Delivering our promise
Better health, for life

Annual Report
2016/17

Imperial College Healthcare NHS
NHS Trust

Contents

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Welcome

Sir Richard Sykes, chairman

Imperial College Healthcare is one of the largest NHS trusts in the country, offering a wide range of acute and specialist care for our local communities as well as for patients nationally and internationally. We also play a lead role in healthcare research and education, as part of one of the UK's nine academic health science centres and 20 National Institute of Health Research biomedical research centres.

With growing challenges and opportunities for health systems across the world – from the increasing volume and complexity of care needs to the huge potential of our growing understanding of genomics – it's more important than ever that the NHS continues to innovate. And we need to do this at a time of unprecedented financial pressure.

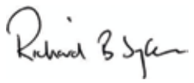
Our approach is to continue to make improvements in all aspects of how we run our services as well as to develop new models of care and ways of working. It's clear the only sustainable way forward is greater integration across the health and care system and a whole population focus on helping everyone to be as healthy as possible. This will require a coming together of all stakeholders, as well as a genuine partnership between health and care services and the patients and local communities we serve, to evolve to meet changing needs while staying true to the values and ethos of the NHS.

Those values were highly visible in the incredible response to those injured in the attack on Westminster Bridge and around Parliament in March. As one of four major trauma centres in London, St Mary's Hospital received eight patients within minutes of a major incident being called. Staff across the Trust immediately went into action, from the major trauma, intensive care and theatres teams to security and other clinical teams making sure all our patients were getting the care they needed while making room for the casualties. Their behaviour reflected the many media reports of the astonishing expertise, professionalism and selflessness on display in the NHS that day.

We also had the unusual experience last year of seeing the Trust in action weekly on national television in the BBC Two documentary series, Hospital. Again, I was very proud of the values and behaviours demonstrated by staff across our hospitals, on the 'shop floor' as well as behind the scenes. Hospital also did a great job of raising awareness and understanding of the challenges and opportunities we all need to respond to if we are to ensure our Trust – and the wider NHS – can deliver its full potential over the coming years.

This annual report provides a snapshot of many more developments at the Trust over the past year as well as, we hope, a clear and balanced account of our achievements and challenges. It also represents the last full year under the leadership of our chief executive Dr Tracey Batten, who is returning to Australia. Tracey has been key to very significant improvements across all aspects of the Trust and our wider health system over the past three years.

I hope you find our report of 2016/17 interesting and helpful – and I would really encourage you, in whatever role you have, to find out more through our website and social media channels, especially on how you could get more involved in shaping and guiding our work this year and for the years to come.



Richard Sykes
chairman

Performance report

Performance report: 2016/17 overview

Dr Tracey Batten, chief executive

Our staff achieved an incredible amount last year, in an increasingly challenging and complex environment.

First and foremost, we responded to rising demand by providing great care to more people than ever before. Compared with the previous year, that included 7,500 more patients seen in A&E, 7,000 more day surgery patients, 11,000 more outpatient contacts and 6,000 more people coming into hospital as inpatients. Overall, we had over 1.5 million patient contacts last year.

We also built on the first year of our new quality improvement approach, with projects underway throughout the Trust as well as significant progress on our strategic improvement programmes and developments. This included refurbished clinics, more streamlined processes and better communications across all of our outpatient services as well as better urgent and emergency pathways and improved facilities.

At the end of May 2017, the Care Quality Commission acknowledged a real improvement in outpatient services and diagnostic imaging at Charing Cross, Hammersmith and St Mary's hospitals, publishing new ratings for outpatient services and diagnostic imaging based on its inspection in November 2016. The ratings are up two levels to 'good' overall at St Mary's and Hammersmith hospitals, and up one level to 'requires improvement' at Charing Cross.

However, increasing demand also meant that we struggled with the national operational performance standards – particularly for waiting times for A&E and for some planned operations. We have put in place clear action plans, though delivering the standards consistently is a key risk as we go into 2017/18.

Collaboration

The past year also saw a step change in collaboration and coordination across the NHS and, increasingly, with social care and other partners. Published in October and setting out a five-year strategy for tackling shared challenges in health and care, the North West London Sustainability and Transformation Plan is still a work in progress in many ways, but it has sparked a renewed and very positive impetus to joint working.

There was significant, tangible progress from collaboration in a number of areas. The Hammersmith & Fulham Integrated Care Programme has expanded to include five NHS organisations as well as lay partners, and we are working closely with social services in the borough to design and test out genuinely joined up care pathways for local people. Our care information exchange, offering patients and their health and care professionals in north west London secure online access to care records and to sharing information, began its pilot roll out, ending the year with 1,000 registered users across 13 services and five organisations.

Our academic health science centre partnership with Imperial College expanded to include The Royal Marsden NHS Foundation Trust and the Royal Brompton & Harefield NHS Foundation Trust. This has doubled the pool of clinicians and other healthcare staff, researchers and academics who are working together to translate research breakthroughs into better patient care as quickly as possible.

Innovation

In terms of innovation, we were delighted to be funded by the National Institute of Health Research to run our biomedical research centre in partnership with Imperial College for a further five years. The BRC is supporting 675 active research projects across 15 different disease areas.

With funding support from Imperial Health Charity, we also began the first UK trial to treat patients with debilitating tremors using focused ultrasound, opening the way for a potentially 'game-changing' non-invasive alternative to conventional brain surgery.

We were rewarded for our role as a leader in the adoption of digital technologies to improve patient care, when we were selected by NHS England to be one of 16 global digital exemplars for acute care. With our partner Chelsea & Westminster Hospital NHS Foundation Trust, we will receive funding and support to drive forward the use of digital technology and create products and approaches that can also be used by other organisations.

Leadership and support

All of this was achieved while meeting a 'stretch' financial plan which allowed us to comply with our 'control total' for the year set by our regulators NHS Improvement. Our outturn of -£15.3 million, including non-recurrent sustainability and transformation funding of £25.4 million, reflected the delivery of £54 million of cost improvements by staff across the whole Trust. Our new systems and enhanced support mean we start 2017/18 more prepared for further cost improvements than ever before. However, given the overall financial challenge, with the NHS facing one of its smallest funding increases in many years, the Trust has again needed to set a budget with a planned deficit.

I believe our new organisational structure – devolving more authority to our clinical teams, supported by more focused corporate support, and reducing the number of management layers – has been an important factor in our ability to deliver more for patients this year. Our nearly 11,000 staff are really beginning to make the most of new opportunities to initiate and lead change in their own areas as well as to influence our strategic developments.

We also benefitted hugely from our close relationship with Imperial Health Charity, who are helping to fund many of our major initiatives as well as supporting patients and staff through their grants schemes, arts programme and volunteering. And we have great support from a number of other charities too, as well as our hospital Friends organisations. We have increasingly active patient and public involvement across all aspects of our work, and I am particularly appreciative of our strategic lay forum, now in its second year.

As ever, I am extremely grateful to all of our staff, supporters and volunteers, and our partners in the NHS, local authority and voluntary sectors, for all of your hard work and commitment in achieving the most that we can for our patients and local communities.

Dr Tracey Batten
chief executive until 30 July 2017

Ian Dalton CBE became chief executive on 31 July 2017

About the Trust

Imperial College Healthcare NHS Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with nearly 11,000 staff.

We seek to ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. We want to play our full part in helping people live their lives to the fullest.

We are part of Imperial College academic health science centre, along with Imperial College London, The Royal Marsden NHS Foundation Trust and The Royal Brompton & Harefield NHS Foundation Trust – supporting rapid translation of research and excellence in education.

Our vision and objectives

Our vision is to be a world leader in transforming health through innovation in patient care, education and research.

To enable us to achieve this, our strategic objectives are:

- to achieve excellent patient experience and outcomes, delivered efficiently and with compassion
- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care
- to pioneer integrated models of care with our partners to improve the health of the communities we serve
- to realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Our ethos

To help everyone to be as healthy as they can be, we want to look out for the people we serve as well as to look after them.

We look after people by providing care, whenever and however we are needed, listening and responding to individual needs. We look out for people by being their partner at every stage of their life, supporting them to take an active role in their own health and wellbeing.

We are one team, working as part of the wider health and care community. We are committed to continuous improvement, sharing our knowledge and learning from others. We draw strength from the breadth and depth of our diversity, and build on our rich heritage of discovery.

By doing all this, we ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. And we are able to play our full part in helping people live their lives to the fullest. Our promise is better health, for life.

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 and services

We provide care from five hospitals on four sites as well as a range of community facilities across the region.

Our five hospitals are:

- **Charing Cross Hospital,** Hammersmith – providing a range of acute and specialist care, it also hosts the hyper acute stroke unit for the region and is a growing hub for integrated care in partnership with local GPs and community providers. Charing Cross has a 24/7 A&E department.
- **Hammersmith Hospital,** Acton – a specialist hospital renowned for its strong research connections. It offers a range of services, including renal, haematology, cancer and cardiology care, and provides the regional specialist heart attack centre. As well as being a major base for Imperial College, the Acton site also hosts the clinical sciences centre of the Medical Research Council.
- **Queen Charlotte's & Chelsea Hospital,** Acton – a maternity, women's and neonatal care hospital, also with strong research links. It has a midwife-led birth centre as well as specialist services for complicated pregnancies, foetal and neonatal care.
- **St Mary's Hospital,** Paddington – the major acute hospital for north west London as well as a maternity centre with consultant and midwife-led services. The hospital provides care across a wide range of specialties and runs one of four major trauma centres in London in addition to its 24/7 A&E department.
- **Western Eye Hospital,** Marylebone – a specialist eye hospital with a 24/7 A&E department.

Increasingly, we offer patient consultations and care in community facilities that would traditionally have been provided in our hospital outpatients clinics, and we are working closely with GPs and other primary and community care organisations to offer integrated health care services.

Imperial Private Healthcare is our private care division, offering a range of services across all of 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 our NHS services.

Research and education

The Trust with Imperial College hosts one of 20 National Institute for Health Research (NIHR) biomedical research centres (BRC). This designation is given 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.

The NIHR Imperial BRC supports 675 active research projects across 15 different disease areas. We also lead one of NHS England's 13 genomic medicine centres – the West London Genomic Medicine Centre – with our partners Chelsea & Westminster Hospital NHS Foundation Trust, The Royal Brompton & Harefield NHS Foundation Trust and The Royal Marsden NHS Foundation Trust, helping to drive innovation in genomics.

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 2016/17, 810 Imperial College medical undergraduates trained with us and we are the lead provider for core, specialty and GP medical postgraduate training across north west London. We have around 500 student nurses and midwives in training annually, many of whom gain their first job or qualification with us.

Our charities

We work increasingly closely with Imperial Health Charity, which supports a wide range of initiatives for patients and staff. In 2016/17 the Charity supported £8.3 million of expenditure on the Trust's capital programme along with a number of other non-capital schemes and initiatives.

During 2016/17 the Trust also received generous support from COSMIC (Children of St Mary's Intensive Care), the Winnicott Foundation, which raises funds to improve care for premature and sick babies at St Mary's Hospital, and each of the Friends of St Mary's, Charing Cross, and Hammersmith hospitals.

Our commissioners

Almost half of our care is currently commissioned by north west London local clinical commissioning groups (CCGs), about 40 per cent is specialist care commissioned by NHS England, and about 10 per cent of our care is by other commissioners including CCGs beyond our local area.

The CCGs in north west London have formed two groupings:

- CWHHE collaborative: NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith & Fulham CCG, NHS Hounslow CCG, and NHS West London CCG
- BHH federation: NHS Brent CCG, NHS Harrow CCG and NHS Hillingdon CCG.

North West London Sustainability and Transformation Plan (STP)

In north west London, we are working together across the NHS, social care and voluntary sector to improve healthcare services for our two million residents. A Sustainability and Transformation Plan (STP) for health and care in north west London was published in October 2016. One of 44 such plans across England, it was developed by 28 NHS, local authority and voluntary sector partners, including our Trust.

Its five delivery areas are:

- radically upgrading prevention and wellbeing
- eliminating unwarranted variation and improving long-term condition management
- achieving better outcomes for older people
- improving outcomes for children and adults with mental health needs
- ensuring we have safe, high quality, sustainable acute services.

Our own strategies are very much in line with the objectives of the STP and a number of our key initiatives are being supported by and/or influencing the STP's implementation.

Our regulators

From 1 April 2016, the NHS Trust Development Authority (TDA) and Monitor, the regulator for NHS foundation trusts, merged to form NHS Improvement, now responsible for overseeing both NHS trusts and foundation trusts. Under NHS Improvement's Single Oversight Framework, the Trust is rated as a three out of four segments. A rating of three is given to providers who are receiving mandated support for significant concerns.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The Trust received an overall rating of 'requires improvement' following the CQC's first, full inspection of our Trust in September 2014.

The CQC returned in November 2016 to inspect our outpatient and diagnostic imaging service, the only core service to be rated overall by site as 'inadequate' following the 2014 inspection. The new ratings for this core service were published in May 2017, and reflected improvements across all sites, moving to 'good' overall at St Mary's and Hammersmith hospitals and 'requires improvement' overall at Charing Cross Hospital.

In March 2017, the CQC carried out unannounced inspections of two core services: maternity at St Mary's Hospital, currently rated as 'good', and medical care at St Mary's, Charing Cross and Hammersmith hospitals, with all sites currently rated as 'requires improvement'. We will receive our ratings from these inspections during 2017/18.

The Trust in numbers 2016/17 (all rounded)

Our care

1,055,000
outpatient contacts

210,000
inpatient contacts

288,500
A&E attendees

10,500
babies born

109,000
inpatient operations

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

Our staff

10,970
Staff, including:

2,500
Doctors

4,400
Nurses & midwives

650
Allied health professionals

950
Scientists & technicians

120
Pharmacists

810
Undergraduate doctors in training

500
Nurses in education, pre-registration

Our finances

£1,096.6m
Turnover

-£15.3m
Deficit at year end

£54m
Efficiency savings

£47.6m
Invested in buildings and infrastructure

Performance analysis: introduction

We regularly review information and feedback about our services and activities at all levels across the organisation. This helps us ensure we are on track to meet our targets and objectives and to deliver our strategic plans, as well as to help us spot and address problems as soon as they arise.

We also contribute to a range of national monitoring programmes, which allows our performance to be benchmarked against that of similar NHS trusts.

Every month, our executive management team reviews a comprehensive set of performance indicators – our 'scorecard'.

A scorecard with a core set of indicators is also reviewed by the Trust board at its public meeting. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies.

On our website, we publish an easy-to-understand monthly performance summary taken from the scorecard as well as the full scorecard that goes to each public board meeting.

Assessing performance against our strategic objectives

Assessing progress against our objectives is an important aspect of performance analysis. All developments within the Trust must aim to achieve one or more of our five strategic objectives:

- to achieve excellent patient experience and outcomes, delivered with care and compassion
- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care
- to pioneer integrated models of care with our partners to improve the health of the communities we serve
- to realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Following our analysis of performance against our strategic objectives for 2016/17, we look forward and set out our two-year, business plan objectives for 2017-19. These objectives take into account the following, significant issues facing the Trust as we enter 2017/18 (further detail on each issue is provided in the governance statement on page 46):

- ability to achieve and maintain financial sustainability
- ability to achieve required performance targets in the emergency department and for elective surgery
- ability to recruit and retain required clinical staff, particularly in relation to ward-based nurses, midwives and radiographers
- ability to gain funding approval from key stakeholders for the redevelopment programme
- ability to fund the appropriate level of back-log maintenance whilst awaiting redevelopment, and the resulting risk to necessary funding for the medical equipment replacement programme.

Assessing performance against the five domains of quality

The scorecard sets out our indicators under the five domains of quality used by the Care Quality Commission to assess the quality of NHS organisations across England – safe, effective, caring, responsive and well-led.

These domains also form the framework for our quality strategy and for our annual quality account that sets out and reports on our annual targets for improving quality.

This performance report draws out the annual performance against key indicators under each domain, see pages 32 to 41. A more detailed assessment of performance against all of our quality targets for 2016/17 can be found in our 2016/17 quality account.

Many of our major initiatives in 2016/17 were intended to support more than one of our strategic objectives. However, for ease of reporting, we have set them out in this report under the primary objective to which they relate.

Performance against corporate objectives

Objective: to achieve excellent patient experience and outcomes, delivered with care and compassion

Improving outpatient services

Around a million people come to the Trust's hospitals as outpatients every year and we have been running a major programme to improve the quality of their experience.

This includes £3 million of refurbishment works, creating a more patient-friendly environment at our clinics at Charing Cross and Hammersmith hospitals, funded by Imperial Health Charity (known as Imperial College Healthcare Charity in 2016/17) who also committed nearly £300,000 to update the outpatient department at Western Eye Hospital.

And it's not just about the physical space. We have also been tackling issues with appointment letters, patients being rescheduled at short notice and long waiting times in some clinics with high demand.

From September 2016 patients were able to get their appointment details by email if they chose, with 90,000 patients opting in to receive email correspondence by March 2017. For those who prefer having their appointments sent by post, we switched to a new postal service in June 2016 that is faster and more reliable. We also made the appointment letters clearer and more informative.

If patients want to change their appointment they will soon be able to ring one phone number for all queries. During the year, we created a single patient services centre at Charing Cross Hospital with funding from our Charity. Here, all of the outpatient administration teams are coming together putting in place new ways of working to make sure we get things right for patients and GPs, first time.

We also introduced appointment reminders by voicemail and expanded text reminders, with more than half of patients contacted now confirming their attendance. All of the improved communication has meant that fewer people are missing their appointment – down from 17 per cent in 2014 to 11 per cent in 2017.

This is all part of our efforts to go digital, helping to make our processes more streamlined. Patient records are held electronically on a secure system, which has many benefits for patient care. Now, when a doctor sees a patient in clinic, they have their key details to hand and there aren't delays waiting for paper records. Furthermore, GPs now receive 96 per cent of documentation, including patient discharge summaries, electronically.

GPs can also refer patients to our hospitals electronically, with a 50 per cent increase in GP electronic referrals in the six months to March 2017. There is a national requirement for all referrals to be made via electronic channels by October 2018.

Patient transport is another key issue for those who are not able to travel to outpatient appointments independently. We reviewed our patient transport service, recruited an additional 28 drivers and introduced a new system that can match short notice requests to the earliest available vehicle.

In November 2016, the CQC carried out an inspection of our outpatient and diagnostic imaging service, provided at St Mary's, Charing Cross and Hammersmith hospitals. This was the only core service to be rated overall by site as 'inadequate' following our first, full inspection in 2014. The new ratings for this core service were published in May 2017, and reflected improvements across all sites, moving to 'good' overall at St Mary's and Hammersmith hospitals and 'requires improvement' overall at Charing Cross Hospital.

Now that we are making good progress with our systems and facilities, we are focusing our efforts on transforming our model of care to meet changing needs and demand as well as on following up on further, recommended actions from our 2016 CQC inspection.

Milestone in St Mary's redevelopment

A planning application for a vital new outpatients building at St Mary's Hospital was submitted to Westminster City Council in December 2016.

The proposal is driven by three main needs, to:

- **support better care** – allowing for more integrated care, tailoring and combining different specialist services to meet individual needs as well as helping patients to recover quickly and stay well.
- **improve patient experience** – providing services in ways that will make it as easy and as stress free for patients, their carers and families, as possible.
- **replace ageing buildings** – a third of buildings at St Mary's are more than 100 years old and expensive to maintain and run. New and more efficient buildings will follow best practice in design and technology.

The proposed eight-storey building will replace the existing Salton House, Dumbell and Victoria and Albert buildings between Praed Street and South Wharf Road on the eastern side of the hospital estate.

The new facility will bring together the majority of St Mary's outpatient services

and supporting diagnostics such as blood tests, which are currently provided from 40 different locations across the hospital site.

The development plans include the latest technology, with follow-up consultations via telephone or Skype where appropriate. And there will be faster, more holistic care with co-ordinated, same day appointments for patients with multiple needs so that people can have their tests, results and consultation all in one day.

There are also plans for fast check-in, a café, children's play area and easy-to-follow signage. Space for community health and wellbeing sessions, research and training is being built into plans. Patients and lay partners are involved in the design to make sure it will work well for everyone using the service. It will serve around half a million patients a year.

Reducing waiting times

With increasing demand for our services, keeping waiting times down for planned care has been a particular challenge. In early 2016, the Trust also identified some issues with how we were managing our waiting lists as well as underlying capacity problems in some areas. This is despite increasing the number of planned operations we carry out by 50 per cent over the past four years.

We invited NHS Improvement's Elective Care Intensive Support Team to review our processes and to provide advice on improvements. In response, we established a dedicated waiting list improvement programme that has focused on:

- a data quality clean up – a systematic and detailed audit of all of our waiting lists. This resulted in an increase in the number of patients reported to be waiting over 18 weeks from referral to treatment – the national standard is for no more than 92 per cent of patients to wait this long. We also identified a number of patients who had been waiting over 52 weeks
- improved waiting list management – better processes, training and on-going audit to make sure all lists are now managed correctly and consistently
- systematic clinical review – detailed reviews by doctors to ensure patients are not coming to clinical harm as a result of their waits
- additional clinical activity – including running more outpatient clinics and theatre sessions, both within the Trust and with the support of independent sector providers
- improved theatres – our Riverside theatres at Charing Cross Hospital were completely refurbished, see below. A temporary mobile operating theatre was used to ensure that we were able to maintain our theatre capacity during the refurbishment period.

A full refurbishment of Charing Cross Hospital's Riverside theatres has enabled us to provide a better experience for patients, expand the range of procedures undertaken there and put in place more efficient ways of working. The four operating theatres in the unit are tailored for planned surgery for short-stay patients. The £1.8 million upgrade programme was supported by a £1 million grant from Imperial Health Charity.

See page 38 for a summary of our performance against the national 18-week referral to treatment standard.

Boosting urgent and emergency care

We saw a three per cent increase in A&E attendances and a five per cent increase in emergency admissions in 2016/17. Like many trusts across the country, we struggled to meet the national standard for 95 per cent of A&E patients to be treated and discharged or admitted within four hours. See page 38 for a summary of our performance against the standard.

We have been rolling out a range of improvements to enable a better 'flow' of patients through our urgent and emergency care pathways. We are working to ensure patients receive care in the right place at the right time by the right healthcare professional, from their first contact with us, through assessment, diagnosis and treatment, to ensuring a safe and timely discharge.

Key initiatives in 2016/17

St Mary's Hospital

A £3.2 million refurbishment of St Mary's A&E began in June, funded by Imperial Health Charity. Due for completion in summer 2017, it is providing:

- an expansion in resuscitation bays – where seriously ill patients are stabilised as priorities – from four to six
- a new four-bed assessment unit within the children's A&E department to provide dedicated facilities for children who need further investigation
- a new adult clinical assessment area
- a redesigned reception area to offer more privacy and a better patient experience
- a new area where friends and families can wait.

In addition, the Trust opened a 12-space surgical assessment unit at St Mary's in January 2017 to enable faster access to a specialist surgical opinion where required.

