Welcome to our AGM 2018
Please take a seat, the AGM is about to begin
Welcome

Sir Richard Sykes
Chairman
Part I

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

Part II

- The stroke care revolution
2017/18 review and a look ahead

Professor Tim Orchard
Chief Executive
Our Trust in numbers 2017/18

1,125,000
Patient contacts
(including inpatients, outpatients and day cases)

299,000
Emergency attendees
(including A&E and AEC)

39,000
Operations
(including day and inpatients)

97%
Inpatients who would recommend us to their friends and family

A top 5 Trust with lowest mortality ratios

£43m
Cost improvements
Operational performance 2017/18

4-hour A&E access

18 week referral to treatment

- Operational standard
- England performance
- Trust performance
Operational performance 2017/18

Cancer: 2 week wait from urgent GP referral

Cancer: 62-day wait from urgent GP referral

Operational Standard

England performance

Trust performance
Responding to challenges and opportunities

• Quality improvement
• Estate and service developments
• Our staff and volunteers
• Research and innovation
• Transformational change
Responding to challenges and opportunities

Quality improvement

Spotlight on: Alert to sepsis
Responding to challenges and opportunities

Estates and service developments

Outpatients
Charing Cross

Thistlethwayte
St Mary’s

LINAC scanner
Responding to challenges and opportunities

Our staff and volunteers

Spotlight on: NHS70 campaign

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

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

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

Dr Ramzi Khamis, consultant interventional cardiologist, Hammersmith Hospital

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

Carmella Obinyan, Imperial Health Charity volunteer, Queen Charlotte’s & Chelsea Hospital
Responding to challenges and opportunities

Research and innovation

Rare genetic eye diseases

Pioneering prostate treatment

BMJ award for PREPARE for surgery
Responding to challenges and opportunities

Transformational change

• Organisational culture - vision and values
• Clinical strategy refresh
• Integrated care
• Estates redevelopment
• Digital strategy
• Patient and public involvement
Financial accounts 2017/18

Richard Alexander
Chief financial officer
Agenda

2017/18
• headlines
• context
• financial snapshot
• investments and savings

2018/19
• looking ahead
## 2017/18 headlines

<table>
<thead>
<tr>
<th>Reported surplus</th>
<th>Capital expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>£3m</td>
<td>£57.4m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Savings delivered</th>
<th>Underlying deficit cut by</th>
</tr>
</thead>
<tbody>
<tr>
<td>£43.1m</td>
<td>£12m</td>
</tr>
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## 2017/18 in context

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

* Adjusted for fixed asset revaluation
2017/18 financial snapshot

Where do £s come from?
- Non-patient care services to other bodies, £18m
- Rent received, £2m
- Other revenue, £36m
- STF, £26m
- Education, training and research, £106m
- Non-NHS patient care, £68m
- NHS patient care, £905m

Where do £s go?
- Staff, £640m
- General supplies and services, £37m
- Clinical supplies and services, £269m
- Property and premises plant equipment, £104m
- Other, £11m
- Financing and interest, £17m
- Clinical negligence, £30m
- Education, training and research, £27m
2017/18 investing in staff (£m)

<table>
<thead>
<tr>
<th>Year</th>
<th>Senior Managers</th>
<th>Administration &amp; Estates</th>
<th>Healthcare Assistants</th>
<th>Nursing</th>
<th>Scientific &amp; Technical</th>
<th>Other Medical</th>
<th>Consultants</th>
<th>Total Fixed workforce</th>
<th>Total Flexible workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>38.9</td>
<td>78.8</td>
<td>76.2</td>
<td>69.9</td>
<td>181.9</td>
<td></td>
<td>39.2</td>
<td>500.0</td>
<td></td>
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<tr>
<td>2016-17</td>
<td>37.4</td>
<td>80.5</td>
<td>79.2</td>
<td>66.9</td>
<td>192.9</td>
<td></td>
<td>42.2</td>
<td>200.0</td>
<td></td>
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<tr>
<td>2017-18</td>
<td>46.4</td>
<td>85.2</td>
<td>88.7</td>
<td>64.0</td>
<td>107.1</td>
<td></td>
<td>46.6</td>
<td>300.0</td>
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2017/18 investing in estates and equipment

