1,137)
Utilisation of allowances (write offs)	(2,166)	(1,441)
Allowances as at 31 March 2022	**9,233**	**8,842**

Note 18 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	51,299	51,842
Capital payables	33,311	17,742
Accruals	145,677	97,734
Social security costs	10,390	10,061
Other taxes payable	9,387	9,467
PDC dividend payable	61	-
Other payables	22,578	30,610
Total current trade and other payables	**272,703**	**217,456**
Of which payables from NHS and DHSC group bodies:		
Current	22,376	19,812

Note 19 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	30,900	27,932
Total other current liabilities	**30,900**	**27,932**
Non-current		
Lease incentives	2,058	2,058
Total other non-current liabilities	**2,058**	**2,058**

Note 20 Borrowings

Note 20 Borrowings Summary

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	1,252	1,247
Other loans	656	656
Obligations under finance leases	1,359	589
Total current borrowings	**3,267**	**2,492**
Non-current		
Loans from DHSC	9,788	11,014
Other loans	3,027	3,472
Obligations under finance leases	3,095	1,438
Total non-current borrowings	**15,910**	**15,924**

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%

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 20.1 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC £000	Other loans £000	Finance leases £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 20.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2020	**29,294**	**3,497**	**1,232**	**34,023**
Prior period adjustment	-	-	-	-
Cash movements:				
Financing cash flows - payments and receipts of principal	(17,031)	631	(275)	**(16,675)**
Financing cash flows - payments of interest	(519)	-	(22)	**(541)**
Non-cash movements:				
Additions	-	-	1,070	**1,070**
Application of effective interest rate	517	-	22	**539**
Carrying value at 31 March 2021	**12,261**	**4,128**	**2,027**	**18,416**

Note 21 Finance leases

Note 21.1 Imperial College Healthcare NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee. The Trust leases assets under finance leases including medical equipment, ICT hardware and property

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**4,454**	**2,027**
of which liabilities are due:		
- not later than one year;	1,359	589
- later than one year and not later than five years;	2,142	1,438
- later than five years.	953	-
Net lease liabilities	**4,454**	**2,027**
of which payable:		
- not later than one year;	1,359	589
- later than one year and not later than five years;	2,142	1,438
- later than five years.	953	-

Note 22 Provisions for liabilities and charges analysis

Note 22.1 Provisions summary

	Redundancy £000	Legal claims £000	Other £000	Total £000
At 1 April 2021	**113**	**245**	**36,449**	**36,807**
Arising during the year	14	91	7,930	8,035
Utilised during the year	(14)	(19)	(68)	(101)
Reversed unused	-	-	(190)	(190)
At 31 March 2022	**113**	**317**	**44,121**	**44,551**
Expected timing of cash flows:				
- not later than one year;	113	317	40,156	40,586
- later than one year and not later than five years;	-	-	3,215	3,215
- later than five years.	-	-	750	750
Total	**113**	**317**	**44,121**	**44,551**

Note 22.2 Clinical negligence liabilities

At 31 March 2022, £833,390k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2021: £507,862k).

Note 23 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(77)	(111)
Net value of contingent liabilities	**(77)**	**(111)**

Note 24 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	26,805	12,126
Total	**26,805**	**12,126**

Note 25 Financial instruments

Note 25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed mean the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities. The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors and within scope of internal auditor.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust also borrows from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31 March 2022 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 1.1.2. Mitigating this, the Trust's operating costs are incurred in relation to contracts with CCGs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure from internally generated resources. The Trust's strategy is to manage liquidity risk by ensuring that it has sufficient funds to meet all of its potential liabilities as they fall due. Liquidity forecasts are produced regularly to ensure the utilisation of current facilities is optimised and liquidity is maintained. The Trust also continually assesses its loan funding.