A&E remained open throughout the refurbishment and staff worked hard to ensure the works did not affect our patients' experience. An expansion in consultant numbers in 2015/16 has enabled us to have more senior staff in the department until later in the evening and at the weekends, and a further expansion of consultants for our children's A&E is planned for 2017/18.

Charing Cross Hospital

A £790,000 redevelopment has enabled us to expand and co-locate services for patients in our urgent and emergency care pathway on the ground floor at Charing Cross, close to the A&E department.

This includes a new acute assessment unit for up to 13 patients and a 35-bed acute medical unit for patients admitted urgently, through A&E or via their GP, who need further short-term observation, diagnostics or treatment before being discharged or admitted to the appropriate inpatient ward.

Some of the doctors and nurses on the new units have moved across from Hammersmith Hospital as part of planned changes in autumn 2016 to consolidate acute medicine services at Charing Cross and St Mary's where we have our A&E departments.

Mental health

Following a change in legislation designating emergency departments as safe places to accommodate those in crisis, the number of patients attending the emergency departments at St Mary's and Charing Cross hospitals with a mental health related complaint increased and has remained high throughout 2016/17. Waiting times for this group of patients continue to rise, with patients requiring admission to a mental health bed experiencing the longest delays.

We are working with commissioners and the mental health trusts to improve the pathway for mental health patients. We have also established a dedicated consultant lead for mental health and added registered mental health nurses in both emergency departments.

Ambulatory emergency care

We extended the opening hours of our ambulatory emergency care (AEC) service at St Mary's and Charing Cross hospitals, which now includes weekends. The AEC service provides specialist diagnostics and treatment for patients who have urgent needs but are well enough to go home in between procedures or consultations and, essentially, to be cared for on an urgent outpatient basis.

Improving safety

We have achieved a 50 per cent reduction in the total number of grade 3 and 4 pressure ulcers (the most serious) since 2014 and we have not had a grade 4 pressure ulcer since 2013. This has been further supported by an app developed by the tissue

viability team in 2015/16 which allows nurses to record and share vital real time data about pressure ulcers enabling better management and prevention.

We continue to focus on preventing ulcers and are collaborating with our partners in the community to adopt a whole systems approach to reducing harm from pressure damage.

We have reduced the number of hospital-acquired infections, reporting:

- three Trust-attributable cases of MRSA BSI compared to seven the previous year
- 63 Trust-attributable cases of Clostridium difficile compared to 73 the previous year.

We continue to work to reduce infections by reducing the inappropriate use of antibiotics, improving hand hygiene, screening and training.

Significant improvements were implemented in relation to safer surgery, including training and audit programmes. A group was established to review how we were conducting interventional procedures across the Trust and to ensure we were providing the safest possible care for our patients. As a result of this work, we are starting to see improvements in compliance with the five steps to safer surgery.

Recognising that we have more work to do to improve our safety culture, in June 2016 we started a programme of work to develop and embed a culture in which all staff can describe their contribution to patient safety, feel confident in raising safety concerns and know how to address such issues within their place of work. This work will continue into 2017/18.

Further information about the work described above and our performance against the five domains of quality can be found on pages 32 to 41, with full details available in our quality account.

Faster access for chest pain and urgent renal and haematology care

Patients with cardiac-related chest pain or urgent renal or haematology conditions are benefitting from the introduction of new ‘direct entry’ urgent care pathways at Hammersmith Hospital in August 2016. Timely treatment in a specialist centre has been demonstrated to improve outcomes.

These patients now see the right clinician and receive the right care in the right facilities, first time. Previously, patients presenting with urgent chest pain or renal or haematology care needs could be seen by the acute medicine service at Charing Cross, Hammersmith or St Mary’s hospitals before being transferred to the appropriate specialist service. This created an unnecessary step in a patient’s care journey.

Patients with cardiac-related chest pain attending A&E at St Mary’s or Charing Cross hospitals are now stabilised and transferred directly to the heart assessment centre at Hammersmith Hospital.

Patients with suspected heart attack are already taken directly by London Ambulance Service to one of London’s eight specialist heart attack centres, including the one at Hammersmith Hospital, rather than the nearest A&E. This has been in place since 2010 and has been proven to save lives.

Hammersmith Hospital’s heart attack centre layout was changed to improve privacy and patient experience as well as to increase capacity by up to 15 beds for patients to recuperate after their treatment.

All of the changes followed extensive engagement with patients, carers, local residents and other stakeholders.

Objective: to educate and engage skilled and diverse people committed to continual learning and improvement

Making quality improvement everyone's business

As part of our 2015-2018 quality strategy, the quality improvement (QI) programme was launched and is now into its second year of building a culture of continuous improvement across the organisation.

The programme:

- engages with staff to ensure everyone knows about QI and feels empowered to see improving patient care as a key part of their role
- builds improvement capability through a programme of QI education to enable staff to lead, champion and coach improvement work within their teams
- supports teams to deliver focused QI projects and programmes aligned to our quality strategy
- embeds rigorous improvement methods in our organisational approach to change.

The method of improvement is to 'plan' – make a plan to do something; 'do' – try it out; 'study' – see what happens using measurement; and 'act' – use the results to tweak things the next time round. In this way we build up lots of small changes that add together to make a big difference.

In 2016/17, the QI team engaged directly with just under 3,000 staff, initiating a broad ranging education and coaching programme for over 400.

At March 2017, the QI team was actively supporting 17 strategic Trust-wide initiatives as well as 45 service-led QI projects. They have provided over 112 pieces of internal consultancy work to Trust improvement projects.

Case study: Improving use of orthopaedic theatres

Our trauma and orthopaedics team provide the lead spinal service for north west London and perform over 3,500 planned surgery procedures per year. Data analysis showed that the service was not performing as efficiently as it could be. First cases were not always starting on time, performance targets for theatre utilisation were not met, and there were too many cancellations on the day of surgery.

Members of the multi-disciplinary team attended a QI training day where they worked together to identify the challenges they wanted to address and plan their first improvements. The team ran a series of diagnostics in order to understand the issues. This included observations of practice, a review of patient experience and development of a data pack.

For their first 'test' improvement, the team introduced an extra bay with a dedicated nurse for the patient next on the surgery list. This means they are ready the minute the theatre is available, decreasing the number of late starts and minimising turnaround time between patients. As a result theatre starting time and utilisation has improved and there is an increased number of surgical lists.

Improving education for our healthcare professionals

We teach a range of healthcare professions and, in 2016/17, this included 810 undergraduate doctors in training, in association with Imperial College London, and 500 nurses and midwives, through King's College and Bucks New University.

Medical education has continued to develop through a transformation programme, resulting in improved feedback from our clinical placements.

We have attracted additional placements for undergraduates by offering innovative new ways of training. Our programme of simulation for foundation doctors and those in surgical training shares unique training facilities with Imperial College, and we run team training and in-situ multi professional simulation to enhance patient safety awareness in several specialties.

The postgraduate medical education department continues to deliver training across our five hospitals, supporting 790 trainees – junior doctors who continue to be developed following graduation. We improved on our performance in the national training survey.

We continue to train the nurses and midwives of the future, and also offer the post graduate education they need to do their jobs and grow professionally. In 2016/17 we prepared to be an early implementer site for the new nursing associate role, with the training programme for these new professionals beginning in April 2017.

We are also exploring the graduate nurse apprenticeship programme which we aim to begin in September 2017. The apprenticeship programme will allow staff who wish to train as a registered nurse to gain their qualifications while being employed by us. We are also looking at growing our apprenticeship training schemes for other professionals.

Expanding our research fellowship programme

Imperial Health Charity and our National Institute for Health Research Biomedical Research Centre's research fellowship programme provides 'first-step funding' for health professionals looking to begin their academic career.

This year, nine projects received grants of up to £50,000 to undertake pioneering research and invest in the training and development of our hospital staff.

The programme allows staff – medical and non-medical – to undertake 12 months of research to develop their research skills for the benefit of patients. Just under £437,000 was allocated to a range of grants, which include research into improving ultrasounds to better assess liver damage and developing a urine test to diagnose oesophageal and gastric cancers.

Developing our staff at all levels

More than 1,000 staff participated in our award-winning staff development programmes in 2016/17.

Courses include the year-long, modular courses for leaders at different stages of their careers – from front line supervisors up to senior leaders. We also ran an innovative 'paired-learning' programme which enables junior doctors and junior managers to learn together.

Our short-course programme aids specific skills development and provides career support. And we run an active coaching and mentoring register and training programme as well as regular sessions on people management topics including performance and development reviews, HR policies and procedures, and handling workplace conflict.

Focus on staff engagement

During 2016/17 there was a focused effort to improve employee experience across the organisation and we achieved our highest ever staff engagement score in the national NHS staff survey in winter 2016.

We understand that staff engagement is essential to excellent organisational performance and the delivery of high quality patient care, taking a holistic approach. This included in-depth engagement with staff in the restructure of the organisation, involvement in our work on values, the launch of *Pulse* magazine and the development of our new people and organisation development strategy *Better health, for life, through our people.*

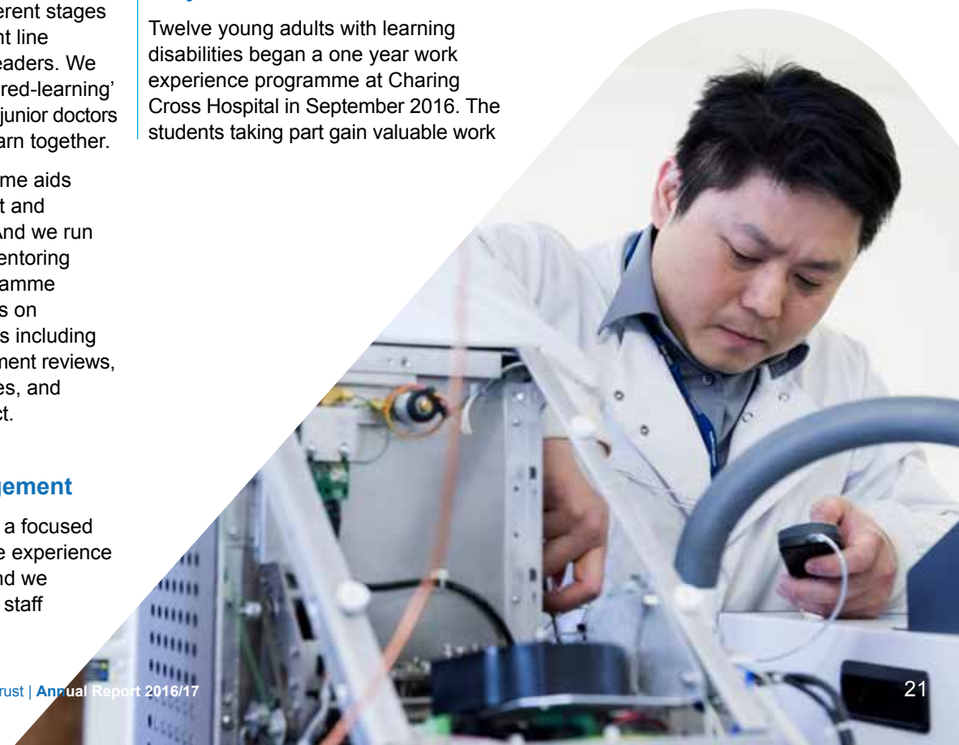
We redesigned our internal engagement survey *Our voice, our trust* to better understand how we can help people have more good days at work. We also rolled out a conversation-based approach to sharing and articulating staff experience called *In our shoes* which over 700 employees have taken part in.

Project SEARCH

Twelve young adults with learning disabilities began a one year work experience programme at Charing Cross Hospital in September 2016. The students taking part gain valuable work experience and built a transferable skill set at the Trust through a supported internship training programme called *Project SEARCH.*

Project SEARCH is aimed at supporting young adults with learning disabilities into paid employment. Only seven per cent of adults with learning disabilities were in some form of paid work in 2012 according to the Department of Health, this is in contrast to the 65 per cent who said they would like a paid job and are capable of having one with the right kind of support and training.

The students work in different departments in the hospital, and are matched to their placements based upon their skills, abilities and interests. They rotate placements every three months in order to gain the maximum amount of experience during their time at the Trust. Our first cohort of students graduated in July 2017.



Objective: as an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care

£90 million biomedical research centre award

In September 2016 we were awarded £90 million, in partnership with Imperial College, to continue our joint research to develop and improve treatments for our patients.

The biomedical research centre (BRC) award, from the National Institute for Health Research (NIHR), covers the five years from April 2017. The NIHR is funded by the UK Department of Health.

The Imperial BRC was first established in 2007 and the new funding allows us to continue our world-class research into cancer, heart disease, brain sciences, immunology, infection, surgery and metabolic disorders.

It will also support research and technology development in areas that cut across conditions such as genomics, imaging, molecular phenotyping and the use and storage of biomedical data and samples. In addition, for the first time, the NIHR award to the Imperial BRC will fund research into gut health, with a focus on innovative approaches to disease that consider the microbiome.

Work funded by the Imperial BRC is already having an impact on how patients are diagnosed and treated. Researchers have:

- developed a promising treatment for the childhood degenerative disease, Friedrich's ataxia
- created a new test for a form of kidney disease
- generated new insights into cardiovascular disease using imaging technology and genomics
- designed a prototype implantable chip that can help control appetite
- designed an intelligent surgical knife called the 'iKnife' which identifies if tissue being cut is cancerous.

Clinical excellence funding for clinical research

The National Institute for Health Research (NIHR)/Wellcome Trust Imperial Clinical Research Facility at Hammersmith Hospital was awarded more than £10 million in funding by the Department of Health for clinical excellence.

This specialist research facility provides dedicated bed space for up to 25 patients participating in research studies that require stays of up to 10 days. The research facility is staffed by a team of 40 dedicated healthcare professionals specialising in clinical research. They facilitate ground breaking trials that otherwise would not be possible due to demand for hospital beds and the expertise required.

The new award, the largest grant awarded in London, will fund the clinical research facility until March 2022. This will allow the Trust to continue to support experimental medicine clinical research studies with patients and healthy volunteers across a wide range of conditions.

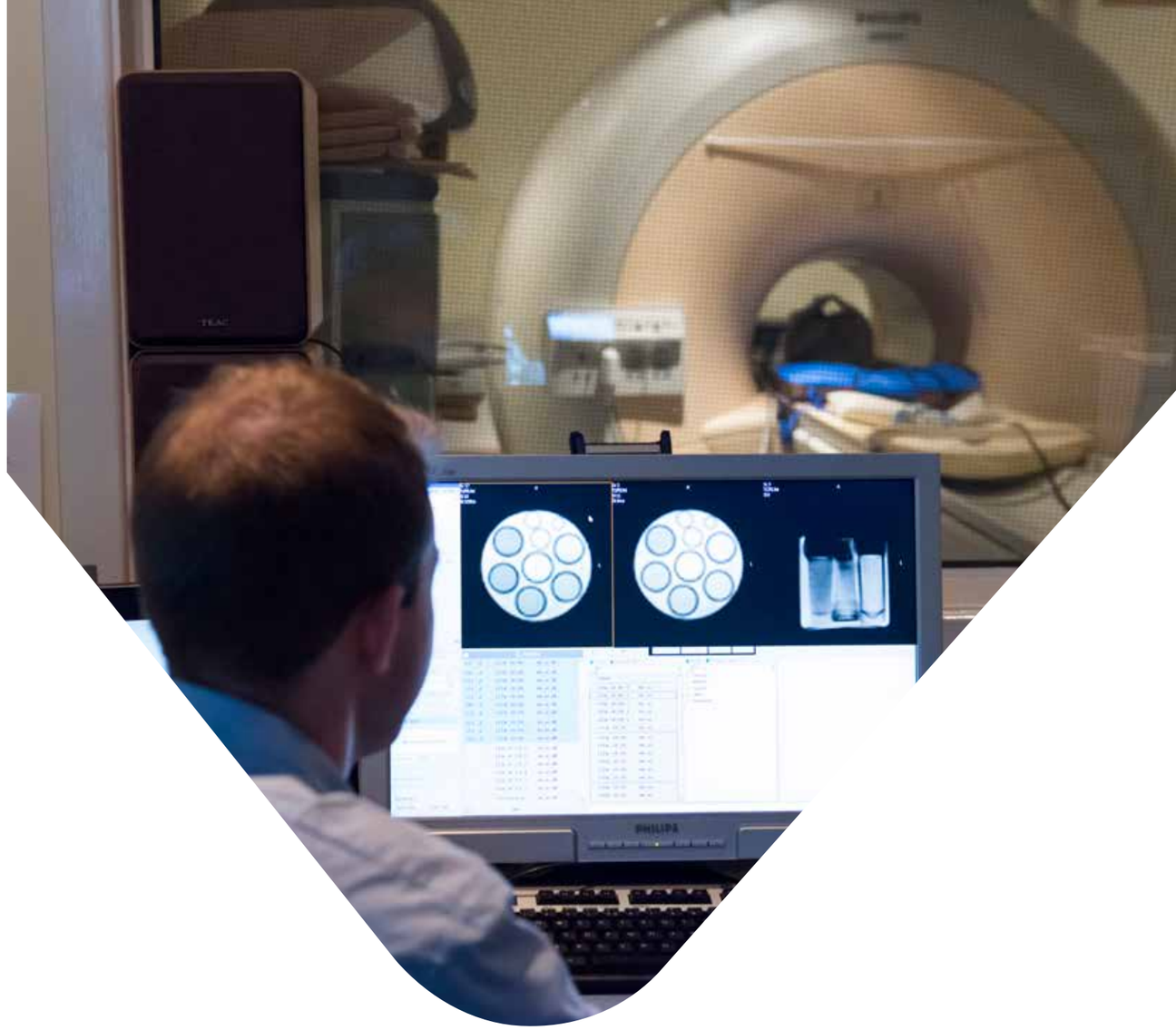
Non-invasive ultrasound for brain surgery

We began the first UK trial to treat patients with debilitating tremors using high-intensity, focused ultrasound waves, avoiding traditional, invasive brain surgery techniques.

Around one million people in the UK are affected by an essential tremor (ET), a brain disorder characterised by uncontrollable shaking. Approximately 100,000 people also have tremors caused by other movement disorders such as Parkinson's disease or multiple sclerosis. Currently, patients with ET or other types of tremor are offered treatment that can have serious side effects.

The Trust hopes that the procedure will be made available on the NHS once the trials have concluded and the effectiveness of the treatment has been proven. It is anticipated that new trials will be set up to examine the benefits of the treatment for people with Parkinson's disease and other types of tremor, including multiple sclerosis associated tremor in the near future.

The trial was supported by a £1 million grant from Imperial Health Charity to enable the purchase of special equipment to deliver the ultrasound.



Building the foundations for personalised medicine

We are the lead organisation for the West London Genomic Medicine Centre, one of 13 NHS centres delivering the 100,000 Genome Project nationally.

The project aims to create a new genomic medicine service for the NHS, transforming the way people are cared for. It focuses on two main groups – patients with a rare disease and their families and patients living with common cancers.

These areas have been selected because eligible rare diseases and cancer are strongly linked to changes in the genome. By understanding these changes, there is potential to better understand how the disease develops and which treatments will be most effective. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

Working alongside our partners Chelsea & Westminster Hospital NHS Foundation Trust, Royal Brompton & Harefield NHS Foundation Trust and Royal Marsden NHS Foundation Trust, the West London Genomic Medicine Centre had collectively recruited 487 rare disease patients and 387 cancer patients to the project as of March 2017.

Objective: to pioneer integrated models of care with our partners to improve the health of the communities we serve

Hammersmith & Fulham integrated care programme

The Trust is part of a growing collaboration of organisations working to develop a radically better way of providing care for the population of Hammersmith and Fulham.

Along with the Hammersmith & Fulham GP Federation (representing GP practices in the borough), Chelsea & Westminster Hospital NHS Foundation Trust, West London Mental Health NHS Trust and Central London Community Healthcare NHS Trust, the partnership aims to:

- design a practical 'accountable care' approach – collectively looking after the holistic needs of local people and helping them stay as healthy as possible, rather than only focusing on treating patients when they present with a health problem
- identify and implement immediate improvements to 'join-up' care, primarily through a series of tested projects
- build strong foundations for forming a formal accountable care partnership – influencing and responding to emerging health policy across north west London and the rest of the country.

Accountable care approaches are a potential way of overcoming dispersed responsibility for the commissioning and provision of care. The programme also involves lay partners in the co-design of all aspects of the emerging care model.

During 2017/18, the partnership plans to test its shared principles in practice by redesigning a number of care pathways for a sample of the population. The partnership is also working closely with Hammersmith & Fulham social care services.

A step change in patient and public involvement

The first Trust-wide patient and public involvement strategy and action plan, created through a series of co-design events, was approved by the Trust board in July 2016. It builds on many great examples of patient and public involvement in supporting and developing specific services across the Trust.

At the heart of the strategy is the commitment to ensure patients and the public are able to help shape and input to every aspect of the Trust's work, specifically:

- maximising individual health and wellbeing, for example with patients engaging directly with their health and care professionals through the Care Information Exchange
- supporting care and service delivery, through volunteering and fundraising
- improving care and services, for example by taking part in workshops to re-design services
- strategy, policy and planning, by providing 'lay partner' input to project groups and programme boards, for example.

During the year, significant progress was made on establishing new ways for patients and the public to get involved. This includes:

- establishing a 12-strong strategic lay forum – made up of patients, carers and local residents to oversee the further development and implementation of the strategy and to ensure key Trust policies and developments have appropriate patient and public input
- recruiting, training and supporting an additional 22 lay partners to oversee Trust programmes and service developments as equal members of the team
- creating a patient communications group to help ensure our materials are clear and effective.

The patient and public involvement work is supported by Imperial Health Charity, who also took over responsibility for volunteering at the Trust during the year.

Care Information Exchange

The Trust is leading a major initiative to build an online care record for patients and those providing their care across north west London.

With £3 million funding from Imperial Health Charity, the goal is to improve care and help patients be more in control of their own health. Patients can access their information at any time, on their computer or smartphone, and choose to share the information as they wish, with health and care professionals, relatives and carers. Patients also have the ability to record their own information into their record.

By the end of 2016/17, over 1,000 patients had registered with the Care Information Exchange, of whom 600 were active users across 13 services and five organisations. A further 500,000 records have been created in the exchange, ready to enable many more patients to register and to become active users.

Improving cancer care with Macmillan Cancer Support

Our partnership with Macmillan Cancer Support is entering its third year. Having successfully improved the experience of patients in active treatment – as evidenced by the latest National Cancer Patient Survey – the programme is now focusing on improving the quality of life for the increasing number of people living with and beyond cancer.

Advances in scientific knowledge mean that at least 50 per cent of people diagnosed with cancer can now expect to live for ten years or longer. But we know that there are side effects, both of the cancer and its treatment, which can impact on quality of life.

Phase two of our partnership specifically aims to:

- develop a deeper understanding of what enables people to live well with and beyond cancer, or stops them from doing so, by way of an in-depth research project
- deliver services which enable people to access timely support and information to help them manage their condition.

Central to the ethos of the programme is strengthening the links between the Trust and the wide range of community-based services in north west London, including GP and primary care services and community and charitable groups. We know that as cancer is increasingly recognised as a chronic condition, support services outside the hospital setting will be critical to the education, self-management and adjustment of patients to their 'new normal'.