<table>
<thead>
<tr>
<th>Trust wide</th>
<th>£44.6m</th>
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<tbody>
<tr>
<td>Backlog maintenance</td>
<td>£17.9m</td>
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<tr>
<td>ICT</td>
<td>£6.4m</td>
</tr>
<tr>
<td>Global digital excellence</td>
<td>£4.1m</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>£4.0m</td>
</tr>
<tr>
<td>Other equipment</td>
<td>£4.1m</td>
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<tr>
<td>Outpatient re-development</td>
<td>£2.9m</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>£2.7m</td>
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<tr>
<td>Other schemes</td>
<td>£2.5m</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Charing Cross Hospital</th>
<th>£5.1m</th>
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<tr>
<td>LINACS</td>
<td>£4.2m</td>
</tr>
<tr>
<td>7 North</td>
<td>£0.7m</td>
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<tr>
<td>Emergency department</td>
<td>£0.2m</td>
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## 2017/18 investing in estates and equipment

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Amount</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Hammersmith Hospital</strong></td>
<td>£1.6m</td>
<td>2 x SPEC CT machines</td>
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<tr>
<td></td>
<td></td>
<td>Energy schemes</td>
</tr>
<tr>
<td><strong>St. Mary’s Hospital</strong></td>
<td>£6.2m</td>
<td>Bed capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paediatric inpatients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PICU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Critical care provision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A&amp;E reconfiguration</td>
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### 2017/18 savings summary

<table>
<thead>
<tr>
<th></th>
<th>Clinical</th>
<th>Corporate</th>
<th>Total</th>
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<tr>
<td><strong>Savings delivered £m</strong></td>
<td>34.1</td>
<td>9</td>
<td>43.1</td>
</tr>
<tr>
<td><strong>of which is Income:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Income</td>
<td>18.8</td>
<td>3</td>
<td>21.8</td>
</tr>
<tr>
<td>Acute New Care Models &amp; Community</td>
<td>3.2</td>
<td>0</td>
<td>3.2</td>
</tr>
<tr>
<td>Private Patients</td>
<td>1.9</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Other Income</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Income Total</strong></td>
<td>24.1</td>
<td>3.1</td>
<td>27.2</td>
</tr>
<tr>
<td><strong>of which is Pay:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank, Agency &amp; Overtime</td>
<td>2</td>
<td>0.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Non-Clinical / Admin</td>
<td>0.7</td>
<td>0.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Clinical Related Pay Savings</td>
<td>1</td>
<td>0.1</td>
<td>1.1</td>
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<tr>
<td><strong>Pay Total</strong></td>
<td>3.7</td>
<td>1.2</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>of which is Non-Pay:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement &amp; Contracts</td>
<td>4.4</td>
<td>2.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Medicines Management/Drugs</td>
<td>1.2</td>
<td>0</td>
<td>1.2</td>
</tr>
<tr>
<td>ICT / Digital Transformation</td>
<td>0.1</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Consumables &amp; Waste Reduction</td>
<td>0.1</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Consultancy</td>
<td>0.3</td>
<td>0.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Other Non-Pay Cost Reductions</td>
<td>0.2</td>
<td>0.5</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Non-Pay Total</strong></td>
<td>6.3</td>
<td>4.7</td>
<td>11</td>
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### 2018/19 looking ahead