Note 25.2 Carrying values of financial assets

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2022		
	£000	**£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**

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2021		
	£000	**£000**
Trade and other receivables excluding non financial assets	78,351	78,351
Cash and cash equivalents	149,055	149,055
Total at 31 March 2021	**227,406**	**227,406**

Note 25.3 Carrying values of financial liabilities

	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2022		
Loans from the Department of Health and Social Care	11,040	11,040
Obligations under finance 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**

	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2021		
Loans from the Department of Health and Social Care	12,261	12,261
Obligations under finance leases	2,027	2,027
Other borrowings	4,128	4,128
Trade and other payables excluding non financial liabilities	197,926	197,926
Total at 31 March 2021	**216,342**	**216,342**

Note 25.4 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 2022 £000	31 March 2021 £000
In one year or less	238,312	200,575
In more than one year but not more than five years	8,203	9,816
In more than five years	7,708	6,130
Total	**254,223**	**216,521**

Note 26 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	38	46	26	33
Bad debts and claims abandoned	416	2,123	274	1,409
Stores losses and damage to property	12	520	11	352
Total losses	**466**	**2,689**	**311**	**1,794**
Special payments				
Ex-gratia payments	54	1,171	41	37
Total special payments	**54**	**1,171**	**41**	**37**
Total losses and special payments	**520**	**3,860**	**352**	**1,831**

Special payments for 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 1 April 2022 they will not be regarded as special payments.

Note 27 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Imperial College Healthcare NHS Trust. During the year 2021/22 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 2022. This list is indicative and not exhaustive.

Department of Health

NHS England

NHS foundation trusts including:

Chelsea and Westminster NHS Foundation Trust

Hillingdon Hospitals NHS Foundation Trust

CCGs including:

Camden CCG

North West London CCG

Richmond CCG

NHS trusts including:

London North West University Healthcare NHS Trust

Other NHS Bodies including:

Health Education England

NHS Litigation Authority

NHS Pension Scheme

NHS Blood & Transplant

Other non-NHS entities:

HM Revenue and Customs

The Trust has undertaken the following transactions with related parties which are not part of the UK Govermnent. Transactions include income and expenditure in the year as well as balances outstanding at the year end.

	Income £000s	Expenditure £000s
Imperial College London	8,782	33,534
The Imperial College Healthcare Charity	3,809	-

	Receivables £000s	Payables £000s
Imperial College London	3,628	-
The Imperial College Healthcare Charity	2,260	-

Note 28 Events after the reporting date

There are no events after the end of the reporting period that warrant disclosure in these accounts.

Note 29 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	159,727	786,235	152,470	756,093
Total non-NHS trade invoices paid within target	157,681	754,296	149,770	726,145
Percentage of non-NHS trade invoices paid within target	98.7%	95.9%	98.2%	96.0%
NHS Payables				
Total NHS trade invoices paid in the year	5,112	68,134	7,209	75,973
Total NHS trade invoices paid within target	4,532	60,558	6,360	70,906
Percentage of NHS trade invoices paid within target	88.7%	88.9%	88.2%	93.3%
Total Payables				
Total trade invoices paid in the year	164,839	854,369	159,679	832,066
Total trade invoices paid within target	162,213	814,854	156,130	797,051
Percentage of trade invoices paid within target	**98.4%**	**95.4%**	**97.8%**	**95.8%**

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 30 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2021/22 £000	2020/21 £000
Cash flow financing	(68,080)	(69,769)
Finance leases taken out in year	1,026	1,069
Other capital receipts	-	-
External financing requirement	**(67,054)**	**(68,700)**
External financing limit (EFL)	(67,054)	92,803
Under / (over) spend against EFL	**-**	**161,503**

Note 31 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	94,861	85,919
Less: Donated and granted capital additions	(16,036)	(7,716)
Charge against Capital Resource Limit	**78,825**	**78,203**
Capital Resource Limit (CRL)	80,855	79,038
Under / (over) spend against CRL	**2,030**	**835**

Note 32 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus / (deficit) (control total basis)	83
Remove impairments scoring to Departmental Expenditure Limit	4,922
Breakeven duty financial performance surplus / (deficit)	**5,005**

Note 33 Breakeven duty rolling assessment

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614
Cumulative breakeven position as a percentage of operating income		**3.8%**	**4.2%**	**3.2%**	**4.1%**	**5.6%**	**7.0%**

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Breakeven duty in-year financial performance	(47,879)	(15,330)	3,023	32,996	11,255	47	5,005
Breakeven duty cumulative position	22,283	6,953	9,976	42,972	54,227	54,274	59,279
Operating income	1,019,905	1,096,575	1,160,803	1,212,959	1,300,616	1,422,789	1,483,121
Cumulative breakeven position as a percentage of operating income	**2.2%**	**0.6%**	**0.9%**	**3.5%**	**4.2%**	**3.8%**	**4.0%**

NHS
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NHS Trust

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