North West London Pathology

A major hub for pathology services in north west London was developed at Charing Cross Hospital in preparation for the launch of North West London Pathology on 1 April 2017.

North West London Pathology is a joint venture between the Trust, Chelsea & Westminster NHS Foundation Trust and Hillingdon Hospital NHS Foundation Trust to provide a modern and efficient pathology service. The partnership is expected to manage 25 million tests per year and become one of the biggest pathology services in Europe.

Most of the routine, specialist and non-urgent activity will be delivered at the 'hub' at Charing Cross Hospital. Pathology required urgently for the immediate treatment of patients will be performed in 24/7 essential service laboratories based at the other hospital sites in the group.

Major projects to prepare for the launch included the development of a common IT system, 150 staff moved from West Middlesex and Hillingdon to Charing Cross in January 2017 and a board was appointed in March 2017.

Objective: to realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

Building financial sustainability

We made significant progress during the year towards achieving financial sustainability, delivering one of our largest ever cost improvement programmes and putting in place robust processes and support for devolving more financial management to clinical directorates and corporate teams. And this was achieved at the same time as caring for more patients and continuing to make improvements in quality.

We were one of 16 NHS trusts to take part in NHS Improvement's national financial improvement programme. We chose to partner with consultants PricewaterhouseCoopers (PwC) whose specialist team worked closely with our clinicians and managers to ensure cost improvement schemes were planned and implemented effectively. They also helped us to establish a project support office to oversee all cost improvement schemes, initially running it with their own staff and then being part of its careful transition to an on-going, in-house function.

We were also one of the first wave of trusts to take part in Lord Carter's review of hospital productivity, helping us to benchmark ourselves against similar trusts across the country to identify where we might be able to make further savings.

Projects that have contributed to our cost improvement programme include:

- bringing our fertility service back in-house, as the Wolfson Fertility Centre
- outsourcing our managed equipment service
- renegotiating contracts with some of our big suppliers
- developing our private services.

At the start of 2016/17 we were not in a position to sign up to our financial control total set by NHS Improvement. However, when we reviewed our financial performance half way through the year we were then confident the Trust would achieve a 'stretch' plan that was £11 million improved. Due to a huge amount of hard work and commitment across the organisation, plus the support of the financial improvement programme, this has enabled us to deliver our control total – of an operational deficit of -£41 million – which has allowed us to access non-recurrent, sustainability and transformation funding of £25.4 million, delivering a year-end position of a deficit of -£15.3 million. This compares with our 2015/16 year-end position of a -£47.9 million deficit.

Our new processes and support have enabled us to be at a more advanced stage of planning and implementation for cost improvement schemes as we entered 2017/18 but the financial challenge this year is even greater than last year's, with increasing demand and additional cost pressures. We are continuing to develop in-year plans as well as focusing on how we can address more strategic aspects of our deficit, such as the costs we incur from having very old and inefficient estate and the high costs of some of our very complex, specialist services.

Trust recognised as global digital exemplar

Our role as a leader in the adoption of digital technologies to improve patient care was recognised in March 2017 when, in partnership with Chelsea & Westminster Hospital NHS Foundation Trust, we were selected by NHS England to be one of 16 global digital exemplars in acute care. As a global digital exemplar, we will receive funding and support to drive forward the use of digital technology and create products and approaches that can be used by other organisations.

Our joint application with Chelsea and Westminster put our shared electronic patient record system at the heart of our plan. Our bid also included commitments to record sharing to support integrated care and patient engagement, development of healthcare apps which will securely connect to the patient record, and technology to support population health.

Kind to each other, kind to patients

Staff are encouraged to reflect together on the personal aspects of their sometimes emotionally challenging work in healthcare through a series of open forums called Schwartz rounds. The rounds aim to directly support staff, enhance relationships and communication within and between teams, and contribute to a compassionate organisational culture while improving patient and carer experience.

Since 2015, when Schwartz rounds were launched, we have hosted 23 rounds across our three main hospitals, attended in total by over 1,000 staff of which around 10 per cent also work in community settings. Staff consistently rate their experience of these meetings very highly.

Funding from Macmillan Cancer Support, Health Education North West London (HENWL) and Imperial Health Charity enabled us to set up and run this project for the first 18 months, and continued support from Imperial Health Charity and HENWL will maintain our programme through 2017.

Highlights 2016/17

HRH The Prince of Wales meets Trust's nursing stars

His Royal Highness The Prince of Wales visited St Mary's Hospital in October 2016 to meet four nurses from the Trust who were shortlisted for the Nursing Times Awards 2016: Abby Harper-Payne – nominated for a rising star award, Becky Johl – nominated for cancer nursing award, Dionne Levy – winner of the rising star award and Louise Savine and the tissue viability team – nominated for technology and data in nursing award. His Royal Highness also received a demonstration of a new app developed by nurses at the Trust to help prevent pressure ulcers.

Trust first in UK to pilot Finnish-style baby boxes

The Trust's Queen Charlotte's & Chelsea Hospital was the first hospital in the country to offer Finnish-style baby boxes for newborns as part of a pilot project. The Trust distributed 800 baby boxes, which in Finland is thought to have contributed to reducing the infant mortality rate in the country from 65 infant deaths per 1,000 births in 1938 to 2.26 per 1,000 births in 2015. The UK has some of highest rates of infant mortality in Europe, ranking 22nd out of 50 European countries, with 4.19 deaths per 1,000 births. It is thought the small size of the baby box prevents babies from rolling onto their tummies which experts think can contribute to sudden infant death syndrome.

New technology partnership to help patient safety and care

The Trust has entered into a new partnership with British technology company DeepMind to help it harness the latest digital technology to support better patient care.

The five-year agreement will see DeepMind and the Trust implement technology for mobile clinical applications (apps), including an application programming interface (API) to manage the secure exchange of information between the Trust's existing electronic patient record system and mobile apps for patient care.

Mayor of London visits St Mary's

The Mayor of London Sadiq Khan visited the Trust's major trauma centre services at St Mary's Hospital to learn more about the youth violence intervention programme which aims to tackle youth gang violence. The programme is the result of a partnership between the Trust, Redthread and Imperial Health Charity.

BBC2's *Hospital*

BBC Two's *Hospital* was a ground-breaking six-part documentary airing January to February 2017 that went behind the scenes at our hospitals to show the complexity of the NHS in action. The series received widespread praise for its honest, informative and compelling depiction of the NHS's complex challenges and huge achievements, drawing record viewing figures and sparking debate across social media. A second series started June 2017.

Wolfson Fertility Centre

The Trust is now able to provide a comprehensive fertility and IVF service for patients at its Hammersmith Hospital site in London. The fertility service, based at the Wolfson Fertility Centre, can provide a full range of IVF treatments for patients, both on the NHS as well as privately through Imperial Private Healthcare. The centre includes a state-of-the-art embryology laboratory, which has recently benefitted from a half million pound upgrade of all equipment.

Virtual physiotherapy

Trust staff were part of the low-cost invention, gripAble™ which was recognised by a NHS England Innovation Challenge Prize in 2016 as a means of delivering cost-effective physiotherapy.

The gripAble™ device is designed for patients to use unsupervised in hospital and at home. This simple device can improve the ability of patients with arm disability to play physiotherapy-like computer games, according to new research with stroke patients who had suffered successive strokes with arm paralysis at the Trust over six months.

100,000 new cases of arm weaknesses are diagnosed each year following a stroke. Often this impairs people's ability to carry out daily activities, requiring long-term care. The use of mobile-gaming could provide a cost-effective and easily available means to improve the arm movements of stroke patients but in order to be effective patients of all levels of disability should be able to access it.

The team is now carrying out a feasibility study in north west London to test the use of the device in patients' homes.

Life-saving technology for trauma patients

Specialist trauma surgeons from the Trust are working with the National Institute of Health Research Diagnostic Evidence Cooperative and instrumentation designers from Developers Highland Biosciences to develop new technology to quickly detect whether a patient is suffering from internal bleeding.

The handheld device, called the Coaguscan, is currently in early prototype stage and will help clinicians determine if a patient is suffering from internal bleeding and the exact number of blood products a patient requires from their transfusion.

Recognition for our staff

Venetia Wynter-Blyth, a gastrointestinal clinical nurse specialist at the Trust was awarded the Royal College of Nursing's highest honour, nurse of the year 2016, for her holistic approach to getting patients both physically and psychologically fit for surgery.

Dr Nicola Strickland, a consultant radiologist at the Trust, was elected as president of the Royal College of Radiologists.

Mr Ahmed Ahmed, a consultant in upper gastrointestinal surgery and lead bariatric surgeon at the Trust, was presented with an award from the National Institute for Health Research (NIHR) for recruiting the first patients onto a trial to test the use of a specialist stapler used in bariatric surgery.

Professor Lesley Regan, head of obstetrics and gynaecology at St Mary's Hospital, has been elected the first female president of the Royal College of Obstetricians and Gynaecologists for 64 years.

Ludwig Lupak, above left, a biomedical scientist at the Trust was awarded the Company Members Prize by the Institute of Biomedical Science, after achieving the top mark in the higher specialist diploma in clinical biochemistry.

Dionne Levy, a midwife from the Trust, was crowned 'rising star' at the Nursing Times Awards 2016. As a specialist mental health midwife she is responsible for making sure pregnant women with mental health problems receive the right levels of integrated care at this crucial time.

Dr Guri Sandhu, a consultant ear, nose and throat surgeon at Charing Cross Hospital has been recognised for his outstanding contribution to laryngology – receiving the Isshiki Award from the British Laryngological Association, and becoming only the fifth recipient worldwide.

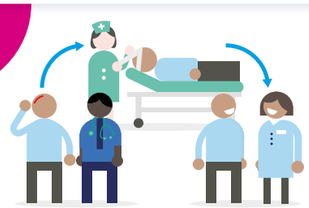
Our promise:

Better health, for life

Imperial College Healthcare NHS Trust

Our objectives 2017-2019

1. Improving the way we run our hospitals



We will create care pathways with processes, ways of working and facilities that consistently achieve the best possible outcomes and experiences for our patients and their families, making the most of digital and other new technologies.

Key initiatives

- ***Outpatient improvement** – including the establishment of a patient service centre, extending digital communications and a major programme of clinic refurbishments.
- ***Improving patient flow** – ensuring patients are cared for in the right place, at the right time, by the right healthcare professional, from first contact, through assessment, diagnosis and treatment, to ensuring a safe and timely discharge; including improvements in A&E, assessment and ambulatory care facilities.
- **Waiting list improvement** – ensuring the most effective management of our planned care, with a focus on better processes and training to improve data quality, enhanced clinical review and more responsive capacity planning.

2. Developing more person-centred approaches to care

We will work in partnership with our patients and partner organisations to create sustainable service and organisational models that help our population stay as healthy as possible and ensure access to the most appropriate care when and where it is needed.

Key initiatives

- **Hammersmith and Fulham integrated care** – testing fully integrated approaches to care in collaboration with other NHS, local authority and lay partners.
- ***Care information exchange** – providing patients and their care professionals in north west London with secure online access to their health records and the ability to share information safely.
- ***Way-finding project** – implementing a Trust-wide approach to ensuring patients and visitors can navigate our sites easily and feel a sense of welcome throughout their journey.
- ***Children's services** – expanding and refurbishing our paediatric intensive care unit, plus a wider redesign of our care and facilities for children.

3. Making our care safer

We will build a culture where all our staff feel safety is key, are able to 'speak up' and understand their responsibilities; and where patients also feel confident to raise safety concerns and believe they will be addressed.

Key initiatives

- **Safety culture** – following research and engagement with staff and patients, making and embedding improvements in core areas of practice, including how we report and learn from incidents in an open and fair way.
- **Critical care reconfiguration** – improved co-ordination of critical care across our sites, including bringing together management of all critically ill patients in dedicated areas by staff fully trained in critical care and organ support.
- **Digital programme** – including greater use of, and easier access to, electronic patient records, automated alerts to identify deteriorating patients and clinical decision-making support.

4. Making the Trust a great place to work

We will create a shared sense of belonging across our organisation, with staff feeling supported, valued and fulfilled, and make a compelling 'offer' in terms of reward and recognition, wellbeing and development.

Key initiatives

- **Embedding our values and behaviours** – promoting positive behaviours and tackling poor ones through support and training for managers, action on bullying and violence, a greater focus on equality and diversity and more accessible senior leadership.
- **One-stop workplace portal** – improving staff experience by replacing our intranet with combined online access to all our business and management functions, including upgraded HR systems, an internal social network and a comprehensive resource library.
- **Recruitment and retention action plan** – developing our 'employer's offer', promoting it more effectively, internally and externally, and simplifying our recruitment processes.

5. Building sustainability

We will continue to build an organisational culture and strategy that enable us to deliver our promise, effectively and sustainably.

Key initiatives

- **Specialty review programme** – a clinically-led approach to supporting our specialties to develop unified and sustainable clinical, workforce and financial plans.
- **Corporate services collaboration** – identifying opportunities for improvement and efficiency from collaborative working, including North West London Pathology and roll out of a joint electronic patient record system with Chelsea and Westminster Hospital NHS Foundation Trust.
- ***St Mary's Hospital redevelopment phase 1** – bringing together the majority of St Mary's outpatient and related diagnostic services in one modern building, reflecting a new model of outpatient care.

*Supported by Imperial Health Charity

Our strategies

Clinical
To help lead the development of integrated care closer to home, the consolidation of specialist care on fewer sites where it improves outcomes and safety, and the advancement of personalised medicine.

Quality
To create a culture of continuous improvement to increase and sustain quality, including through a Trust-wide quality improvement methodology and using the Care Quality Commission's quality framework – safe, effective, caring, responsive and well-led.

Financial
To achieve planned savings and more efficient ways of working so that we can move to a sustainable financial position, allowing us to invest sufficiently in the development of our staff, services and estate.

Workforce
To ensure we are recruiting, engaging and developing sufficient staff with the right skills and capabilities in the right roles, responding to changing needs and service models.

Digital
To facilitate improvements in care pathways, enable data to be shared safely, help empower patients to take an active role in their care, and support population health, using our Cerner electronic patient record system as the foundation.

Estates
To secure a significant re-development and new build on the St Mary's and Charing Cross sites, with Western Eye Hospital relocating to the St Mary's site, and a smaller re-development on the Hammersmith and Queen Charlotte's & Chelsea site.

Research
To make the most of opportunities to align translational research across our expanded academic health science centre partnership and to implement our biomedical research centre programme in partnership with Imperial College.

Education
To support the delivery of our clinical, quality, research and workforce strategies including through multi-professional approaches, new educational models and increased use of technology for learning.

PPI
To ensure that patients and our communities actively shape, and can help contribute to, every aspect of our work, including as lay partners, co-design and research participants, volunteers and fundraisers.

Private healthcare
To develop high quality private practice on all of our sites, with all surplus being reinvested to improve care and support NHS services.

Our values

Kind **Expert** **Collaborative** **Aspirational**

Performance against the five domains of quality

Our quality strategy is delivered through the achievement of our quality goals which ensure quality is our number one priority. Our goals are:

Safe

To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm and extreme harm/death.

Effective

To show continuous improvement in national clinical audits with no negative outcomes.

Caring

To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if they needed care or treatment to 94 per cent.

Responsive

To consistently meet all national access standards.

Well-led

To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis.

Our quality improvement priorities for 2016/17 were defined in our quality account last year following consultation with our clinical and management teams, and with our external stakeholders and patient representatives through our quality steering group.

Progress with these goals and the targets which support them is described here under each quality domain. Areas where we are proud of the improvements we have made or sustained are outlined under ‘quality highlights’. Areas where we have not performed as well as we would wish are summarised under ‘quality challenges’. For full details, please see our quality account, which is published on our website.

Safe

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm and extreme harm/death

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm.

Safe quality highlights

We remain below average for incidents causing severe or extreme harm to patients: We had fewer incidents which cause the most harm to patients compared to other acute trusts this year and have decreased the number overall, with 28 reported in 2016/17 compared to 31 in 2015/16.

We increased our incident reporting rate: An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety, learn from them and deliver improved care. A high reporting rate is viewed as evidence of a positive reporting culture, as staff feel able to report incidents that occur. By the end of the year, we had increased our reporting rate to 49.09 per 1,000 bed days, which puts us in the top 25 per cent of reporters nationally.

We maintained safe staffing levels: Although our vacancy rates remain higher than our target, we have ensured staffing meets planned safe levels this year. The use of temporary workers is one of the ways we have achieved this. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses.

We have reduced the number of non-clinical transfers of patients between our hospitals out-of-hours and have reported none which occurred without clinical agreement: The move of acute medicine from Hammersmith Hospital to the Trust's other main sites at Charing Cross and St Mary's hospitals has supported a decrease in the number of inter-site transfers out-of-hours occurring for capacity reasons, with none occurring in December 2016. For the second year in a row, we have not reported any serious incidents where a non-clinical out-of-hours transfer was a contributory factor.

We have achieved a 50 per cent reduction in the number of grade 3 and 4 pressure ulcers since 2014: Although we have not achieved our target of a 10 per cent decrease compared to 2015/16, we are proud that we have reduced the occurrence of these types of pressure ulcer by nearly 50 per cent in three years and that we have not had a grade four pressure ulcer – the most serious kind – since March 2014.

Safe quality challenges

We reported four surgical related never events: Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2015/16, we reported six never events related to practice in surgery. Improvements were implemented in response, including training and audit programmes. However, four more surgical never events occurred in 2016/17. We carried out a major review and, as a result of this work, we are starting to see improvements in compliance with the five steps to safer surgery.

We reported 12 avoidable infections: In 2015 we began to report 'avoidable' incidences of MRSA blood stream infections (BSI) and Clostridium difficile infections. Although we did not meet our target, we had a slight decrease in avoidable infections in 2016/17, reporting 12 compared to 13 the previous year and with an overall reduction in both infections.

There are two key elements to reducing the risk of infections occurring in hospital, which we will continue to work on into 2017/18:

- reducing the inappropriate use of anti-infectives (antibiotics)
- improving hand hygiene – we developed a new audit which will allow us to monitor and improve compliance for all of the five moments of hand hygiene.

We did not meet the VTE (Venous thromboembolism) assessment target between December and March this year: The risk of hospital acquired VTE – blood clots in the vein - can be reduced by assessing patients on admission. In 2015/16, an internal audit raised concerns about recording VTE assessments. We have been working throughout 2016/17 to ensure effective recording of this assessment. Once this is fully embedded, we expect a return to reporting above target.

Effective

Goal: To show continuous improvement in national clinical audits with no negative outcomes

The goal and targets in our effective domain are designed to drive improvements to support good practice in our services and ensure the best possible outcomes for our patients.

Effective quality highlights

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur in the Trust: As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator). Both of these have remained low, with our Trust being amongst the five lowest risk acute Trusts in the country throughout the year.

Reviewing every death which occurs in our hospitals enables us to learn from any errors and pick up quickly on potential issues which could result in harm to other patients. Of the 1,897 deaths which have so far been reviewed through our new online system, five of them have been confirmed as avoidable deaths. These have all been investigated as serious incidents and the actions and learning have been shared across the Trust.

Since December 2016, we have had a system in place to enable us to review cardiac arrests occurring outside our intensive care units and emergency departments: this is because when a cardiac arrest happens outside these two areas, it is often due to patients not being monitored properly or staff failing to recognise and act on deterioration in their condition. Any incidents where harm has been found are now able to be properly investigated and learning shared. Since this process was implemented, one case has been found to have resulted in harm.

Effective quality challenges

We have not been able to report against our goal to show continuous improvement in national clinical audits with no negative outcomes: Unfortunately, as national clinical audits report in different ways, we have struggled to measure performance against our goal. We will change our goal next year so that we are able to measure our performance more effectively.

Our PROMs health gain was unable to be measured for all procedures due to insufficient numbers of forms being returned: Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced following four surgical procedures: surgery for groin hernia, varicose veins, hip replacement and knee replacement. We are working to ensure more questionnaires are completed by patients to allow us to make improvements based on what our patients are telling us.

We have not achieved our target to discharge at least 35 per cent of our patients on relevant 'pathways' before noon: Untimely discharge has been identified as one of the most common reasons why A&E departments fill and patients have long waits to be seen, admitted or discharged. We have not met our target this year. This is partly due to patients being unable to be discharged as they are waiting for a bed at a care home. We are working with our partners in the community to solve this issue.

We did not meet our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days: Since 2014, up until quarter one 2016/17, we have consistently reported above 90 per cent against this target. However, our results fell below target in quarter two 2016/17, reflecting changes to the Health Research Authority (HRA) approvals process for clinical trials. The average approval times have increased nationally as well as locally. We are identifying ways of shortening approval times so that we can meet our target.

Caring

Goal: To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if they needed care or treatment to 94 per cent

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we ensure that we listen to our patients, their families and carers, and respond to their feedback.

Caring quality highlights

We have exceeded our target for the percentage of our inpatients who would recommend us to friends and family and have maintained our performance in the national inpatient survey published in July 2016, with results very similar to other acute NHS Trusts: 97 per cent of our inpatients said they would recommend the Trust to friends and family.

For patients reporting a positive experience, interaction with staff is usually the most significant factor. When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and to ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible.

The percentage of our A&E patients who would recommend us is over our target and significantly above national average: Like many NHS trusts, we continue to struggle to meet the national standard for A&E patients waiting under four hours to be treated and discharged or admitted. Despite this, we are pleased that 95 per cent of our patients would still recommend our A&E services, which we are continuing to work to improve.

Our results in the national cancer patient experience survey (NPES) show significant improvement: Considerable work has been undertaken to improve the experience of patients with cancer, most notably through our partnership with Macmillan Cancer Support. Results in 2016 demonstrate the positive impact of that work – they are the best set of results that we have returned in the five years that the survey has been running.

We have exceeded our target to respond to 90 per cent of complaints within the timeframe agreed with the patient: In 2015/16 we restructured the complaints service and process following feedback to create a more responsive and caring service for our patients and identify learning for our staff. We have continued to build on the improvements we made last year, focusing on analysing themes and learning from complaints to enable us to direct quality improvement based on what our patients are telling us.

Caring quality challenges

The percentage of outpatients who would recommend our Trust to friends and family is below average and has dropped to 91 per cent from 94 per cent the previous year: Although we are disappointed that this percentage has declined, we are confident that the changes we are making as part of our outpatient improvement programme – see page 15 – will significantly improve outpatient experience.

Responsive

Goal: To consistently meet all national access standards

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment. To consistently meet national standards, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

We know we have much work to do to tackle long-standing pressures around demand, capacity and patient flow to enable us to meet these targets.

Responsive quality highlights

We continue to deliver our outpatient improvement programme and are seeing improvements as a result: We have reduced the amount of outpatient clinics cancelled by the trust, reduced the number of patients who do not attend their outpatient appointments by improving our communications with them, and increased the number of appointments made within five working days of receipt of referral from 70.7 per cent in August to 78.9 per cent in March 2017. For more on outpatients, see page 15.