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Plan (£'m)</th>
<th>Actual (£'m)</th>
<th>Underlying position</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>-18.5</td>
<td>-47.9</td>
<td>-53.7</td>
</tr>
<tr>
<td>2016/17</td>
<td>-16.9</td>
<td>-49.8</td>
<td>-50.0</td>
</tr>
<tr>
<td>2017/18</td>
<td>-4.5</td>
<td>-37.4</td>
<td>-30.5</td>
</tr>
<tr>
<td>2018/19</td>
<td>3.0</td>
<td>13.6</td>
<td></td>
</tr>
</tbody>
</table>

Plan, Actual, Underlying position.
2018/19 Looking ahead

• challenging financial position in 2018/19 and beyond

• addressing the underlying financial challenge is key and we have to be prepared to change

• we continue to invest in maintaining and improving our estate and equipment but redevelopment is now critical
The stroke care revolution

Dr Soma Banerjee
Consultant stroke physician

Dr Kyri Lobotesis
Consultant interventional neuroradiologist
Epidemiology and burden of stroke

• second commonest cause of death in the world

• largest single cause of severe disability

• >100,000 people will suffer a stroke in England each year

• more common with increasing age

• cost to NHS: £1.7bn
What is a stroke?

• brain attack

• occurs when there is an interruption of blood supply to part of the brain

• this means there is a lack of oxygen delivered to the affected part of the brain

• brain cells (neurons) in the area affected start dying within minutes
Types of stroke

Ischaemic (80%)

Haemorrhagic (20%)
Treatment of ischaemic stroke

- treatments are time dependent and aim to restore blood flow to the brain

- gold standard treatment ‘clot busting medicines’  
  .......until recently

- new and exciting development: mechanical thrombectomy
Old generation thrombectomy devices
New generation devices - stentriever
Mechanical thrombectomy
How stentriever work
How stentrievers work
What is the evidence?

Thrombectomy within 8 Hours after Symptom Onset in Ischemic Stroke

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

**Methods**
We randomly assigned eligible patients on other intracranial arterial lesions plus usual care or usual care alone. Eligible patients had a proximal arterial occlusion in the anterior cerebral circulation that was confirmed by imaging. The primary outcome was the modified Rankin scale score at 90 days, categorized as effective functional outcome with scores ranging from 0 to 5 as in previous trials. Functional outcome was assessed using ordinal regression as a continuous variable, adjusted for prespecified prognostic factors. The adjusted odds ratios were calculated using a logistic regression model and expressed as the odds of effective functional outcome.

**Results**
We randomized 509 patients in 16 medical centers in the Netherlands (238 assigned to thrombectomy and 271 assigned to usual care). The mean age was 65 years (range, 48 to 96), and 459 patients (90%) were enrolled within 24 hours of symptom onset. The median time from symptom onset to groin puncture was 47 minutes (IQR, 39 to 64), and the median time from symptom onset to intravenous tissue plasminogen activator (t-PA) administration was 52 minutes (IQR, 45 to 60). The primary outcome was achieved in 75% of patients in the thrombectomy group and 50% in the usual care group (P=0.001). The median time from groin puncture to the first pass of the thrombectomy device was 22 minutes (IQR, 16 to 28). The median time from symptom onset to intravenous t-PA administration was 60 minutes (IQR, 48 to 78). The median time from symptom onset to the first pass of the thrombectomy device was 48 minutes (IQR, 40 to 60). The median time from symptom onset to the final pass of the thrombectomy device was 60 minutes (IQR, 50 to 78). The median time from symptom onset to recanalization was 78 minutes (IQR, 60 to 96).

**Conclusions**
In patients with acute ischemic stroke caused by a proximal arterial occlusion, thrombectomy reduced the severity of disability over the range of the modified Rankin scale by 2 scores (95% confidence interval, 1.05 to 2.48) and led to higher rates of functional independence (an score of 0 or 1) and 0- to 2-day mortality compared with usual care alone. Thrombectomy reduced mortality by 2.4 times (95% CI, 1.2 to 4.8 days) and recanalization was achieved in 75% vs 50% (P=0.001). The median time from symptom onset to recanalization was 48 minutes (IQR, 40 to 60). The median time from symptom onset to the first pass of the thrombectomy device was 22 minutes (IQR, 16 to 28). The median time from symptom onset to intravenous t-PA administration was 60 minutes (IQR, 48 to 78). The median time from symptom onset to the final pass of the thrombectomy device was 60 minutes (IQR, 50 to 78). The median time from symptom onset to recanalization was 78 minutes (IQR, 60 to 96).