Responsive quality challenges

We have not consistently met the national standard for non-clinical on-the-day cancellations of surgery: We experienced increased demand for emergency care in 2016/17 which did contribute to the cancellation of a number of planned operations, although we worked hard to minimise them being cancelled on the day of surgery. We did deliver the 0.8 per cent target for three quarters of the year, but not in quarter four where we delivered 0.9 per cent. We also increased our theatre capacity in key surgical specialties and through the new Riverside Theatres at Charing Cross hospital. For more, see page 17.

As a major centre for emergency care and trauma in London, we do have to work to make sure that planned surgery is not impacted by the nature of our emergency work. A project is underway for 2017/18 to ensure that planned surgery and care gets the priority it needs.

We have not met the standard for all patients who have planned operations cancelled for non-clinical reasons on the day of surgery (or day of admission) to be offered another binding date within 28 days. A full review of this is underway for 2017/18.

We have not met the national four hour A&E standard: Like many NHS trusts, we continue to struggle to meet the 95 per cent standard for A&E patients to be treated and discharged or admitted within four hours, reporting 89.6 per cent against this target in 2016/17. Pressures on A&E are complex and include pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery.
We have an on-going programme of improvements and interventions in place to reduce waits, improve flow and capacity and manage extra winter demand. For more, see page 16.

We have not met the national performance targets for referral to treatment (RTT) within 18 weeks: We reported 83.9 per cent of people treated within 18 weeks between April 2016 and March 2017 compared to the national standard of 92 per cent.

We also reported 1,578 patients who had waited over 52 weeks for treatment throughout the year, with 475 in October reducing to 275 in March compared to the national standard of zero. Our failure to meet these standards is due to poor procedures for managing waiting lists internally and to a mismatch of demand and capacity in some specialties.

In response we developed a waiting list improvement programme, which is working closely with our commissioners and NHSI, and is making good progress. For more, see page 16.

We recognise that extended delays will negatively affect patients' experience of care and cause associated anxiety and distress. While we are focusing on minimising delays and improving our waiting list processes to ensure patients are treated in a timely manner, we have implemented robust arrangements to ensure that patients are not coming to clinical harm as a result of waiting too long.

We have not consistently met all eight cancer standards: We met four out of eight cancer standards in all four quarters this year. However we did not achieve the targets for the following standards across every quarter: two week wait from urgent referral to first being seen; two week wait from referral for breast cancer to first being seen; and 62-day wait for first treatment from urgent GP referral and from screening. We have been working hard to stabilise and improve performance and met all but two of the standards by quarter four.

We have not improved our PLACE (Patient led assessment of the care environment) scores in all categories: We have improved our performance in three of the areas measured by PLACE – cleanliness, food and hydration, and condition, appearance and maintenance – compared to our scores for 2015/16. However, in the three other areas – privacy and dignity, dementia and disability – our results have deteriorated. A detailed action plan is underway with themes of flooring repairs, access such as seating and hand rails, and improved signage. Dementia and disability requirements are at the heart of the designs for our new outpatients departments, A&E departments and strategy to improve our wayfinding.

Well-led

Goal: To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation and to help us to deliver our annual targets.

Well-led quality highlights

We have achieved our goal to increase the percentage of staff who would recommend our Trust as a place to work and as a place for treatment: We monitor staff engagement through the national staff survey and through our annual internal survey *Our Voice, Our Trust* which was run between July and September 2016. We were very pleased to see a significant improvement in the scores for both of these; they are our best results for these two questions since the staff survey was introduced in 2013.

We have slightly decreased our voluntary turnover rate: A key aspect of reducing the voluntary turnover rate (the number of staff who choose to leave and work elsewhere) is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. Although we have not met our target, we are pleased that we have seen a slight decrease in staff voluntarily leaving the Trust this year from 10.6 per cent to 10.2 per cent.

Our sickness absence rate remains low: Low sickness absence is an indicator of effective leadership and good people management. This year we have focused on embedding our sickness absence policy, which was launched last year, and on supporting the health and wellbeing of our staff. Our Occupational Health service provides a range of activities and services, including staff counselling, stress management services, yoga and meditation classes, weight management programmes, smoking cessation clinics and rapid access physiotherapy.

We have increased the percentage of our doctors who have had an appraisal: Although we are still slightly behind our target of 95 per cent, we are pleased that our appraisal rates for doctors are now above national average.

We have significantly improved our results in the General Medical Council's National Training Survey of junior doctors and have maintained our performance for placement satisfaction for all medical student placements: As one of London's largest teaching hospitals, we want to provide the best training for our doctors, as we believe this is a key element of being a 'well-led' organisation. We launched a comprehensive education transformation programme in 2015 and have seen improvements in the satisfaction of our trainee doctors and medical students as shown through:

- Student Online Evaluation (SOLE): In 2015/16, we achieved this target for 73 per cent of our programmes, which was an improvement of almost 50 per cent on the previous year. We are pleased that we have succeeded in slightly improving still further, with 76 per cent of students agreeing that 'overall (they are) satisfied with their placement' in 2016/17.
- General Medical Council's national training survey (GMC NTS): Our results have improved significantly with a reduction in red flags (where we are a significant national outlier) by 50 per cent. We have also more than doubled the number of green flags (where we are doing well) from 20 to 54, with three times as many programmes having green flags than in the previous survey.

We re-ran our ward accreditation programme and saw improvements in 25 wards: Our programme of ward inspection carries out regular checks and instigates immediate improvement where necessary. Overall, out of 75 areas reviewed across the Trust, 25 had improved since 2015/16. The Trust's quality improvement team is supporting projects on individual wards to help address their key issues.

Well-led quality challenges

We have not increased the percentage of staff who have had a performance development review (PDR): Our appraisal scheme for staff is aimed at driving a new performance culture across the Trust. Although we are below target and slightly below last year's result, our rate remains high at 86.2 per cent with over 7,200 staff completing their PDR. We will continue to embed and improve the process in 2017/18.

We have not achieved our target of 90 per cent of staff being compliant with core skills training, with 85.6 per cent of our staff fully trained by the end of March 2017: Our core skills training programme ensures the safety and well-being of all our staff and patients and we continue to target areas where compliance is particularly low. We are reviewing all mandatory training modules to streamline and improve them.

Sustainability report

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

We are developing a sustainable development management plan. The aims will include the following:

- minimising our carbon footprint
- reducing our energy usage and increase our proportion of green energy
- ensuring water efficiency
- encouraging sustainable transport
- ensuring procurement that is sustainable both environmentally and socially
- improving our preparations for adverse climate impacts.

The plan will show how we consider the social and environmental impacts to ensure that the legal requirements in the Public Services (Social Value) Act (2012) are met. The Trust currently has 294,304m^2 of floor space.

Minimising our carbon footprint

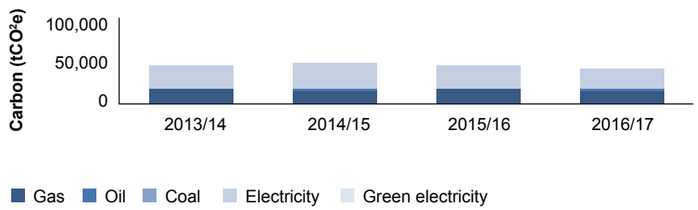
We acknowledge the responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint. As an NHS Trust, it is our duty to contribute towards the national aim of reducing the carbon footprint of the NHS, public health and social care system by the equivalent of 28 per cent by 2020, (from the footprint created in 2013). It is our aim to go beyond this target and, thus far, against our own stretch target, emissions in 2016/17 are down 18 per cent compared with 2010.

Every action counts, and we are a lean organisation trying to realise efficiencies across the board to achieve both cost and carbon (CO^2e) reductions. We have improved our advanced buying allowance, from the carbon reduction commitment energy efficiency scheme, saving £32,000 on our carbon tax payments. Two of our sites, Hammersmith and Charing Cross hospitals, are no longer required to be in the carbon reduction commitment energy efficiency scheme; this will give a net reduction in our carbon tax liability of almost £2 million over the next five years.

We recognise that there is more to be done to reduce the impact of Trust activities on the environment. During 2017/18, we plan to reinvigorate and revive our plans with reference to the NHS Sustainability Development Unit guidance.

Our application for a flue gas heat recovery project at Charing Cross Hospital has received funding approval in the form of an interest-free loan, and will be completed in 2017/18. This will help the Trust to achieve a reduction of 1,738 tonnes per annum in emissions at Charing Cross. The Trust is also planning to make a subsequent application to upgrade burners and controls for boilers at Hammersmith Hospital, draught proofing at Charing Cross Hospital, as well as carry out lighting upgrades across all sites.

Carbon emissions – energy use



Reducing our energy usage and increase our proportion of green energy

Whilst, with a spend of £9,345,463 on energy in 2016/17, costs continue to rise (a 1.1 per cent increase in spend from 2015/16), the Trust achieved a small reduction of 2.9 per cent in energy used over the same period. On-going energy saving initiatives and favourable climate conditions have enabled this reduction despite increases in clinical activity. However, the age of much of our estate, particularly on the St Mary's, Hammersmith and Western Eye sites, makes it very difficult to reduce energy consumption. The breakdown overleaf also demonstrates that the Trust has yet to procure green energy as, at present, this is cost prohibitive.

Work continues to review the mechanical and electrical infrastructure across all sites to assess both current and future needs. This work focuses on the development and implementation of an automated meter reading system, and improved integration with the building management system and energy monitoring, as well as targeting and reporting systems. This will provide improved 'real time data', and an improved speed and quality of plant performance and energy consumption data. The data will be visible to staff, patients and visitors and this will assist in engaging them in supporting our future energy reduction plans. When the systems integration is complete, the reporting interface will display costs, consumption and emissions data at main entrances and employee workstations.

The combined heat and power system, now operating for extended hours, has led to additional electricity export income and heat savings.

We have installed LED lighting and, through a continuous review of the building management system, adjusted temperature set points and system operating times to ensure improved energy efficiency.

During the year we also saw benefits arising from a number of projects which have reduced overall electricity consumption, reduced gas consumption by eight per cent and also reduced water consumption (with a total reduction of 13 per cent from 2012/13).

The Trust is now planning to connect its combined heating and power plant to the UK Power Network, benefitting the Trust both environmentally and financially. This will help the Trust to significantly reduce its carbon emissions as well as to save on pass-through costs on our utility bills i.e. transmission and distribution charges.

Ensuring water efficiency

The Trust has been working on water efficiency measures for the past five years. Significant progress has been made on reducing water consumption waste through a variety of initiatives. Unfortunately, water consumption has increased this year, partly due to Thames Water identifying a meter that they had not previously billed against, some infrastructure leaks and the loss of the borehole service at Hammersmith Hospital for a significant period of time.

Resource		2013/14	2014/15	2015/16	2016/17
Gas	Use (MWh)	85,332	82,453	86,702	82,617
	tCO^2e	18,102	17,299	18,145	17,266
Oil	Use (MWh)	553	2,834	2,843	1,495
	tCO^2e	177	907	908	474
Electricity	Use (MWh)	52,617	54,034	53,444	54,749
	tCO^2e	27,809	31,669	28,898	27,105
Coal	Use (MWh)	0	0	0	0
	tCO^2e	0	0	0	0
Green electricity	Use (MWh)	0	0	0	0
	tCO^2e	0	0	0	0
Total energy CO^2e		46,088	49,874	47,951	44,845
Total energy spend		£8,835,331	£8,916,631	£9,012,756	£9,345,463

Water		2013/14	2014/15	2015/16	2016/17
Mains	m3	446,440	408,319	428,001	493,895
	tCO^2e	407	372	390	450
Water & sewage spend		£630,451	£640,411	746,213	940,393

Category		2013/14	2014/15	2015/16	2016/17
Patient and visitor travel	miles	1,597,675	1,801,377	1,741,784	1,608,420
	tCO^2e	590.30	661.88	629.89	581.30

The Trust's non-emergency patient transport service undertakes about 325,000 journeys per annum. Recent changes to the vehicle fleet have introduced more appropriate vehicles to improve service quality and also deliver lower vehicle emissions.

Ensuring procurement that is sustainable both environmentally and socially

The Trust uses the approved Department of Health terms and conditions for procurement, which contain sustainability clauses, and regularly review our compliance against these. We use the NHS e-class procurement system and will be looking to implement improved reporting and analysis of the carbon impact of the various procurement streams.

The Trust purchases all furniture via the Crown commercial services framework, which is Forestry Commission certified. It also purchases most paper and stationery from the 'premier elements earth' range, which has a high post-consumer waste content. We recycle medical equipment that is decommissioned through auctions and reinvest these funds in new medical equipment.

The Trust is considering the use of the good corporate citizenship (GCC) tool to help promote social sustainability awareness in 2017/18.

Improving our preparations for adverse climate impacts

Events such as heat waves, cold snaps and flooding are expected to increase as a result of climate change, and the Trust has ensured that both current and projected environmental conditions are addressed in the estates redevelopment programme approved by the Trust board.

We have developed and implemented a number of policies and protocols in partnership with our site partners and other local agencies to mitigate the impact of these changes including heat wave and business continuity plans.

Accountability report

Corporate governance report
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 organisation's vision, objectives and policies, whilst safeguarding the quality standards and public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and acknowledge the responsibilities set out in the NHS Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level, and as such can only provide reasonable and not absolute assurance of effectiveness. The system of control is based on an on-going process designed to identify and prioritise the risks to achievement of Imperial College Healthcare NHS Trust's vision, objectives and policies, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. This system has been in place at the Trust for the year ended 31 March 2017, and up to the date of approval of the annual report and accounts.

The system of internal control is underpinned by the existence of a number of individual controls that are in place: executive and senior manager review; policies; procedures; and clinical guidelines.

The governance statement has been constructed against the key lines of enquiry of the recently published well-led framework, which has been developed jointly by NHS Improvement and the Care Quality Commission. The Department of Health Group Accounting Manual requirements for directors' report items are included within the governance statement. In listing items as 'significant issues', a number of factors have been considered, including whether the issue:

- is likely to prejudice the achievement of priorities
- could undermine organisational integrity or reputation
- may divert resources from another significant aspect of business
- could have a material impact on the accounts.

The following have been identified as significant issues facing the Trust as it enters 2017/18; further detail on each is provided at appropriate points throughout the governance statement:

- ability to achieve and maintain financial sustainability
- ability to achieve required performance targets in the emergency department and for elective surgery
- ability to recruit and retain required clinical staff, particularly in relation to ward-based nurses, midwives and radiographers
- ability to gain funding approval from key stakeholders for the redevelopment programme
- ability to fund the appropriate level of back-log maintenance whilst awaiting redevelopment, and the resulting risk to necessary funding for the medical equipment replacement programme.

Is there the leadership capability to deliver high quality, sustainable care?

The Trust board

The Trust board is accountable, through the chairman, to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

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 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. The Trust board is confident that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability. Both the selection process (led by NHS Improvement) and the board seminar programme in place, ensure that the non-executive directors have appropriate skills and level of understanding to undertake their role.

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 board development programme has been largely incorporated into the normal working of the board. Its aims are to ensure that the board is: fit to govern the Trust; able to set and review performance standards in all areas of responsibility; operates as a unitary function; aware of, and successfully manages, competing priorities and future challenges against the Trust's strategic objectives; and can assure itself on aspects of clinical quality.

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 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 chairman; and for the chairman, by NHS Improvement.

The Trust board, and each of the committees, undertook a self-assessment of performance and effectiveness, using a detailed questionnaire developed for this purpose. The questionnaire was sent to all committee members and standing attendees for completion. The findings were reported back to, and discussed at, the relevant committee, and also to the Trust board in May 2017 to improve future performance.

Overall, the results showed a slight improvement in both members and attendees reported scores, and also a more homogenous view across responders. Areas of particularly positive behaviour were seen in 'impact at board level' and 'frank open relationships with executive directors' and good processes existing in 'sufficient number and timing of meetings' and the 'right people being invited to attend and present at committee meetings'.

Much improved scores were received for the question relating to 'understanding of the interaction of sources of assurance and how these map to risk'; this would appear to demonstrate the work on the board assurance framework had been impactful. However, scores remained varied on the 'length, relevance and timeliness of papers', which would suggest further work is required on the way in which papers are written; this will be addressed in 2017/18.

Leadership development

The Trust needs managers equipped with the skills to lead people through a significant programme of change. We have developed an award winning suite of leadership programmes and a performance development review framework to support the high performance culture required to deliver this. The Trust is committed to the personal development and performance of its staff and supports this through an annual rated performance development review (PDR) process which includes a review of the performance to agreed objectives, an agreed personal development plan and new objective setting including evidence of the Trust values and behaviours against objectives within the PDR rating process.

Engagement with our people will remain an executive team priority for the next two years and will be supported through a number of actions, including raised awareness and understanding of good behaviours and performance, an enhanced leadership development portfolio and empowering all staff to challenge poor behaviour and poor performance, to improve our engagement levels. The executive team will also focus on improving visibility, approachability and communications, all points which were raised in the Trust staff survey.

The Trust has a talent management programme aimed at identifying the highest performers and the developmental support required to enhance their contribution:

- Horizons, a strategic leadership programme has run two cohorts in-year, preparing our most senior leaders for their current and next role. The Aspire programme supports those new to a senior leadership role and has run three cohorts this year, with some significant workplace projects completed as a result
- those in management roles are offered the Headstart programme, with four completed cohorts, and the fourth programme, Foundations, provides support to those in their first supervision of team leadership role. In addition we have offered our unique paired learning programme which aims to bring together junior doctors and junior managers or other clinicians into a joint leadership development programme.

To support all leaders, the Trust runs a twice yearly leadership forum to bring together all senior leaders for a day of development and networking. Bespoke training in undertaking PDR skills, to support the refreshed process, and training in coaching and mentoring is also provided, and all delegates on programmes are provided with access to an internal coach to support their development.

Succession planning is increasingly an integral part of the Trust's culture and the Trust aims to significantly increase the number of people recruited from the existing workforce. The identification of skill gaps is supported by the provision of education and training opportunities to ensure people are up-skilled in response to service needs as well as enabling initiatives such as more integrated patient pathways and an increase in community based care.

Informal meetings of board members continued on a bi-monthly basis during 2016/17. Where appropriate, these took a developmental approach, either in learning or in enabling a broader debate on key areas of interest. During 2016/17 these included:

- a number of people and organisational subjects, including a multi-professional education strategy, a broader people strategy, talent management, staff engagement and retention and equality and diversity
- a focus on drawing together elements of individual strategies to form an over-arching Trust strategy
- the estates strategy and approach to the significant backlog maintenance issues
- the proposals for the business plan for 2017/18 and continued progress towards building a sustainable financial plan.

As part of continuing development for non-executive directors, clinical divisions take it in turns to present to board members a review of key issues and developments, culminating in a board members 'walk about' to a number of relevant clinical areas.

Organisational restructure

Embedding the organisational restructure, whereby there are now only four levels of management accountability 'from ward to board' (replacing up to eight in place previously), with accountability and responsibility for delivering quality, operational, and financial targets sitting clearly at both a divisional and directorate level, was highlighted in the 2015/16 governance statement as a significant issue.

An independent review of the embedding of the organisational restructure in December 2016 concluded that the chief executive and senior team had transformed the way in which the Trust was managed, and, as such, the restructuring had been substantially and successfully implemented. The report also noted the improvement in the quality and consistency of financial reporting and financial discipline. Further recommendations made within the report are being implemented.

Significant issue: Ability to achieve and maintain financial stability

At the beginning of the year the Trust set a deficit budget of £52 million for the year including a challenging saving target, a cost improvement plan (CIP) of £53.8 million.

The Trust's underlying deficit position, which had emerged during 2015/16 was estimated to be £54 million. In April, the Trust began the implementation of a significant simplification of the Trust's organisational structure which was completed in September. The Trust was also successful in its application to be part of the NHS Improvement financial improvement programme (FIP) and PricewaterhouseCoopers (PwC) were engaged at the end of April to support the Trust in delivering its challenging CIP programme. PwC worked both centrally setting up a project support office and in the re-organised divisions helping to embed improvements in financial information and financial discipline.

Halfway through the year, confidence in the delivery of the CIP programme, the identification of some non-recurrent gains and an on-plan performance enabled the Trust board to submit a revised financial plan, stretching by £11 million, to reduce the deficit to £41 million for 2016/17. This was accepted as the Trust's control total which gave the Trust access to a further £24 million of non-recurrent sustainability and transformation funding (STF), subject to delivering the financial targets and operational trajectories for A&E and waiting times.

The Trust remained on its stretched plan throughout the second half of the year and delivered a pre-STF deficit £0.2 million better than plan, receiving STF in full plus a £1.1 million bonus payment recognising that achievement and resulting in a deficit after STF of £15.3 million. CIP savings of £54 million were delivered, meeting the original plan target of £54 million but short of the stretch target of £58 million. This was offset by greater than expected non-recurrent benefits and significantly higher than planned levels of activity as the hoped for demand reductions were only partially successful.

The Trust's control over its cash position and capital programme were very significantly strengthened during the year resulting in the delivery of both our cash and capital targets. The improved cash control and the receipt of the STF meant that far less of the approved working capital facility was required.

The 2017/18 plan has been submitted with a deficit of -£41 million representing an improvement in the underlying deficit of about £10 million but requiring another challenging CIP of £54.4 million. The focus on the FIP in 2016/17, with its intensive focus on in-year payback meant that the planned specialty level service reviews had to be postponed and were started in April 2017.

The Trust has also been successful in its application to be part of the second financial improvement programme (FIP2) but the support is likely to take a different format reflecting the progress that the Trust has made. We have asked for support in three areas: firstly, an independent verification of the year-on-year external cost pressures impacting the Trust which requires in excess of £40 million or 4 per cent savings just to avoid the underlying deficit worsening; secondly, support for our speciality review programme; and thirdly, the potential for support if work currently underway fails to bridge a gap of £10 million in our CIP programme.

Currently the planned deficit of £41 million has not been accepted as our control total and therefore in 2017/18 the Trust is not eligible for STF and may be liable to highly punitive performance fines against national targets. This will also result in the Trust moving into a cumulative financial deficit position during the year.

The issue of going concern has been discussed at audit, risk and governance committee with the active engagement of external audit. The Trust is dependent upon the working capital facility provided by the Department of Health to remain financially viable from a cash perspective. If appropriate repayment conditions can be agreed then this short term facility will be converted into a more appropriate funding model during 2017/18.

The Trust board exercises much of its financial governance via the finance and investment committee and the audit, risk and governance committee; both of these committees are engaged in the oversight of the issues and actions outlined previously.

Significant issue: Ability to fund the appropriate level of back-log maintenance whilst awaiting redevelopment, and the resulting risk to necessary funding for the medical equipment replacement programme

The Trust has one of the largest backlog maintenance liabilities of all trusts, largely due to the age of estate, with St Mary's Hospital dating from 1851 and Hammersmith Hospital from 1904, combined with Charing Cross Hospital dating from 1973, but being of an age where plant, machinery, and the infrastructure would normally have been replaced or refurbished. The Trust has numerous instances where equipment is now obsolete and this means that on occasion parts have to be specifically manufactured to support this obsolete equipment – this can lead to prolonged downtime, adversely affecting patient experience, service provision, and, at times, create a risk to patient safety.

A detailed survey and compliance audit (called a six-facet survey) was undertaken in 2015, suggested total investment / project costs of £1.3 billion to bring all the estate to an acceptable condition. In July 2016, the Trust board considered the Trust's ten year estates strategy, and the Trust's five year capital strategy. The five year capital strategy focussed on the Trust's capital priorities and resultant challenges such that internal and external funding sources could be explored, and allow the Trust to make strategic choices about its investment priorities, over the proposed five year period to 2020-21.

A further discussion of options was had at a Board seminar in October 2016, at which the Trust agreed to: pursue the re-profiling of the capital programme to create some headroom to fund backlog maintenance; re-profile the £130 million of high risk backlog maintenance over eight years rather than five years; and provide to the Trust board an annual

report on the progress in delivering the programme of works and a re-assessment of the risk mitigation strategy. In addition, as part of the submission of the 2017/19 business plan to NHS Improvement, the Trust made a case for help in funding the backlog maintenance given the extreme position that the Trust finds itself in and the potential impact on clinical services.

Taking account of the above requirements, and following a number of high-level iterations of the plan, the Trust developed a number of principles that were used to agree appropriate allocations across the different categories of capital spend. Using these principles, and alongside £16.2 million being allocated to backlog maintenance, the Trust has now agreed increased funding to a small number of major projects, service developments and ICT, allocated funding to elements of the redevelopment programme (planning, legal fees and OBC costs), supported a rolling works programme (incorporating a rolling theatres' improvement programme), and created a corporate project fund specifically for corporate projects that support clinical divisions in achieving their objectives or those that directly support Trust objectives.

A total of £3.9 million has been allocated to medical equipment replacement, which will be used to address priorities agreed by the capital steering group. However, this leaves significant amounts of aging and unreliable (but clinically safe) equipment in use for patient care, and does not address any in-year catastrophic failure of clinical equipment which could affect the service provided to patients, or lead to increased waiting times for patients.

The Trust is already exploring whether it can create a partnership across north west London for the delivery of imaging, similar to the partnership we have agreed for pathology. The objective of such arrangements from a financial perspective is to standardise processes, increase efficiency and take advantage of economies of scale. A key focus is to create a structure that enables the partnership to access the equipment (or capital) without impacting on the Trust's capital position. However, even if an arrangement can be found where an external party supplies the equipment (or capital), the costs of installation could still fall to the Trust and could be significant. Options include: leasing arrangements for equipment; hosted services; joint ventures; and a private sector solution.

The Trust is fortunate in being the recipient of significant funding from Imperial Health Charity, a total of £8.3 million in 2016/17, to enable real improvements in patient care and patient and staff experience, both in the provision of capital equipment and other initiatives; with so many calls on the limited capital funds available, many of these improvement would not be achieved without such support. Recognising the Trust's already leading position in the use of digital technology, the Trust was awarded a Global Digital Exemplar award towards the end of 2016/17. This has provided an opportunity for the Trust to develop a business case to receive £10 million match funding to be focused on driving forward the Trust's use of digital technology in both clinical and non-clinical environments; a Trust focus which can now be achieved without creating even further demand on the stretched capital programme.

Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services, and robust plans to deliver?

Strategic direction

As outlined on page 8, our vision as a Trust is to be a world leader in transforming health through innovation in patient care, education and research. The strategic objectives developed to deliver this vision are also outlined in that section. These objectives continue to reflect our long-term commitment to improve the quality of care we provide, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce. They are supported by our values, behaviours and promise, also described in the performance report and will be delivered by our strategies.

The Trust has, in-year, drawn together its individual strategies to create a single strategy document, approved by the Trust board in November 2016, which can be accessed on the Trust's website. As an organisation, the Trust believes it is essential to progress longer-term developments as well as tackle immediate challenges if it is to provide the very best care, both now and in the future.

Our key strategies are described as:

- **Clinical** – to help lead the development of integrated care, closer to home, the consolidation of specialist care on fewer sites where it improves outcomes and safety, and the advancement of personalised medicine.
- **Quality** – to create a culture of continuous improvement to increase and sustain quality including through a Trust-wide quality improvement methodology and using the Care Quality Commission's quality framework – safe, effective, caring, responsive and well-led.
- **Financial** – to achieve savings and more efficient ways of working so that we can move to a sustainable financial position, allowing us to invest sufficiently in the development of our staff, services and estate.
- **Workforce** – to ensure we are recruiting, engaging and developing sufficient staff with the right skills and capabilities in the right roles, responding to changing needs and service models.
- **Digital** – using our Cerner electronic patient record as the foundation, and our place in NHS England's Global Digital Exemplar programme, to facilitate improvements in care pathways, to enable data to be shared safely, to help empower patients to take an active role in their care and to support population health.
- **Estates** – to secure a significant re-development and new build on the St Mary's and Charing Cross sites, and a smaller redevelopment on the Hammersmith and Queen Charlotte's and Chelsea site.
- **Research** – to make the most of opportunities to align translational research across our expanded academic health science centre partnership and to implement our biomedical research centre programme in partnership with Imperial College.
- **Education** – to support the delivery of our clinical, quality, research and workforce strategies including through multi-professional approaches, new educational models and increased use of technology for learning.
- **Patient and public involvement** – to ensure that patients and our communities actively shape, and can help contribute to, every aspect of our work.
- **Private healthcare** – to support the development of high quality private practice on all the sites, with all surplus being reinvested to improve care and support NHS services.

The North West London Sustainability and Transformation Plan (STP) for health and care was published in October 2016. One of 44 such plans across England, it was developed by 28 NHS, local authority and voluntary sector partners, including the Trust. Its five delivery areas are:

- radically upgrading prevention and wellbeing
- eliminating unwarranted variation and improving long-term condition management
- achieving better outcomes for older people
- improving outcomes for children and adults with mental health needs
- ensuring we have safe, high quality, sustainable acute services.

The Trust's own strategies are very much in line with the objectives of the STP and a number of key initiatives are being supported by and/or influencing the STP's implementation.

The redevelopment programme heralds the most significant transformational changes to the estate in recent years, and takes into account the STP, and reflects the earlier programme for service reconfiguration agreed for North West London, Shaping a Healthier Future (SaHF), led by our clinical commissioning groups. Plans for a comprehensive outpatient and diagnostic facility at St Mary's Hospital are being considered by the Westminster planning committee in 2017. This will form phase one of the redevelopment of St Mary's Hospital, and of the plan to ensure the Trust can provide care in fit for purpose care environments and is able to redesign pathways and care models.

During 2016/17, commercially sensitive negotiations have continued around Trust-owned estate, estate owned by the Charity but used by the Trust and estate leased by the Trust. These negotiations have been overseen by a formal redevelopment committee of the board and a specially constituted single issue commercial sub-committee reporting back to the Trust board. To the extent that there are any financial implications these are covered in the accounts which are prepared under the oversight of the audit, risk and governance committee and finance and investment committee as appropriate.

Capacity to handle risk

The Trust board has overall accountability for the Trust's risk management approach through the executive directors. The framework and policy, approved at the audit, risk and governance committee, supports the development of an organisational culture whereby effective risk management is an integral part of providing healthcare and day to day decision-making.

Whilst executive directors are full-time employees who manage the daily running of the Trust, the entire Trust board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The Trust board is also accountable for upholding high standards of governance and probity. The chairman and non-

executives in particular provide strategic guidance and support.

The board assurance framework 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 assurance framework was most recently reviewed in March, with the Trust board noting that it formed a key part of providing their assurance on the Trust's activities. Responsibility for maintaining the framework rests with the trust company secretary. The framework is described further on page 63.

Significant issue: Ability to gain funding approval from key stakeholders for the redevelopment programme

The Trust has been working on its redevelopment plans over the last year to identify potential ways of funding the redevelopment programme. Due to the condition, functional suitability and high levels of backlog maintenance on the St Mary's Hospital site, this site has been identified as a priority. The current master plan demonstrates a phased redevelopment plan, with the first phase being the building of a new outpatient's facility, followed by a new acute and major trauma facility in the second phase. Delivery of this will then declare land surplus for NHS use on the St Mary's site. In order to deliver a new NHS hospital, the Trust will need to use the surplus land receipts to fund the development and any potential shortfall will need to be funded by alternative sources such as public dividend capital or loans.

If this does not get delivered then the effect on patient experience, potentially clinical outcomes and the estate will be significant as the estate will deteriorate further, backlog maintenance will continue to grow, and frequency of power and equipment failures is likely to increase, thus affecting patient care, outcomes and staff morale.

Our plans to mitigate this risk, developed by the redevelopment committee and supported by NHS Improvement, include the development of a strategic outline case for the St Mary's site which will include undertaking a soft market test of potential developer interest and land receipts to provide assurance of the feasibility and deliverability of our redevelopment plans. This process is supported by a selected team of strategic advisors including legal, surveying, town planning and cost consultants.

A planning application for phase one, a new outpatient services building, has been submitted to Westminster City Council for determination. There is active engagement with the developer on an adjoining site who has expressed an early interest in buying the current outpatients site which is owned by Imperial Health Charity.

There is an on-going and active engagement programme with all stakeholders including, patients, staff, commissioners, local resident groups, public authorities and our regulators and commissioners. The Trust plans to continue this throughout the duration of the programme.

For the Charing Cross site, it has been agreed by the Trust and commissioners that SaHF changes will not occur on that site until after the end of the STP period. This will also mean no SaHF changes at the Hammersmith Hospital site, as services were due to transfer from Charing Cross Hospital to Hammersmith Hospital.

Is there a culture of high quality, sustainable care?

Approach to quality improvement

The Trust's Quality Strategy 2015-2018 sets out our definition of quality under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction. The strategy is designed to ensure we are providing safe, high-quality care and can achieve a 'good' rating in our next Care Quality Commission (CQC) inspection, while striving for 'outstanding'.

It was developed following an extensive consultation period with internal and external stakeholders to ensure it meets national, local and Trust priorities. The strategy will support the newly developed North West London Sustainability and Transformation Plan, outlined above, by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care across north west London.

The quality strategy will come to an end in March 2018. From summer 2017, the Trust will start the consultation process to develop a new quality strategy, which will build on the progress made over the last three years.

Quality governance

We work closely with our commissioners throughout the year to monitor our performance with the strategy, and develop the annual quality account, acute quality schedule and priorities for the next year through the clinical quality group and quality steering group, which also involves members from Healthwatch and local councils. This ensures that our quality agenda aligns with local and national priorities.

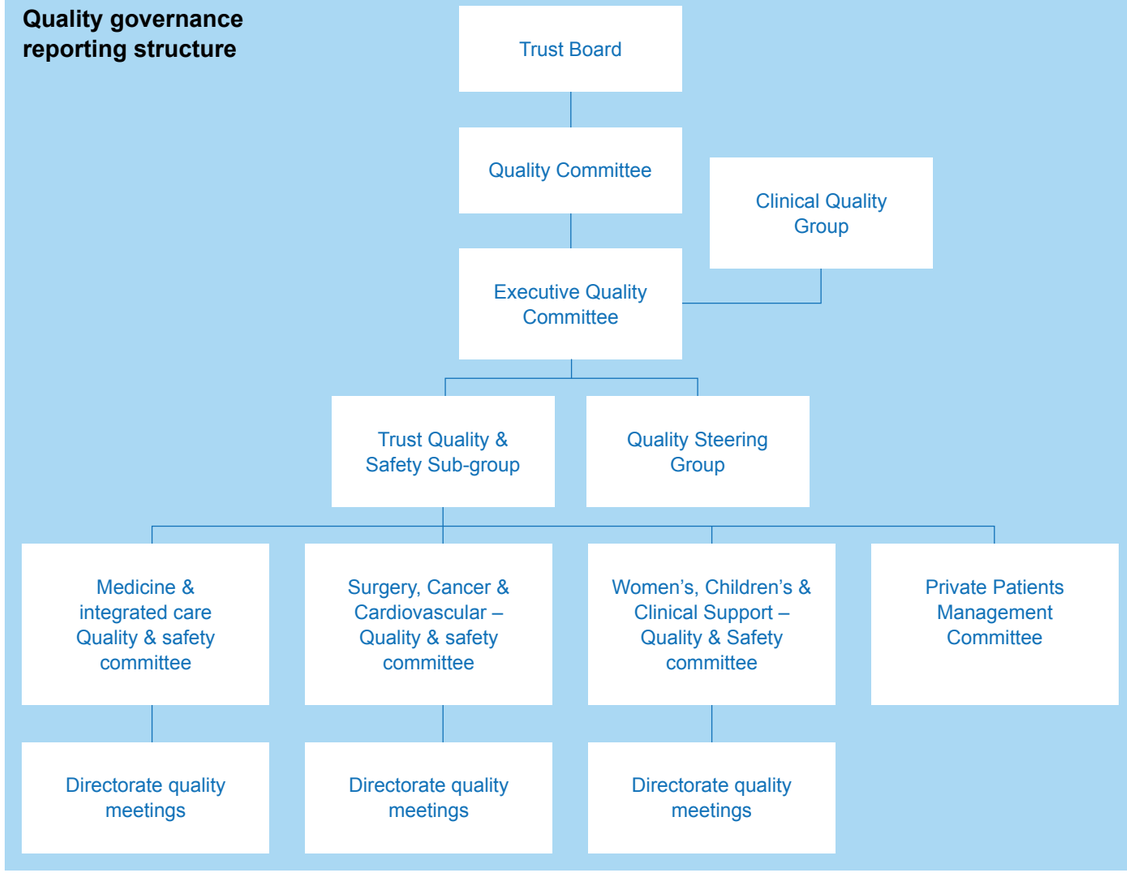
The governance arrangements for quality in the organisation are led by the medical director who has executive responsibility, and are summarised below. Progress with our quality priorities is reported through this framework, to enable monitoring from ward to board. Mechanisms for ensuring this include the 'harm free care report' which monitors specific indicators at ward level, with exception reporting upward, the monthly quality report and the integrated performance scorecard.

An improvement and assurance framework is also in place to ensure we are compliant with regulatory requirements, and to drive improvements to help services deliver 'good' or 'outstanding' care. Key components of the framework include internal comprehensive CQC-style quality reviews of core services. The ward accreditation programme (nursing peer review programme) is now an established process for all inpatient areas.

Summary of the quality improvement plan

The Trust's quality strategy will be delivered through achievement of our quality goals, which are aligned to the five CQC quality domains. These goals are supported by specific annual targets with associated improvement programmes to ensure delivery. The targets are reviewed yearly and described in our quality account as the Trust's priorities for that year. Alongside the quality goals and targets are a

Quality governance reporting structure



number of structured quality improvement projects to drive change in priority areas. The combination of these elements makes up our quality improvement plan for the year ahead, which is defined in our quality account.

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Our annual quality account reports on progress with delivery of the strategy and confirms the priorities for the following year.

The data included within the quality accounts are subject to audit, by both a structured annual programme from the internal auditors, and specific item review by the external auditors. The external auditor performs limited scope procedures on two of the indicators shown in the quality accounts. In the current year, this limited assurance opinion is being provided in relation to our reporting of Clostridium difficile cases and incidences of severe harm and death. The external auditor also performs a review of the consistency of the quality accounts in relation to the Trust's performance and communication with regulators in the year.

Summary of quality impact assessment (QIA) process

The Trust uses a Trust board approved QIA process that is based on the National Quality Board's best practice guidance (2012) to review its cost improvement programme. Cost improvement schemes are recorded on standard templates using a quality risk based system and managed in a Trust database. They are then reviewed by the responsible divisional or corporate director.

Schemes approved at this level are presented to the medical director and director of nursing for final sign off.

Each scheme is risk scored and reviewed against the five CQC domains. Schemes scored 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.

A quarterly summary is provided to the executive quality committee, the board quality committee and the Trust board, and shared with our commissioners; this also includes information on schemes that were not approved for progression.

Care Quality Commission (CQC) registration

The CQC is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care that meet fundamental standards. The Trust is required to register with the CQC at all of our sites and our current registration status is 'registered without conditions'. The CQC has not taken enforcement action against Imperial College Healthcare NHS Trust during 2016/17.

We have participated in one review by the CQC related to the following area during 2016/17:

- *Learning, candour and accountability:* A review of the way NHS trusts review and investigate the deaths of patients in England (published December 2016)
- This involved filling out a questionnaire with data about how the Trust has investigated deaths, but the Trust was not visited or inspected.

We intend to take the following action to address the conclusions or requirements reported by the CQC:

- In December 2016, the CQC published its report from the review, entitled *Learning, candour and accountability.* The report does not make recommendations for individual trusts; recommendations are made which all trusts are expected to take account of in their local processes for investigating deaths.
- Following review of the recommendations by the office of the medical director, proposals for amendments to the Trust's current approach will be made via normal Trust governance processes, and changes will be incorporated when these are approved.

The Trust had received an overall rating of 'requires improvement' following the CQC's first, full inspection of our Trust in September 2014. The CQC returned in November 2016 to inspect our outpatient and diagnostic imaging service, the only core service to be rated overall by site as 'inadequate' during the 2014 inspection. The new ratings for this core service were published in May 2017, and reflected improvements across all sites, moving to 'good' overall at St Mary's and Hammersmith hospitals and 'requires improvement' overall at Charing Cross Hospital.

In March 2017, the CQC carried out unannounced inspections of two core services: maternity at St Mary's Hospital, currently rated as 'good', and medical care at St Mary's, Charing Cross and Hammersmith hospitals, with all sites currently rated as 'requires improvement'. We will receive our ratings from these inspections during 2017/18.

The CQC's previous regulatory strategy concluded in March 2016, and a new regulatory framework took effect for NHS trusts from 1 April 2017.

The Trust's improvement and assurance framework is reviewed annually to evaluate its effectiveness, consider lessons learned and ensure it remains fit for purpose. To this end, the framework for 2017/18 will incorporate lessons learned from 2016/17 as well as the CQC's new regulatory approach.

Other regulatory reviews

The Trust received a helpful review from NHS Protect in 2016/17 (then known as the NHS Counter Fraud Authority) of the annual self-assessment of the ten standards for security arrangements. The report and the management action plan were reviewed by the executive committee; a short report will be presented to the audit, risk and governance committee in July 2017.

An incident occurred in February 2017 in the transport of a biological agent (resulting in no harm) from Hillingdon Hospital to Charing Cross Hospital. This triggered a Health and Safety Executive inspection at Hillingdon Hospital in April, at which time North West London Pathology had taken over managerial responsibility for the laboratories. A further issue was identified in relation to management arrangements for training, and ensuring competence, of staff, which resulted in the issue of an Improvement notice to the Trust. An action plan has been developed to address the issues which were identified.

Raising concerns (whistleblowing)

The Trust policy encourages everyone to raise concerns openly as part of normal day-to-day practice so that action can be taken to ensure high quality and compassionate care based on individual human rights.

The policy outlines the different steps people can take if they want to make a qualifying disclosure, as defined by the Public Interest Disclosure Act:

- Step 1: Raise concern with immediate management team
- Step 2: Contact the employee relations advisory service
- Step 3: Raise your concern with an executive director.

Step 2 and step 3 qualifying disclosures are reported to the executive committee and quality committee.

The Trust recorded 10 new protected disclosures on its whistleblowing database, a decrease on the 17 disclosures in 2015/16. Protected disclosures were made by people across the organisation and in a range of work settings, by people working in the corporate directorates and each of the divisions. Disclosures related to a range of issues including patient safety, competence of staff, harassment and bullying, working environment and unsafe staffing levels.

On-going campaigns to encourage people to report incidents are likely to increase the number of centrally recorded protected disclosures in future years. People are encouraged to contact the freedom to speak up guardians and/or the designated non-executive director if they do not have confidence in the normal processes for raising concerns or if they have already raised a concern but not received a satisfactory response. Two freedom to speak up guardians have now been appointed with a third due to be appointed shortly.

The staff survey results for 2016 indicate a reduction in the number of staff witnessing errors or incidents and an increase in the perception of the fairness and effectiveness of procedures put in place designed to deal with these issues. The Trust was in the top 20 per cent for both indicators when compared to other English acute trusts. Work will continue to promote raising concerns (whistleblowing) throughout the Trust to maintain these improvements.

The Trust will continue to promote awareness through a communications campaign which will include posters, briefings and manager information via the Trust's main communications channels.

National staff survey 2016

The national staff survey was reported to the Trust in March 2017. With an improved response rate, at 42 per cent, the overall engagement score improved from the Trust being in the bottom 20 per cent of acute trusts, to being average, with a number of very positive scores. These include that: the majority of staff reported having had an appraisal; staff were satisfied with the quality of work and care they were able to deliver; and staff were positive about the quality of training and development available. In the majority of questions the Trust saw an improved position.

Unfortunately, there were less positive areas, staff reporting physical violence, and staff experiencing discrimination at work, which are now receiving management focus, an engagement action plan having been agreed by the executive team in April 2017.

Emergency preparedness

The Trust participates in the annual emergency preparedness, resilience and response (EPRR) assurance process carried out by NHS England. As part of the assurance arrangements,

NHS England has developed a framework of indicators that each trust uses to measure the level of confidence and ability of the organisation to respond. The assurance process centres around eight core standards for EPRR (containing 51 detailed evidential measures), and a further four core standards relating to hazardous materials(HAZMAT)/ chemical, biological, radiological and nuclear (CBRN) EPRR response core standards (containing 31 evidential measures).

A total of 85 compliance questions were peer reviewed and validated by NHSE London. The Trust achieved a total of 85 per cent green (full or substantial compliance) and 15 per cent amber (partial) against EPRR standards, and 100 per cent green for CBRN and HAZMAT standards. It received no red non-compliant ratings. Overall, the Trust's rating is 'substantial', and an action plan has been developed to improve compliance in the remaining amber rated areas.

The 'deep dive' of the 2016/17 NHS England EPRR assurance was business continuity planning. The Trust has well-rehearsed business continuity arrangements from power failure to ICT downtime, and the wards and staff are aware of the plans and actions to be taken to provide patient care during incidents where business as usual is interrupted. The review rated the Trust as amber, requiring the updating of plans following the Trust re-structure in April 2016, alignment to the British ISO 22301, and rewriting of the strategic policy. An action plan is in place to deliver the required improvement, which will be completed by summer 2017; it will be monitored through the executive committee and the six-monthly EPRR update report to Trust board.

The Trust's EPRR arrangements were tested following the Westminster Bridge major incident on 22 March 2017; staff demonstrated an amazing professional and compassionate response, and it highlighted particularly effective co-ordination between sites. The Trust board and a number of national bodies extended thanks to all staff involved. As for all major incidents, detailed reviews have been undertaken to identify learning from the event.

Significant issue: Ability to recruit and retain required clinical staff, particularly in relation to ward-based nurses, midwives and radiographers

In 2016/17, the Trust has seen an improvement in overall vacancy rates and voluntary turnover, with significant improvements in its approach to resourcing, including the length of time it takes for a member of staff to start work with the Trust following appointment.

As with other London trusts, however, the Trust has experienced a worsening of the vacancy rate amongst Band 2 to 6 nursing and midwifery staff. Across London, this has been estimated at 17 per cent; the Trust's position is a 15 per cent vacancy rate for this group.