Stent-Retriever Thrombectomy after Intravenous t-PA vs. t-PA Alone in Stroke

In patients with acute ischemic stroke caused by a proximal arterial occlusion, thrombectomy reduced the severity of disability over the range of the modified Rankin scale by 2 scores (95% confidence interval, 1.05 to 2.48) and led to higher rates of functional independence (an score of 0 or 1) and 0- to 2-day mortality compared with usual care alone. Thrombectomy reduced mortality by 2.4 times (95% CI, 1.2 to 4.8 days) and recanalization was achieved in 75% vs 50% (P=0.001). The median time from symptom onset to recanalization was 48 minutes (IQR, 40 to 60). The median time from symptom onset to the first pass of the thrombectomy device was 22 minutes (IQR, 16 to 28). The median time from symptom onset to intravenous t-PA administration was 60 minutes (IQR, 48 to 78). The median time from symptom onset to the final pass of the thrombectomy device was 60 minutes (IQR, 50 to 78). The median time from symptom onset to recanalization was 78 minutes (IQR, 60 to 96).
What is the evidence?

- **Extend-IA**
  - IV-tPA: 40.0%
  - Endovascular: 71.4%

- **Swift Prime**
  - IV-tPA: 35.5%
  - Endovascular: 60.2% (p<0.001)

- **Escape**
  - IV-tPA: 29.3%
  - Endovascular: 53.0%

- **Revascat**
  - IV-tPA: 28.2%
  - Endovascular: 43.7% [15.5%]

- **Mr Clean**
  - IV-tPA: 19.10%
  - Endovascular: 32.60% [13.5%]
Thrombectomy in Europe
Our thrombectomy service

• available seven days a week, from 7am to 11pm

• patients need to arrive within 5 hours of onset of symptoms

• usually given clot busting drugs first

• thrombectomy is suitable if scan shows a clot in a large vessel
## Our external referrers

<table>
<thead>
<tr>
<th>Stroke centre</th>
<th>Distance</th>
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</thead>
<tbody>
<tr>
<td>Northwick Park</td>
<td>10 miles</td>
</tr>
<tr>
<td>Watford</td>
<td>22 miles</td>
</tr>
<tr>
<td>Wycombe</td>
<td>31 miles</td>
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<tr>
<td>Luton</td>
<td>37 miles</td>
</tr>
<tr>
<td>Reading</td>
<td>37 miles</td>
</tr>
<tr>
<td>Lister</td>
<td>38 miles</td>
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</table>
Our service at Charing Cross Hospital

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

- **Emergency Department**: All potential thrombectomy patients arrive at ED
- **Stroke Team**: Patients met in Emergency department by stroke team. Consultant review required for all thrombectomy patients
- **Neuroradiology**: All imaging discussed/reported by neuro-radiologist
- **Neuro-IR Suite**: All thrombectomy procedures performed by interventional neuro-radiologist with anaesthetic presence
- **ITU / HASU**: HASU or intensive care unit after procedure
Case presentation

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

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

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

• immediate improvement whilst still in angiography suite

• able to move left side

• mild difficulty in speech

• discharged from hospital after 2 days
What could have happened
Early recognition of symptoms is vital

Public Health England FAST campaign
Conclusions

• ‘time is brain’

• thrombectomy is a ‘game-changer’ for stroke treatments

• immediate challenge is the delivery of 24/7 thrombectomy service locally & nationwide

• future NHS must continue to support research and innovation
Thank you

Sir Richard Sykes
Chairman