A resourcing and retention strategy has been developed, with a dedicated team in place focused on delivering the strategy. Attention has been focused on broadening the channels used to increase the 'pipeline', the different routes by which we attract staff to work at the Trust, including optimising the supply of students (recognising the challenges nursing students face with the withdrawal of bursaries) and apprenticeships (to utilise the new opportunities available), and ensuring that staff are offered attractive reward packages (including further training and career development).

As part of the divisional business planning and budget setting for 2016/17, the management teams undertook a detailed and comprehensive review of nursing and midwifery establishments using the clean sheet approach, and taking note of the work taking place nationally to achieve and maintain safe, sustainable and productive nursing and midwifery staffing. Safe staffing levels on wards are monitored on a monthly basis through fill rate reports with monthly exception reports produced for divisional quality and safety meetings, regular reports to the executive team, and an annual report to the Trust board. On a day-to-day basis no wards are left with an unsafe level of staffing as staff would always be redeployed to address any areas of concern.

Are there clear responsibilities, roles and systems of accountability to support good governance and management?

The Trust board and its committees

The Trust board

The Trust board is accountable, through the chairman, to NHS Improvement. The Trust board at 31 March 2017, consisted of the chairman, six non-executive director posts, chief executive, medical director, director of nursing, and chief financial officer, as outlined, right. Two designate non-executive directors were appointed on 1 September 2016, in preparation of the expiration of further non-executive terms of office. They are collectively responsible for the strategic direction and performance of the Trust, and have a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

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

During the year, there have been a number of changes to board members:

- The appointment of two new non-executive directors, Peter Goldsbrough and Professor Andy Bush from 1 September 2016.
- Sir Anthony Newman-Taylor and Jeremy Isaacs completed their terms of office on 31 August and 30 September 2016 respectively.

The Trust board at 31 March 2017 was as follows:

Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy chairman
Professor Andy Bush	Non-executive director
Dr Rodney Eastwood	Non-executive director
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Dr Tracey Batten	Chief executive
Dr Julian Redhead	Medical director
Professor Janice Sigsworth	Director of nursing
Richard Alexander	Chief financial officer

The Trust also appointed two designate non-executive directors from September 2016, Victoria Russell and Nick Ross, who take a full part in the role of the Trust board but do not chair committees, and may not take part in any Trust board vote.

There was one vacant executive and one vacant non-executive post as at 31 March 2017.

Disclosure to auditor

As directors of the Trust, the directors confirm that, as far as they are aware, there is no relevant information of which the auditor is unaware. Each director has taken all of the steps that they ought to have taken as a director in order to make himself or herself aware of any relevant information and to establish that the auditor is aware of that information.

Attendance at Trust board meetings: 1 April 2016 – 31 March 2017

The Trust board met seven times in the reporting period. Attendance at the Trust board and attendance at and role of the board committees is described below:

Member	Attendance (actual/possible)
Non-executive directors*	
Sir Richard Sykes, chairman	6/7
Sir Gerald Acher, deputy chairman	7/7
Jeremy Isaacs	2/3
Professor Sir Anthony Newman Taylor	2/3
Dr Rodney Eastwood	7/7
Dr Andreas Raffel	6/7
Sarika Patel	6/7
Peter Goldsbrough	3/4
Professor Andy Bush	3/4
Executive directors	
Dr Tracey Batten, chief executive	7/7
Richard Alexander, chief financial officer	7/7
Professor Janice Sigsworth, director of nursing	7/7
Dr Julian Redhead, medical director	7/7

* Changes to the board membership are outlined above

The board has a total of five committees which meet regularly; each is chaired by a non-executive director. A number of board responsibilities are delegated either to these committees or individual directors. The Trust board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide a report to the Trust board showing how they are fulfilling their duties as required by the Trust board. In addition, audit minutes are reported to the Trust public board, and the minutes of other committees reported to the Trust private board.

Audit, risk and governance committee

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

In its broader, non-mandatory role, the committee oversees and seeks assurance that risk management and corporate governance arrangements are also 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 taking. 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 seven times in the reporting period:

Member	Attendance (actual/possible)
Sir Gerald Acher (chair)	6/7
Professor Sir Anthony Newman Taylor	2/4
Prof Andy Bush	1/3
Sarika Patel	5/7
Dr Andreas Raffel	5/7
Dr Tracey Batten	7/7
Richard Alexander	6/7
Prof Janice Sigsworth	5/5
Dr Julian Redhead	4/5

During 2016/17, the committee has remained observant of the key financial, operational and strategic risks facing the Trust through review of the board assurance framework (to gain on-going assurance of risk and internal control processes), and through internal sources of validation and by way of triangulation with the quality committee.

The committee has reviewed and approved the annual internal and external audit plans, and has reviewed and evaluated internal audit reports on key systems of internal audit control, including finance, governance, risk management, policy scrutiny, human resources and payroll. A full list of internal audits provided by TIAA (the Trust's internal auditor) in 2016/17 is attached as appendix one.

The committee also received management action plans where any internal audit finds limited or no assurance. The committee has received regular reports on the counter-fraud activity at the Trust, ensuring appropriate action in matters of potential fraudulent activity and financial irregularity.

The corporate risk register is also reviewed regularly. The committee has undertaken a number of in-depth reviews where specific risks were identified, including the length of time patients wait from GP referral to receiving definitive treatment (RTT) and the waiting list improvement programme, condition of the estate and the backlog maintenance requirements, the emergency planning, risk and resilience plans, and recruitment and retention plans particularly around the significant number of nursing and midwifery vacancies.

The committee also liaises with other committees within the Trust whose work can provide relevant assurance to the audit risk and governance committee's own scope of work. The committee received regular reports on losses and compensation payments; waiver of tendering process and competitive quotations; and any allegation of suspected fraud notified to the Trust.

The Trust places strong emphasis on countering fraud and corruption and follows the Secretary of State's directions to ensure that public funds are protected.

The Trust has an annual counter-fraud work plan which is agreed with our local counter-fraud specialist (LCFS) to ensure that appropriate coverage is provided and maintained. We have firm counter-fraud policies which are promoted widely to staff and patients through awareness sessions and at the Trust's corporate induction. The Trust policies are reviewed on a regular basis by the LCFS and the Trust. An annual plan has been developed and reviewed by the committee.

The audit, risk and governance committee acts as an auditor panel; as from 2017/18, the Trust has appointed Deloitte LLP as the new external auditors for a three year period. The Trust's audit, risk & governance committee formed the audit panel to oversee the tender process.

The Trust issued an invitation to quote to all service providers in Lot 1 (External Auditors) of the East of England NHS Collaborative Procurement Hub Framework for Audit and Consultancy Audit services. Following evaluation of bid submissions and clarification sessions the preferred bidder was selected on the basis of the overall highest score. This decision was made by the audit panel and ratified by the Trust board.

The standing orders, standing financial instructions, scheme of reserved and delegated powers, and scheme of delegated financial authority were reviewed and updated and approved at the finance and investment and audit, risk and governance committees as appropriate.

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 and provides assurance in relation to patient and staff experience, and health and safety; performance is monitored in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the Care Quality Commission and ensures that there is a clear compliance framework against these.

The committee met 10 times during the reporting period:

Member	Attendance (actual/possible)
Professor Sir Anthony Newman Taylor (chair to 31/08/16)	4/4
Prof Andy Bush (chair from 01/10/16)	3/6
Sir Gerald Acher	7/10
Dr Rodney Eastwood	10/10
Dr Tracey Batten	8/10
Prof Janice Sigsworth	9/10
Dr Julian Redhead	9/10

Discussion included regular review of divisional risks, the Trust's comprehensive quality report, including the infection prevention and control report, serious incident monitoring report, claims and complaint data and the outpatient improvement programme. A number of in-depth reviews were also undertaken in areas of potential quality concern such as the Trust's referral to treatment process, safer surgery programme and the scale of nursing and midwifery vacancies.

Finance and investment committee

The committee is responsible for seeking and securing assurance that the Trust achieves the high levels of financial performance expected by the Trust board and also for ensuring that the Trust's investment decisions support achievement of its strategic objectives.

The committee met seven times in regular session during the reporting period, and also held one extra-ordinary meeting:

Member	Attendance (actual/possible)
Dr Andreas Raffel (chair)	8/8
Dr Rodney Eastwood	7/8
Jeremy Isaacs	1/3
Peter Goldsbrough	4/4
Dr Tracey Batten	7/8
Richard Alexander	8/8

Specific discussions included the Trust's financial position including delivery of cost improvement plans and financial recovery plans as part of its engagement in the financial improvement programme supported by PwC; review of key business cases including North West London Pathology laboratory services and the emergency department refurbishment at St Mary's, and business planning arrangements and proposals for 2017/18.

In March 2017, the committee gave consideration to ensuring an improved balance between immediate operational requirements and an appropriate focus on longer term strategic items. The committee would, in future, also review the developing productivity dashboard, and the redevelopment programme financials, as well as outputs of the specialty review programme which sought to enable transformational change across the clinical directorates.

Redevelopment committee

The committee undertakes thorough and objective review of the development transformation programme, including performance reviews and financial issues, and reviews investment requirements and risks associated with the overall redevelopment transformation programme.

The committee met 13 times in the reporting period:

Member	Attendance (actual/possible)
Sir Richard Sykes (chair)	13/13
Jeremy Isaacs	3/4
Dr Andreas Raffel	13/13
Dr Tracey Batten	12/13
Richard Alexander	11/13
Victoria Russell	8/9

Discussions focused on the redevelopment programme at the St Mary's site, the Trust's public consultation and the subsequent planning application for a comprehensive outpatient and diagnostic facility development. The committee also considered and monitored impact on hospital operations of the Paddington Quarter development planning application. The committee has raised objections to the safety of the proposed road with Westminster City Council, Greater London Authority and Secretary of State for communities and local government.

A letter has been written on behalf of all NHS parties (NHSE, NHSI, London Ambulance Service and the Trust) by Dr Anne Rainsberry, NHS England's

National Senior Responsible Officer for Emergency Preparedness Resilience and Response (EPRR) endorsing these concerns. The matter is unresolved at the time of publication and the committee continues to review the matter regularly.

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 five times during the reporting period, where discussions included reviewing executive performance, the noting of the appointments of the new non-executive directors, the appointment of a new divisional director of surgery, cancer and cardiovascular, the chief information officer's joint appointment with Chelsea and Westminster and executive succession planning:

Member	Attendance (actual/possible)
Jeremy Isaacs (chair to 30/09/16)	2/2
Sarika Patel (chair from 01/10/16)	5/5
Sir Richard Sykes	4/5
Peter Goldsbrough	3/3
Nick Ross	2/3

Information governance

The Trust has a published information governance structure, as part of the requirements of the NHS Information Governance requirements, designed to strengthen assurance controls for NHS information assets. The Caldicott committee is responsible for the review of the Trust information governance policy, strategy, staff communications plan and subordinate information governance policies.

The chief information officer acts as the senior information risk officer, a role designed to take ownership of the Trust's information risk policy, and act as advocate for information risk on the Trust board, with overall accountability for information governance. The chief clinical information officer, as Caldicott Guardian, is the appointed senior clinician, and carries the ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information.

The information governance manager has operational and strategic responsibility for information governance compliance and the provision of an information governance compliance and advice service.

Information governance toolkit return

In order to meet its contractual obligations the Trust must submit an annual information governance toolkit return that is rated satisfactory and subject to independent audit. On 31 March 2017 the Trust published an overall return of 67 per cent (satisfactory). The satisfactory rating was achieved by a minimum level 2 assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2016 and in March 2017. The final audit report gave the Trust 'reasonable assurance' of the self-assessment.

Information governance training

All staff including students, temporary staff and honorary contract holders, must undertake annual mandatory information governance training. The Department of Health's (DH) information governance training toolkit was decommissioned in December 2016. As a result, the Department of Health's annual target of 95 per cent of staff having undertaken approved information governance training on an annual basis was held over for a period of 12 months. The Trust maintained its commitment to information governance training whilst returning the compliance figures for the previous financial year (2015/16) in accordance with the interim DH instruction. In the 2015/16 financial year, the Trust achieved 97 per cent compliance.

Information security incidents

There is dual reporting for information governance incidents. Firstly, all Trust incidents have to be recorded on the Trust incident system (Datix). Any information governance incidents must also be recorded on the DH IG Toolkit incident system. In 2016/17 the information governance team undertook a matching and reconciliation exercise of incidents recorded on Datix and on the DH information governance system. A significant time delay was noted in reporting incidents to the DH information governance system. The figures opposite represent an interim position. The final reported position will be known by early July when a further matching exercise has been completed and all outstanding reports have been returned. The interim figures show the Trust had no data security breaches that required reporting to the Information Commissioner's Office during 2016/17.

Incidents are reported to the Caldicott Guardian at the weekly Caldicott review meeting. They are also reported via the Caldicott Guardian annual report and the Caldicott Guardian half year report to the health records, applications and Caldicott committee. Incidents relating to ICT Security are discussed at the ICT security audit and risk committee where they can be used to inform the ICT risk register and/or the informatics audit programme managed by TIAA, the Trust's internal auditors. A summary of the 48 incidents reported thus far reported is set out below:

IG SIRI / IF CYBER SIRI	Number
Level 2 Serious Incidents (Reported to DH and Information Commissioner's Office)	0
Level 1 IG SIRIs (internally reported)	42
Level 0 IG SIRIs (near misses)	4
Other	2
Total	**48**

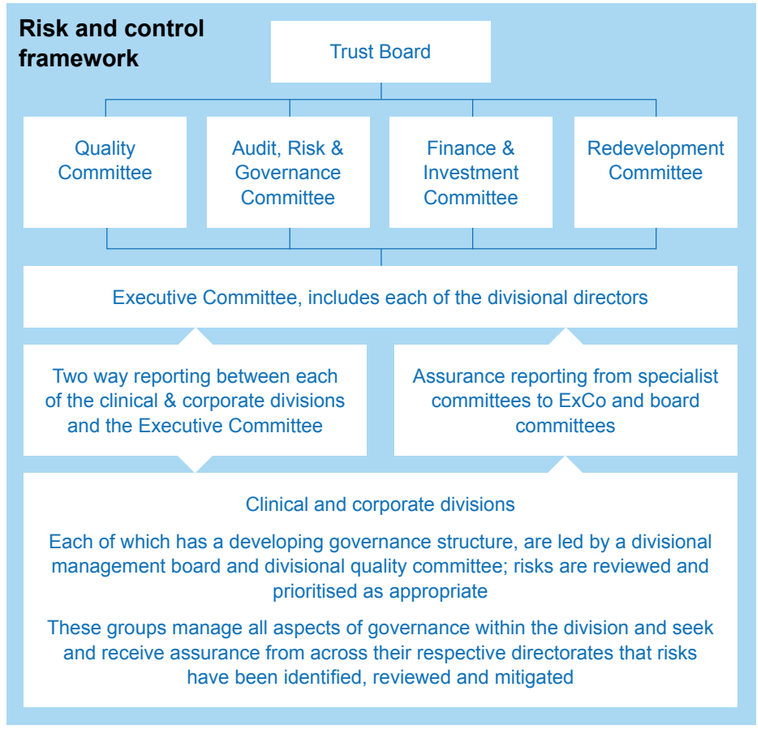
Are there clear and effective processes for managing risks, issues and performance?

Risk and control framework

The Trust has a systematised framework for ensuring effective reporting mechanisms, not only from the divisional management and divisional quality groups, but also from the specialist committees (for example the health and safety committee and infection control committee); the framework for this is outlined in the chart below:

The chart below articulates the way in which the clinical and corporate divisions link into the board assurance framework.

As outlined previously, the risk management policy describes the approach that the Trust will take to identifying, managing and mitigating risk. All risks and potential hazards are identified and are recorded at directorate level, which identify key controls and mitigating action plans formulated to deal with these. Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be satisfactorily resolved or managed at a local level, they are considered for inclusion in the divisional or functional



registers, with risks on these registers in turn reviewed for inclusion in the corporate risk register. Each division has a governance lead; their key role is to support the division in identifying and mitigating risks.

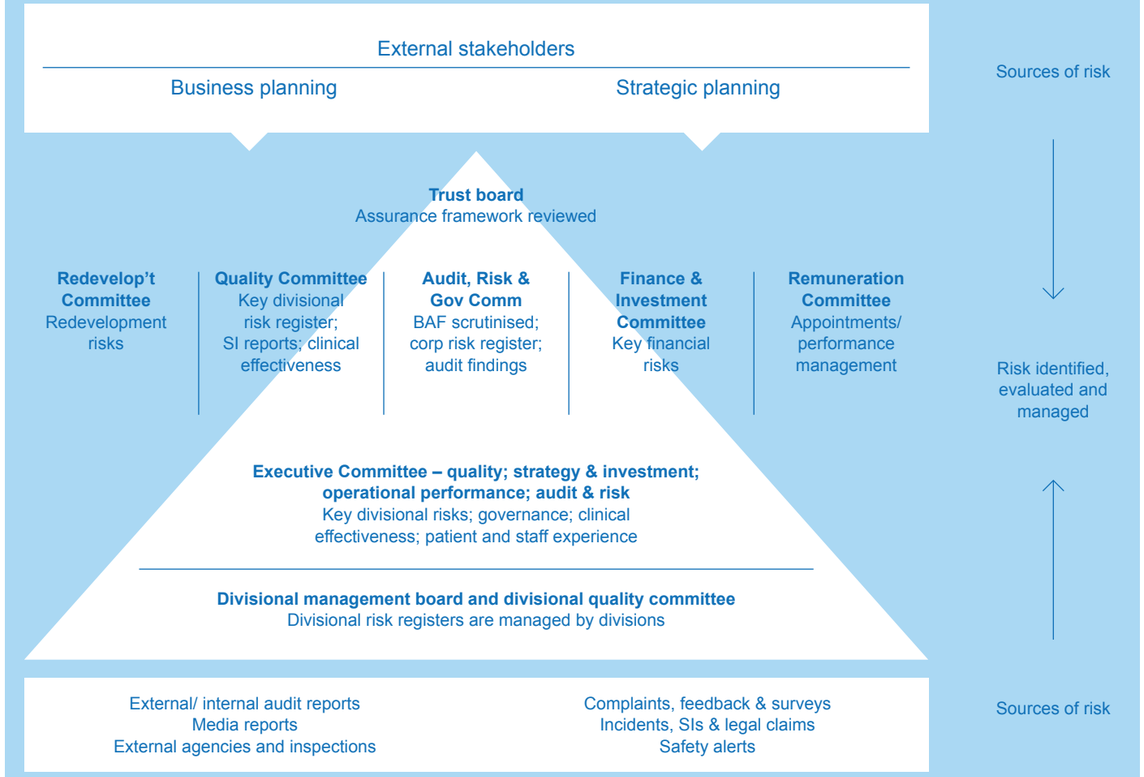
Risks are identified through feedback from many sources such as proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, whistleblowing, stakeholder/partnership feedback and internal and external assurance assessments. There are clear examples of risks being identified 'bottom to top' and 'top to bottom'. The transfer of recording of risks onto the Datix system will provide a tool for ensuring that risks are reviewed and action taken in a timely manner.

Risk management is embedded within the organisation through the corporate, divisional and directorate structures and the reporting and feedback mechanisms are in place as outlined below:

The Trust considers on an on-going basis whether the arrangements in place deliver assurance for the prevention of risk, deterrent to risk (particularly fraud), and mitigation of risk. A number of the developments described demonstrate that improvement is always possible and actively sought, but the existing arrangements are considered to provide a reasonable level of assurance, a view supported by an independent internal audit.

The executive committee meets on a weekly basis to review the adequacy of, and progress against, action plans and to consider acceptance or further resolution. If additional resources are required to reduce the risk to an acceptable level this is considered, prioritising those risks where there is a higher likelihood or consequence.

Risk identification a reporting framework



Risk assessment and assurance framework

The board assurance framework provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the robustness of internal controls to reduce or manage the risks to an acceptable level. An assurance mechanism is of a different nature, requires different information and will follow a difference structure to that of the usual reporting arrangements of an organisation.

Within the Trust, the overall role of an assurance mechanism is to:

- bring to the attention of the Trust board information that may have an impact on the ability of the Trust to achieve its strategic objectives; and
- assure the Trust board that the appropriate accountability is being taken for those areas of responsibility held by a group or individual

The risk and control framework described above was in place from April 2016, but strengthened by a new approach to the board assurance framework approved by the Trust board in July 2016. This references areas of risk in the Trust against the strategic objectives, and also highlights the specific relevant risks on the corporate risk register. The key sources of control and assurances, both internal and external, are reviewed for their adequacy and relevance. This replaced a more traditional risk register-style board assurance framework which had been in place previously.

The Trust is committed to openness and transparency in managing the risks to which it is exposed; the full board assurance framework and corporate risk register are presented at intervals at the public Trust board meeting, following more regular review by the executive committee and audit, risk and governance committee. It is kept under on-going managerial review, and would be brought forward for formal review if changes were considered necessary.

As the Trust moved into 2017/18, the following were considered to be its current key risks as detailed on the corporate risk register.

Risk reported on corporate risk register (May 2017)

Strategic risks	Risk mitigation and control
Failure to maintain financial sustainability	• Agreement of revolving working capital facility up to £65 million from the Department of Health • All working capital arrangements reviewed and improvements implemented to forecasting and income recovery • Financial improvement programme approach now within Trust ownership • Cost management teams in each directorate Specialty reviews designed to identify further opportunities towards sustainability • Cash controls, including: stock control, cash monitoring, debt collection, creditor management • Longer term, engagement in the STP and SaHF
Failure to comply with CQC regulatory requirements and standards could lead to a poor outcome from a CQC inspection and /or lead to enforcement action being taken against the Trust	• Dedicated Regulation Manager, with broad experience in inspections and policy development • Improvement & Assurance Framework in place based on CQC's inspection methodology • All areas have local monitoring activities in place, reported as necessary to executive committee • Incidents and complaints are monitored and reported as part of divisional and Trust quality reports
Failure to meet required or recommended vacancy rate for band 2-6 nursing and midwifery staff	• Further extension of recruitment team, continuing to reduce the total time to hire • Recruitment and attraction strategy and plan in place, and broadening channels used to increase pipeline • All current vacancies for nursing in key areas advertised • Safe staffing on wards monitored through monthly fill rate reports • Monthly exception reports produced for divisional quality and safety meetings • Resourcing and retention task and finish group established, as part of wider staff retention plan
Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	• Regular meetings with NHS England, NHS Improvement, CCG partners for early identification of potential issues / changes in requirements • Regular reporting to executive and Trust board • Regular meetings with Council planners and Mayor's Office • Active management of backlog maintenance • Active ways of engaging clinicians through models of care work • Approval given to explore development of a comprehensive outpatient and diagnostic facility at St Mary's Hospital • Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluations • Internal and external resource and expertise in place
Operational risks	**Risk mitigation and control**
Failure of estates critical equipment and facilities that prejudices Trust operations and increases clinical and safety risks	• Implementation of new Hard facilities management managed service solution through specialist Maintenance provider • Statutory and regulatory inspections rescheduled to ensure compliance whilst minimising impact on front line services • All planned and repair maintenance works managed through computer aided system to improve programming and reporting • Total of £16.2m allocated to backlog maintenance in 2017/18 capital programme • PLACE (Patient-Led Assessment of the Care Environment) undertaken to understand patient perceptions and identify priorities from a patient perspective • Monthly estates & facilities quality committee for closer working with front line services and improved reporting; H&S, fire and compliance committee established to formally report and monitor statutory compliance
Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship • CPE policy in place and patient and staff information available • Flagging system in CERNER for identifying readmissions of positive patients • CPE management discussed weekly at HCAI taskforce • Action plan monitored through quality and safety sub-group; exceptions reported to executive • Reduction in un-indicated use of carbapenem antibiotics
Failure to deliver safe and effective care	• Centralised safety and effectiveness structure implemented to ensure streamlined management and governance • Compliance and improvement monitoring governance process through quality and safety sub-group and executive quality committee • Root cause analysis and learning from incidents, and weekly incident review meeting • Being open processes being comprehensively reviewed and improved • Updated invasive procedures policy published – five steps to safer surgery • Active clinical audit programme to identify areas most in need of improvement, and trust wide clinical audit and effectiveness group established reporting through to executive • Staff training for incident and risk management including clinical audit, Datix, duty of candour, and organisational learning
Failure to maintain key operational performance standards	• Emergency department • Increase in capacity at Charing Cross and St Mary's • Comprehensive escalation and 'full capacity' plans in place • Revised trajectory agreed with NHS Improvement • Escalation of Vocare issues with commissioners • Referral to treatment • Comprehensive validation of all waiting lists to identify long waiters, and risk of clinical harm • Focus on treating all long waiters asap • Retraining of staff to ensure future adherence to process • Cancer waiting times • Implemented validation of cancer pathways • Three year funding agreement with Macmillan • Increased investment in cancer MDT coordinators and improved pathway tool • Diagnostic waiting times • Increased radiological sessions and clear escalation plans • Outsourcing of MRI scans where appropriate • Investment in new scanning equipment
Failure to meet some of the core standards and service specifications for high dependency areas within the Trust	• Review of all incidents by critical care and independent consultants • Escalation of staffing issues within agreed framework; cross cover from other clinical areas • Support from ICU and use of outreach (hours extended)
Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors	• New management structure in place • Anti-bullying strategy implemented • Revised governance strategy implemented • Safety panel monitoring incidents weekly • Annual programme of specialty reviews chaired by medical director • Annual trainee 'deep dive' programme in place • Task & finish group for recruitment and retention of non-training grades to cover gaps in rota

Cyber security threats to Trust data and infrastructure	• Maintaining lowest possible attack profile to reduce exposure to malware and hacking • Maintaining firewalls and a documented change control process • Servers and desktops installed with anti-virus software • Monthly cyber security dashboard reviewed at ICT security • Anti-malware procedure in place • Third party supplier to provide specialty security services
Adverse patient experience and quality of care in the emergency departments caused by the significant delays experienced by patients presenting with mental health issues	• Agreeing and piloting a new escalation framework with commissioners • Meetings with the mental health trusts to raise concerns • Escalation to the A&E Delivery Board and NHS Improvement • Escalation of delays in real time to both the relevant mental health trust and commissioners • Augmenting the nursing establishment in the emergency departments with registered mental health nurses, and increasing the security presence • Establishment of a dedicated consultant lead for mental health in both emergency departments

Each of the risks described above has a detailed mitigation plan, with actions and timescales in place to achieve a level of risk that the Trust considers manageable for that risk.

Performance management

The Trust implemented a new integrated performance framework in July 2016, to provide oversight of over 70 core indicators at each of the four levels of the organisation (board, division, directorate and where relevant ward/clinic). The framework is split into the five quality domains, with a further domain on money and resources.

Quality, workforce and financial indicators are all included e.g. patient safety incidents and incident reporting rate, pressure ulcers, staffing fill rates, mortality, sickness absence, bank and agency spend, Friends and Family Test results, national operational standards, in month variance to plan and CIP delivery.

The quality report, which provides up-to-date information on a wider range of quality and safety indicators, is also reviewed monthly at the executive committee and, in 2016/17, monthly at meetings of the quality committee where detailed reviews are undertaken of areas where potential issues are identified. A suite of metrics aligned to the five CQC domains of quality, have been agreed as the indicators of progress towards achieving the quality strategy, as outlined above. These metrics have been developed on a divisional and site basis as well as at Trust level, covering patient safety, patient experience and clinical effectiveness, highlighting current quality and safety issues and action being taken.

NHS Improvement's Single Overview Framework (SOF) has replaced the Trust Development Authority accountability framework by which individual trust's performance had previously been assessed. Aiming to provide an integrated approach for NHS Improvement to oversee both NHS trusts and foundation trusts, and identify the support they need to deliver high quality, sustainable healthcare services, its stated aim is to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

The Framework has been considered by the executive committee, and arrangements are in hand to ensure the KPI scorecard and other performance monitoring processes align fully with the new requirements.

The SOF has introduced a new mechanism of categorising trusts according to their performance against a number of metrics across five themes (quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability), as below:

1 providers with maximum autonomy, and no potential support needs have been identified

2 providers are offered targeted support, where there are concerns in relation to one or more of the themes

3 providers are receiving mandated support for significant concerns

4 providers are in special measures.

Since introduction of the framework, the Trust has been placed, by NHS Improvement, in segment 3 of 4 segments, relating predominantly to financial position and performance on constitutional standards.

Significant issue: Ability to achieve required performance targets in the emergency department and for elective surgery

Emergency department: The Trust is currently not achieving the national target to see, treat and discharge 95 per cent of patients that present to an urgent or emergency care setting in four hours. The key drivers of this underperformance are rising demand, particularly from ambulance arrivals, high levels of inpatient bed occupancy and under performance of the outsourced urgent care centre on the St Mary's site.

In response to these pressures, the Trust has developed an on-going programme of developments to improve the whole urgent and emergency care pathway. The priority of this plan is to reduce waits, improve flow and capacity and manage additional demand. The plan is supported by a trajectory for improvement, agreed with the Trust's commissioners and approved by NHS Improvement, which will bring performance to 95 per cent by the end of March 2018.

Progress with delivering the action plan and monitoring performance against the improvement trajectory is undertaken through the four hour performance working group, chaired by the divisional director for medicine and integrated care, and reported to the executive committee.

Referral to treatment: The Trust brought in external expertise to support it in addressing a number of underlying issues identified in waiting list management early in 2016; the data validation team had picked up inconsistencies in how waiting list processes were being managed, there were some continuing data quality issues highlighted on risk registers, and not enough outpatient and elective treatment were being planned to ensure there was capacity to meet demand.

With the support of local commissioners, the Trust invited a national team to review our information systems and processes, data validation and rules application in relation to the 18 weeks referral to treatment (RTT) standard. In response to the report, the Trust established a waiting list improvement programme to develop and implement an action plan to:

- support the office of the medical director in embedding processes to assure patient safety
- put in place and maintain best practice waiting list management processes
- complete work to ensure a fully comprehensive and accurate understanding of all of our waiting lists
- improve our systems and processes to ensure good data quality at point of entry
- achieve the national waiting list standard sustainably.

The programme is driven by a dedicated waiting list improvement team supported by an external waiting list expert and incorporates a number of work streams: establishing comprehensive and accurate data quality; focus on treating patients waiting over 52 weeks; improving responsiveness, including through increased capacity both within the Trust and with the support of independent sector providers; improving waiting list management processes and data quality practice; and governance and monitoring.

Progress with delivering the action plan and monitoring performance against the improvement trajectory is undertaken through the RTT working group, chaired by the divisional director for surgery, cancer and cardiovascular, and reported to the executive committee.

As part of the Trust's broader response to the issues identified, a data quality steering group, chaired by the chief information officer, reporting to the executive committee, has been formed to improve data quality assurance for waiting time and activity data.

Is robust and appropriate information being effectively processed and challenged?

The Trust board ensures that the resources are used economically, efficiently and effectively by means of regular detailed finance and performance reports. These are considered in detail by the finance and investment committee. The audit, risk and governance committee receives regular reports from the Trust's internal auditors, TIAA, and external auditors, BDO LLP.

As part of the Care Act 2014, it became a criminal offence to provide false or misleading information; this relates to commissioning data and other specified information including information in the quality accounts. The Trust has reviewed the requirements of the Act and has ensured appropriate managers have been briefed and reviewed the internal audit plan to ensure coverage of these data sets in planned audits.

The Trust brought in external expertise to support it in addressing a number of underlying issues identified in waiting list management early in 2016. The data validation team had picked up

inconsistencies in how waiting list processes were being managed, there were some continuing data quality issues highlighted on risk registers, and not enough outpatient and elective treatment were being planned to ensure there was capacity to meet demand. Further details are outlined in the previous section.

In relation to the data accuracy in the quality accounts, there are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include:

- Data are derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data are collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its board have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of all data reported. To the Trust board's knowledge, all information provided is a true and fair reflection of the Trust's performance. There is a broad programme of internal audits focus on different aspects of the Trust's data quality (details of audits at appendix one).

Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

The first Trust-wide patient and public involvement (PPI) strategy and action plan, created through a series of co-design events, was approved by the Trust board in July 2016. It builds on many great examples of patient and public involvement in supporting and developing specific services. The vision for this strategy is outlined in *About the Trust.*

Good progress has been made in many areas of the strategy, in particular the adoption of lay partners across the Trust. As of March 2017 we had 22 new potential lay partners and 11 key projects in which they are becoming involved. It was decided that PPI should not be a central function and the PPI project manager works closely with partner teams across the Trust and the Charity.

Outcomes of this have been good co-ordination and teamwork on projects such as the lay partner development day held in November 2016, the PPI toolkit, working with seldom-heard groups, the current review of patient stories, setting up lay partner infrastructure and the maternity PPI pilot. Success in raising the profile of PPI has also been achieved through other networks and organisations like the College/Biomedical Research Centre and the Patient Safety Translational Research Centre, and all new lay partner opportunities are promoted through Healthwatch's network.

It is crucial that our patient communications are clear and understood by the Trust's diverse range of patients. The patient communications group read, review and provide advice (by email) on patient communications. The group was established in February 2017 and currently has 21 members. It is intended that the group will meet about twice a year to share Trust news and refine the process of working together.

Since January 2016, the Trust has been working closely with a group of other providers of healthcare services to the population of Hammersmith & Fulham. The partnership, that now includes the Trust, Chelsea & Westminster Hospital NHS FT, West London Mental Health NHS Trust, Central London Community Health NHS Trust and the Hammersmith & Fulham GP Federation, is focused on establishing an accountable care system for the population of the borough and is recognised as a local trailblazer in north west London.

This requires providers to work together in a materially more collaborative way to deliver patient-centred care and to act as a system for the good of the local community, rather than a set of sovereign organisations. The ethos of the partnership is rooted in co-design: between provider partners, between providers and commissioners and, most importantly, together with our representative patients and carers. Representative patients and carers are embedded in all relevant aspects of the programme and its decision-making structure with lay representation on the programme board, steering group and project work streams. Regular updates on the programme are provided to the Trust's strategic lay forum.

A transport working group has also been established to develop the collaborative approach to improving transport and travel to and across our sites with key stakeholders. Notably the group comprises members nominated by the local branches of Healthwatch across north west London. The work of the group is aligned with the priorities and timelines of both the Trust redevelopment programme and other north west London transformational programmes of work.

The group's focus is primarily strategic though through its membership of wider stakeholders and Trust staff in particular those from the nursing, estates and facilities team it is able to ensure any operational concerns related to travel or patient transport services can be directed to the most appropriate forums for action. The group has been very helpful in reviewing and suggesting improvements to key redevelopment transport initiatives such as the Trust travel plan.

Are there robust systems, processes for learning, continuous improvement and innovation?

A learning organisation

The Trust is committed to providing a learning environment for all levels of staff, to ensure that good practice is developed and disseminated to all areas of the organisation and that there is effective and robust learning from incidents and near misses. This is achieved by:

- a commitment to individual appraisal and personal development planning for all staff
- policies to encourage the open reporting and investigation of adverse incidents including near misses
- a commitment to root cause analysis of problems and incidents and the avoidance of blame
- a range of problem resolution policies and procedures, including capability, raising concerns or 'whistle blowing', workplace stress, harassment and discipline which are designed to identify and remedy problems at an early stage
- supporting operational teams with corporate expertise in developing their risk registers as an effective management tool
- detailed director level scrutiny of the risk register
- direct recording of risks onto the Datix risk system to improve their review and management
- a range of clinical and non-clinical audit mechanisms.

All staff are trained in these policies as part of the corporate and local induction policies and updated via regular staff briefings and the Trust intranet.

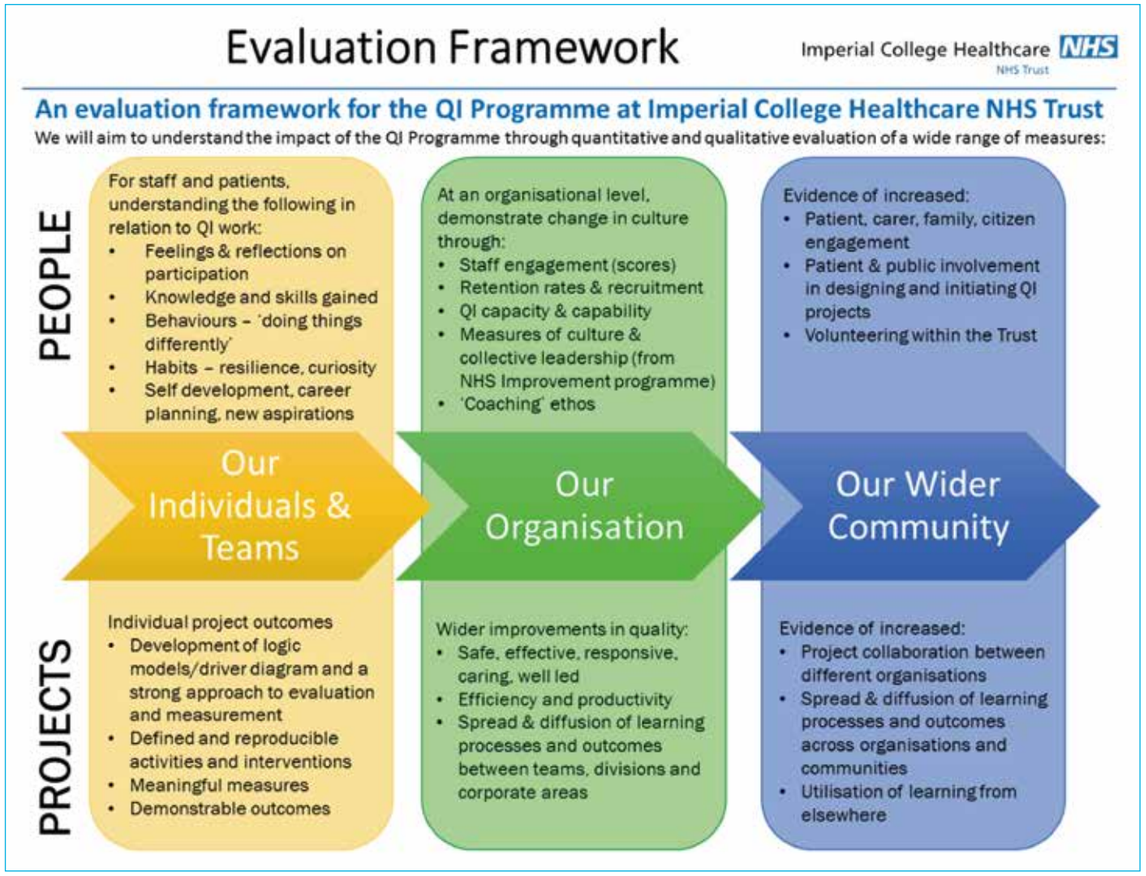
The Trust recognises that it is important to be outward looking and to learn and improve from the experience of other organisations and experts and where possible to benchmark the quality and performance of the services we provide to our patients. This is done in a variety of ways.

Building quality improvement capability and capacity

In October 2015, we launched a Quality Improvement (QI) programme to support the implementation of the quality strategy. The programme provides staff with the necessary skills and tools to enable and empower them to lead QI projects in their work areas. Its two core elements comprise: a quality improvement training programme providing blended training for staff, based on a standardised and consistent model for improvement; and a team – the QI hub – to support improvement delivery and potential.

The team have developed a capability and capacity framework to help build an organisation that has the skills and knowledge to support and sustain improvement, ultimately supporting delivery of both the quality strategy and the STP. This framework consists of a number of education opportunities for staff, including team-based 'QI Tools for Change' and skills series sessions, and a coaching and leadership programme to develop cohorts of QI champions across the organisation.

To ensure we can demonstrate and evidence the impact of our QI programme, an evaluation framework is in place (see overleaf). It gives equal weighting to the value of developing improvement capability in people as to the outputs of projects. It encourages measurement at the level of the individual or team, at an organisational level and across the wider communities we work with and serve.



Learning from serious incidents and never events

The Trust investigates all patient safety incidents which are reported on the Trust's incident reporting system, Datix. In addition, all patient safety incidents graded moderate and above are reviewed at a weekly panel chaired by the medical director. Each incident is reviewed when it is first reported on Datix, and then again each week until the investigation has been completed and it is closed from a Trust perspective. Incidents that are deemed to be serious Incidents or never events also undergo an investigation which involves root cause analysis.

This investigation is conducted in the service in which it occurred by the identified investigation team, with oversight by the divisional management and governance teams. On completion of the investigation, the report is approved by the divisional director and their senior management team. The report is then heard at panel by the medical director or his deputy, with the divisional senior management team and members of the investigation team in attendance to present the investigation report. The report is then approved as complete by the medical director or deputy and submitted to our clinical commissioning group (CCG). The CCG review the report and have the opportunity to submit any comments or questions they may have to the Trust before confirming closure at which point the report is final. All actions arising from the investigation are assigned a lead and logged centrally on the Datix system.

Feedback from staff and patients, and a review of how we meet the duty of candour requirements for serious incidents, has identified areas of improvement in how we manage and investigate serious incidents. We have therefore undertaken a number of actions to improve our processes, including: a more rigorous quality assurance process; clarification around timelines, roles and responsibilities of those involved in the investigation process; and improvements in practice regarding how we involve patients and families. We are currently undertaking a full review of the Trust policies and processes around incident investigation, comparing these to national policy and legislation.

The Trust reported four never events in 2016/17, each related to practice in surgery. Each of these has individual actions in place to reduce the risk of recurrence, however the investigations highlighted similar issues with leadership and teamwork, the application of the WHO checklist, and Trust policies and procedures either not being followed or not complying with best practice.

A safer surgery task and finish group was established in July 2016 to review how we were conducting interventional procedures across the Trust and to ensure we were providing the safest possible care for our patients. The work of this group will continue into 2017/18.

A review of trust-wide themes and learning from serious incidents and never events has resulted in the identification of nine key safety improvement work streams. These have been defined and approved as the Trust's priority areas under the safe domain for the quality strategy for the remainder of 2016/17 and into 2017/18:

- pressure ulcers
- safe mobility and prevention of falls with harm
- recognising and responding to the very sick patient
- optimising hand hygiene
- safer surgery
- foetal monitoring
- safer medicines
- abnormal results
- positive patient confirmation.

Each safety improvement stream has an identified clinical lead and is supported by a working group. The working groups will undertake further analysis of SI reports and themes on an on-going basis. Since February 2017, each safety stream has reported quarterly to the quality and safety sub-group with exception reporting to the executive quality committee.

Learning from clinical audit

The Trust's clinical audit programme was developed in 2014, when responsibility for effectiveness transferred to the medical director. This programme ensures that we are providing healthcare in line with standards, and lets us and our patients know where services are doing well, and where improvements could be made. It is an annual comprehensive process of practice review which delivers a defined programme of priority audits to support our improvement priorities. It also ensures that we are participating in national clinical audits and that any recommendations and areas for improvement are acted upon.

This programme is managed through the newly established clinical audit and effectiveness group, which reports to the quality and safety sub-group each month and to executive quality committee on a quarterly basis. This group was introduced to improve how we manage clinical audit, but also to improve how we learn from the outputs of clinical audit and deliver improvements to patient care as a result. We have further work to do into 2017/18 to fully embed this effectively.

Other disclosures

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 that 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 at each board meeting; the register as at 31 March 2017 is attached at appendix two, and is available to the public on the website at www.imperial.nhs.uk. The Trust board considers that all its non-executive directors are independent in character and judgement, although it notes that Professor Andy Bush as an appointee of Imperial College London, brings its views to the Trust board.

NHS England have recently issued new guidance which aims to: introduce common principles and rules for managing conflicts of interest; provide simple advice to staff and organisations about what to do in common situations; and support good judgement about how interests should be approached and managed. A policy model template has also been produced; the policy model and associated guidance have been reviewed to ensure Trust processes are in line with the new requirements, and strengthening is being agreed where appropriate. The Trust seeks annual declarations from all staff graded band 8a and above; approximately 1,655 staff, approaching 65 per cent, had been return at the end of May 2017.

Modern Slavery Act - 2016/2017 annual statement

At Imperial we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles.

We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

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 are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Details of directors' remuneration and further information on the wider workforce are set out in the remuneration and staff report as are exit packages and severance payments, and the Trust off-payroll engagement disclosures (which are in accordance with HMRC requirements). The Trust's external auditor and details of their remuneration and fees are set out in the accounts.

Cost allocation and charges for information

The Trust complies with HM Treasury's guidance on setting charges for information required.

Equality disclosures

The Trust is committed to the promotion of equality of opportunity for all its employees. Our equal opportunities policy is to provide employment equality to all, irrespective of race, gender, disability, age, sexual orientation or religion. The Trust produces a yearly workforce equality data report that provides information on how different groups of staff are affected by recruitment and human resources procedures and policies. This is available on our website:

www.imperial.nhs.uk/equalityanddiversity/workforcedata/index.htm

Better payment for suppliers

The Trust supports the Prompt Payment Code which applies the following principle to payment practices: pay suppliers on time; give clear guidance to suppliers; and encourage good practice. The Trust's performance is summarised in the table in the accounts.

Emergency preparedness

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 Planning Guidance 2005. Details are included earlier in the governance statement.

Principles for remedy

The Trust handles all complaints in line with the Principle of Good Administration and aims to resolve complaints in line with the Principles for Remedy.

Other items

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with, and objectives forming part of the Trust's equality delivery scheme are reported to the Trust board.

In seeking good practice (and noting that it is not required to comply with this), the Trust has noted the 2014 update of the Financial Reporting Council (FRC) Corporate Governance Code, which has focused on the provision by organisations of information about the risks which affect longer term viability. This is clearly the role of the board assurance framework, and has underpinned the review of the structure and content of the assurance framework.

Conclusion

As accountable officer, I have responsibility for reviewing the effectiveness of the systems of internal control. My review of the effectiveness of the system of internal control is informed in a number of ways:

- The head of internal audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. I believe that the organisational restructure, and investments made in the financial team and the financial improvement programme, have helped the Trust deliver a real improvement in accountability and sustainability, leading to delivery of the 2016/17 financial plan, whilst also achieving improvements to patient safety and experience in a number of areas. Internal audits carried out (listed in appendix one), have provided assurance from significant assurance to limited assurance; following the audit reports, management have accepted, and taken action to address, recommendations made.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that each has taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.
- The board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- 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 lead assessments of the care environment.

I can confirm, having taken all appropriate steps to be aware of potential breaches or failure to comply, that arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant.

I consider that any significant issues are included in the report, namely: ability to achieve and maintain financial sustainability; ability to achieve required performance targets in the emergency department and for elective surgery; ability to recruit and retain required clinical staff, particularly in relation to ward-based nurses, midwives and radiographers; ability to gain funding approval from key stakeholders for the redevelopment; and ability to fund the appropriate level of back-log maintenance whilst awaiting redevelopment, and the resulting risk to necessary funding for the medical equipment replacement programme. Action to address each of these areas is detailed in the relevant section of the governance report.

Signed:

Dr Tracey Batten
Chief executive

Date: 31 May 2017

Statement of the chief executive's responsibilities as the Accountable Officer of the Trust

The chief executive of NHS Improvement, in his capacity as the Accounting Officer for the NHS Trust Development Authority legal entity, has designated that the chief executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officer's Memorandum issued by the chief executive of NHS Improvement. 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
- annual statutory accounts are prepared in a format directed by the Secretary of State, with the approval of the Treasury, to give a true and fair view of the state of affairs as at the end of the financial year, and include income and expenditure, recognised gains and losses, and cash flows for the year.

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.

I confirm that, 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 Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts, and the judgments required for determining that it is fair, balanced and understandable.

Signed:

Dr Tracey Batten
Chief executive

Date: 31 May 2017

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 the 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, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Trust board

Dr Tracey Batten
Chief executive

Date: 31 May 2017

Richard Alexander
Chief financial officer

Date: 31 May 2017

Remuneration and staff report

Remuneration report

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

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

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

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

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

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based. Salary levels (which typically take effect from 1 April) for executive directors in 2016/17 are set out in the staff report.

The Trust has taken advantage of flexibilities offered in the agenda for change to offer pay spot salaries to 11 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.

Subject to any future reform of national terms and conditions the Trust plans to increase the number of senior managers on spot salaries in order to better control cost, maintain a competitive position in recruiting for senior positions and to readily link salary increases to performance.

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, and receive payments based on benchmarking data for similar posts elsewhere in the NHS.

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

Pay multiples (subject to audit)

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the Trust and the median remuneration of all staff. The remuneration of the highest paid director in the financial year 2016/17 was £308,999 (£315,991 in 2015/16 – restated). This was 8.10 times (9.23 times in 2015/16 - restated) the median remuneration of the workforce, which was £38,143 (£34,244 in 2015/16 – restated).

The change in the ratio from 9.23 (2015/16) to 8.10 this year is partly due to a reduction in the highest paid director's remuneration, which is a caused by a temporary relocation allowance which was earned last year. The remainder of the change is due to an increase in median remuneration for the general workforce which is due to incremental drift (whereby agenda for change contracts reward staff with movement up the scale based on satisfactory levels of performance), inflation and the grade mix of staff brought into the Trust to support increased activity.

In both 2015/16 and 2016/17 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £7,760 to £308,999 (£7,348 to £315,991 in 2015/16 - restated).

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

Remuneration report

Salary and pension disclosure tables: Information subject to audit

Remuneration report 2016/17

Single total figure table	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	Salary	Expense payments (taxable)	Performance pay and bonuses[9]	Long term performance pay and bonuses	All pension related benefits	Total remuneration
	(bands of £5,000)	(total to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name & title	£000	£00	£000	£000	£000	£000
Sir Richard Sykes, chairman	20 - 25	0	0	0	0	20 - 25
Sir Gerald Acher, deputy chair	5 - 10	0	0	0	0	5 - 10
Jeremy Isaacs, non-executive director[1]	0 - 5	0	0	0	0	0 - 5
Dr Rodney Eastwood, non-executive director	5 - 10	0	0	0	0	5 - 10
Prof Sir Anthony Newman Taylor, non-executive director[2]	0 - 5	0	0	0	0	0 - 5
Sarika Patel, non-executive director	5 - 10	0	0	0	0	5 - 10
Dr Andreas Raffel, non-executive director	5 - 10	0	0	0	0	5 - 10
Prof Andy Bush, non-executive director[4]	0	0	0	0	0	0
Peter Goldsbrough, non-executive director[5]	0	0	0	0	0	0
Dr Tracey Batten, chief executive[6]	295 - 300	0	5 - 10	0	0	305 - 310
Richard Alexander, chief financial officer	210 - 215	0	0	0	52.5 - 55	265 - 270
Dr Julian Redhead, medical director[3]	235 - 240	0	0	0	20 - 22.5	255 - 260
Prof Janice Sigsworth, director of nursing[8]	175 - 180	0	0	0	207.5 - 210	380 - 385

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31st March 2017	Lump sum at pension age related to accrued pension at 31st March 2017	Cash equivalent transfer value at 1st April 2016	Real increase in cash equivalent transfer value[6]	Cash equivalent transfer value at 31st March 2017	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name & title	£000	£000	£000	£000	£000	£000	£000	£000
Sir Richard Sykes, chairman	0	0	0	0	0	0	0	0
Sir Gerald Acher, deputy chair	0	0	0	0	0	0	0	0
Jeremy Isaacs, non-executive director[1]	0	0	0	0	0	0	0	0
Dr Rodney Eastwood, non-executive director	0	0	0	0	0	0	0	0
Prof Sir Anthony Newman Taylor, non-executive director[2]	0	0	0	0	0	0	0	0
Sarika Patel, non-executive director	0	0	0	0	0	0	0	0
Dr Andreas Raffel, non-executive director	0	0	0	0	0	0	0	0
Prof Andy Bush, non-executive director[4]	0	0	0	0	0	0	0	0
Peter Goldsbrough, non-executive director[5]	0	0	0	0	0	0	0	0
Dr Tracey Batten, chief executive [6]	0	0	0	0	0	0	0	0
Richard Alexander, chief financial officer	2.5 - 5.0	10 - 12.5	25 - 30	75 - 80	410	96	506	0
Dr Julian Redhead, medical director[3]	0 - 2.5	0 - 2.5	50 - 55	140 - 145	782	75	857	0
Prof Janice Sigsworth, director of nursing	10 - 12.5	30 – 32.5	80 - 85	245 - 250	1,369	287	1,656	0

1 Jeremy Isaacs left the Board on 30 September 2016.

2 Prof Sir Anthony Newman Taylor left the Board on 31 August 2016

3 Dr Julian Redhead, the amount of 135-140 of his salary relates to payment for clinical role

4 Prof Andy Bush joined the Board on 1 September 2016

5 Peter Goldsbrough joined the Board on 1 September 2016

6 Dr Tracey Batten's salary disclosed is gross pay excluding purchase of additional annual leave

7 Real Increase in CETV: This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period

8 Prof Janice Sigsworth's pension was subject to correction by the NHS Pension's Agency in 2016/17 in respect of historical data recording issues in their system

9 Performance bonus for 2015/16 was paid following approval by the Board remuneration committee

There were no non-contractual payments made to individuals named above

Remuneration report 2015/16

Single total figure table	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and Allowances	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	Pension related benefits	Total remuneration
	(bands of £5,000)	(Total to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name & title	£000	£00	£000	£000	£000	£000
Sir Richard Sykes, chairman	20 - 25	0	0	0	0	20 - 25
Jeremy Isaacs, non-executive director	5 - 10	0	0	0	0	5 - 10
Sir Gerald Acher, non-executive director	5 - 10	0	0	0	0	5 - 10
Dr Rodney Eastwood, non-executive director	5 - 10	0	0	0	0	5 - 10
Prof Sir Anthony Newman Taylor, non-executive director	5 - 10	0	0	0	0	5 - 10
Sarika Patel, non-executive director	5 - 10	0	0	0	0	5 - 10
Dr Andreas Raffel, non-executive director	5 - 10	0	0	0	0	5 - 10
Dr Tracey Batten, chief executive	295 - 300	140	10 - 15	0	0	320 - 325
Alan Goldsman, chief financial officer[1]	115 - 120	0	0	0	0	115 - 120
Richard Alexander, chief financial officer[2]	135 - 140	0	0	0	New Board member	135 - 140
Steve McManus, chief operating officer	185 - 190	0	0	0	37.5 - 40	225 - 230
Prof Janice Sigsworth, director of nursing	155 - 160	0	0	0	20 - 22.5	180 - 185
Prof Chris Harrison, medical director[3]	200 - 205	0	0	0	Left	200 - 205
Dr Julian Redhead, medical director[4]	215 - 220	0	0	0	New Board member	215 - 220

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31st March 2016	Lump sum at pension age related to accrued pension at 31st March 2016	Cash equivalent transfer value at 1st April 2015	Real increase in cash equivalent transfer value[5]	Cash equivalent transfer value at 31st March 2016	Employer's contribution to stakeholder pension
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)				
Name & title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Sir Richard Sykes, chairman	0	0	0	0	0	0	0	0
Jeremy Isaacs, non-executive director	0	0	0	0	0	0	0	0
Sir Gerald Acher, non-executive director	0	0	0	0	0	0	0	0
Dr Rodney Eastwood, non-executive director	0	0	0	0	0	0	0	0
Prof Sir Anthony Newman Taylor	0	0	0	0	0	0	0	0
Sarika Patel, non-executive director	0	0	0	0	0	0	0	0
Dr Andreas Raffel, non-executive director	0	0	0	0	0	0	0	0
Tracey Batten, chief executive	0	0	0	0	0	0	0	0
Alan Goldsman, chief financial officer[1]	0	0	0	0	0	0	0	0
Richard Alexander, chief financial officer[2]	New Board member	New Board member	20 - 25	65 - 70	New Board member	New Board member	410	0
Steve McManus, chief operating officer	2.5 - 5	0 - 2.5	60 - 65	170 - 175	972	38	1,010	0
Prof Janice Sigsworth, director of nursing[3]	0 – 2.5	5 – 7.5	70 - 75	210 - 215	1,324	45	1,369	0
Prof Chris Harrison, medical director[3]	Left	Left	Left	Left	1,144	Left	Left	0
Dr Julian Redhead, medical director[4]	New Board member	New Board member	45 - 50	135 - 140	New Board member	New Board member	782	0

1 Alan Goldsman left the Board on 31 July 2015. The amount above is payable to Alan Goldsman Limited and is net of VAT

2 Richard Alexander joined the Board on 3 August 2015

3 Prof. Chris Harrison left the Board on 31 January 2016. The amount of 125-130 of his salary relates to payment for his clinical role

4 Dr Julian Redhead joined the Board on 1 February 2016. The amount of 205-210 of his salary relates to payment for his clinical role

5 Real Increase in CETV: This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period

Staff report

Headcount data as at 31 March 2017 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 2016/17 the Trust employed 10,973 staff. Approximately 70 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 & clerical	1,831
Allied health professional (qualified)	576
Allied health professional (unqualified)	83
Doctor (career grade)	32
Doctor (consultant)	979
Doctor (training grade)	1,453
Nursing (qualified)	3,513
Nursing (unqualified)	924
Pharmacist	125
Scientific & technical (qualified)	702
Scientific & technical (unqualified)	264
Senior manager	491
Trust total	**10,973**

Workforce composition by sex

Seventy one per cent of our workforce is female and 29 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 2016/17 women accounted for 55 per cent of senior managers, 27 per cent of board directors and 30 per cent of executive directors.

Gender – all	Headcount
Female	7,765
Male	3,208
Trust total	**10,973**

Gender – senior managers	Headcount
Female	263
Male	211
Trust total	**474**

Gender – board of directors	Headcount
Female	3
Male	8
Trust total	**11**

Gender – executive team	Headcount
Female	3
Male	7
Trust total	**10**

Workforce composition by age and ethnicity

Age group	Headcount
16-19 years	8
20-29 years	2,244
30-39 years	3,359
40-49 years	2,740
50-59 years	2,010
60 years and over	612
Trust total	**10,973**

Ethnic origin	Headcount
White – British	3,028
White – Irish	364
White – any other White background	1,461
Mixed – White & Black Caribbean	69
Mixed – White & Black African	63
Mixed – White & Asian	79
Mixed – any other mixed background	164
Asian or Asian British – Indian	830
Asian or Asian British – Pakistani	187
Asian or Asian British – Bangladeshi	120
Asian or Asian British – any other Asian background	1,081
Black or Black British – Caribbean	431
Black or Black British – African	982
Black or Black British – any other Black background	445
Chinese	174
Any other ethnic group	574
Undefined	543
Not stated	378
Trust total	**10,973**

Average staff numbers (subject to audit)

Average staff numbers	Total	Permanently employed	Other	Total prior year	Prior year permanently employed	Prior year other
Medical and dental	1,974	1,929	45	1,954	1,846	108
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,406	2,260	146	2,534	2,232	302
Healthcare assistants and other support staff	1,428	1,391	37	1,397	1,340	57
Nursing, midwifery and health visiting staff	3,863	3,676	187	3,683	3,525	158
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	890	773	117	877	755	122
Social care staff	0	0	0	0	0	0
Healthcare science staff	559	559	0	548	548	0
Other	0	0	0	0	0	0
TOTAL	**11,120**	**10,588**	**532**	**10,993**	**10,246**	**746**
Staff engaged on capital projects (included above)	11	11	0	11	11	0

Analysis of staff costs

	2016-17			2015-16 (Restated)		
	Permanent	Other	Total	Permanent	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	423,012	78,993	502,005	412,489	85,116	497,605
Social security costs	45,439	1,912	47,351	35,696	1,670	37,366
Employer contributions to NHS BSA	50,740	623	51,363	48,771	517	49,288
Other pension costs	15	4	19	12	2	14
Termination benefits	243	0	243	234	0	234
Total employee benefits	519,449	81,532	600,981	497,202	87,305	584,507
Employee costs capitalised	678	323	1,001	643	1,194	1,837
Gross employee benefits excluding capitalised costs	518,771	81,209	599,980	496,559	86,111	582,670

Separate to the table above, consultancy spend in 2016/17 was £5,541k (£3,283k in 2015/16).

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. In 2016/17, the Trust achieved a sickness absence rate of three per cent in March 2017 against a target of 3.10 per cent. This compares to a rate of 3.2 per cent in 2016.

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. 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.

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, see opposite.

Off-payroll engagements longer than 6 months

For all off - payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

Number of existing engagements as of 31 March 2017	30
Of which, the number that have existed:	
for less than one year at the time of reporting	15
for between one and two years at the time of reporting	11
for between 2 and 3 years at the time of reporting	3
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

New off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	20
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	7
Number for whom assurance has been requested	7
Of which:	
assurance has been received	6
assurance has not been received	1
engagements terminated as a result of assurance not being received	0

For the one individual where information was not received, this was due to the fact that the Trust was still awaiting this information at the reporting date.

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 2016 and 31 March 2017

Number of off – payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (2016/17)	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.(2016/17)	13

Exit packages (subject to audit)

In 2016/17 the Trust approved severance payments to 10 staff.

2016/17								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	2,464	2	4,373	3	6,837	0	0
£10,000-£25,000	2	34,649	1	17,200	3	51,849	0	0
£25,001-£50,000	1	26,284	0	0	1	26,284	0	0
£50,001-£100,000	2	181,297	1	55,822	3	237,119	0	0
£100,001 - £150,000	0	0	0	0	0		0	0
Total	**6**	**244,694**	**4**	**77,395**	**10**	**322,089**	**0**	**0**
2015-16								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	2	10,081	0	0	2	10,081	0	0
£10,000-£25,000	3	50,498	0	0	3	50,498	0	0
£25,001-£50,000	1	29,761	1	27,479	2	57,240	0	0
£50,001-£100,000	1	67,632	2	139,432	3	207,064	1	78,240
£100,001 - £150,000	1	124,708	0	0	1	124,708	0	0
Total	**8**	**282,680**	**3**	**166,911**	**11**	**449,591**	**1**	**78,240**

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 pensions 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

	2016-17		2015-16	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	2	89
Exit payments following Employment Tribunals or court orders	4	77	1	78
Total	**4**	**77**	**3**	**167**

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.

Signed:

Dr Tracey Batten
Chief executive
Date: 31 May 2017

Chief financial officer's review

During 2016/17 the Trust met all four statutory financial duties (see table on the right) and met its financial plan for the year. This is a significant achievement given that mid-year the Trust agreed an additional stretch of £11 million to its original plan to gain access to central Sustainability and Transformation Funding (STF). This performance included delivering efficiencies of £54 million.

The financial performance in 2016/17 demonstrates that the Trust recognises the need to minimise its financial deficit by setting stretching but achievable budgets.

Statutory financial duties

Duty	Requirement	Achievement
Breakeven duty	To ensure total expenditure does not exceed income, on a year-on-year cumulative basis	Achieved – cumulative surplus of £6.9 million remaining
External financing limit (EFL)	To remain within Department of Health (DH) borrowing limit	Achieved – cash outflow of £18.6 million
Capital absorption rate of 3.5 per cent	To pay a dividend of 3.5 per cent to the DH	Achieved
Capital resource limit (CRL)	To ensure capital expenditure is within the limit set by DH	Achieved – Net spend of £39.1 million

Before STF, the Trust delivered a year-end deficit of £40.8 million, £0.2 million favourable to the planned deficit of £41.0 million. The Trust received £25.4 million of STF, £24.1 million which was allocated based on operational and financial performance and an additional £1.3 million based on meeting the year end control total. The overall Trust position after STF was therefore a £15.3 million deficit, £1.5million favourable to the plan and control total of £16.9 million, mainly due to the additional STF received.

This deficit in 2016/17, combined with a deficit financial plan for 2017/18, will lead to the Trust receiving a qualified use of resources assessment from our auditors. While the Trust board acknowledges that the majority of major teaching hospitals recorded a financial deficit in 2016/17 and were similarly qualified in their use of resources assessment we are in no way complacent about the challenge of our financial position.

Our current plan for 2017/18 will see us breach our statutory breakeven duty during the upcoming year. We have a source of central cash funding which we expect to be sufficient for the upcoming year, but as our plan does not currently qualify us to receive STF we do not have a guaranteed source of funding beyond 2017/18. Our auditors have confirmed that it remains appropriate for the Trust to prepare accounts on a going concern basis.

In year, the Trust was successful in our application to join the NHS Improvement financial improvement programme. The key areas of work undertaken were to improve the assurance process for our extremely challenging efficiency programme, support our processes for cash management, and to work on specific efficiency schemes such as outpatient and theatre productivity. In 2017/18, to further develop our strategic financial improvement, the Trust is embarking on a programme of specialty reviews. This is our internal, clinically focused approach to transformation looking at three interrelated themes: clinical strategy, sustainability and workforce transformation. Preliminary analysis suggests that many of our services now cost significantly more to deliver than we receive as funding and like every other NHS organisation we will have to address the causes of this.

Financial performance metrics

From October 2016, the Trust has been monitored based on the single oversight framework. This uses five key metrics to measure the financial risk of an organisation. Each metric has a rating from 1-4 with 1 being the best performance and 4 the worst. These ratings are then combined to give an overall score. If any metric has a score of 4, then the overall rating cannot score better than a 3 (see table overleaf).

Metric	Explanation	Rating (1-4)
Capital servicing capacity	Does the organisational income cover loans and other financing costs	2
Liquidity	Days of operating costs that can be covered by cash in the organisation	4
Income & expenditure (I&E) margin	Surplus/deficit as a percentage of income	4
Distance from financial plan	Variance between the planned I&E margin and actual	1
Agency spend against cap	The variance between the agency cap and the actual agency costs spent	1

The poor scores for liquidity and income and expenditure (I&E) margin are due to our low cash balances and deficit plan. Achieving our financial plan and significantly reducing our agency spend led to the best rating against these two metrics. As there are two metrics on which the Trust scores a 4, the Trust cannot score higher than 3 (without this override the average of the five metrics is 2.4).

Income and expenditure

The Trust's total operating revenue (see notes 4 and 5 to the accounts), before the allocation of STF, grew five per cent or £51 million against the previous year. This increase in income included a £24 million increase in the value of services commissioned locally for local patients, a £21 million increase in that commissioned nationally for specialised services offset by continued reductions in education and training income.

The total operating expenditure (see note 7 to the accounts) was £1,071 million including a gain on asset revaluation of £20.7 million. After adjusting for the revaluation, overall expenditure has increased by £38 million when compared to the previous year. This increase has been driven primarily by the cost of delivering additional activity, together with costs associated with inflation and other NHS policy driven cost pressures alongside high costs of maintaining a poor quality estate and some additional costs required to reduce patient waiting times.

In line with established accounting practice the Trust commissioned an independent professional firm to undertake a valuation of its estate. The accounts record an overall net increase of £21 million in the value of the Trust asset base. This revaluation is excluded from the Department of Health's assessment of the Trust's breakeven duty.

The Trust's efficiency programme was initially set at £53.8 million, increased to £57.8 million as part of the mid-year stretch. The final plan aimed to deliver efficiencies in excess of approximately 5.4 per cent of planned turnover, of which around 93 per cent (£53.8 million) was achieved. During the financial improvement programme the Trust revised its processes for the identification, assessment and assurance of efficiency plans.

All efficiency plans are risk assessed and reviewed by the medical and nursing directorates to assure that patient safety, quality and experience, which are rigorously monitored, are not detrimentally impacted. Separately, the programme support office maintains a framework to assure the effective delivery of these improvement programmes. The key themes included increases in income derived from NHS work including community and specialist services, as well as increases in private work. It also included reduced costs through reviewing key contracts, negotiating better prices with suppliers, and reducing overheads.

Capital expenditure

The Trust continues to invest in its capital infrastructure to help achieve its strategic service objectives. During 2016/17 the Trust invested a total of £39.1 million to modernise its estate, deal with the most critical backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2016/17 included:

- backlog maintenance £11.4 million
- medical equipment £6.1 million
- IT investment £5.8 million.

Liquidity, cash and working capital

The Trust focused successfully on improving its cash management throughout the year, remaining within its external financing limit (EFL), with a year-end cash position of £20.9 million. This is supported by £15.8 million of NHS Improvement's revolving working capital facility which is considerably less than the anticipated borrowings when the cash plan was developed at the start of the financial year, reflecting improved cash management practices.

Financial outlook

The Trust has entered 2017/18 with a significant underlying deficit, and has therefore set another challenging target for improving productivity and cost reduction with an efficiency programme totalling £54 million; around five per cent of turnover. These savings are consistent with those achieved in 2016/17, and are above the four per cent required by NHS Improvement. As explained above, these initiatives are assessed by the Trust's medical director and director of nursing to ensure there is no impact on the quality of care.

Taking into account the known pressures to the Trust from national and local decisions and the significant additional costs arising from our aged estate and treating highly complex patients combined with reduced research and development and education funding, a planned deficit of £41 million has been set by the Trust board. This plan is significantly short of the £17.6 million deficit required by NHS Improvement for the Trust to be eligible for STF funds in 2017/18.

The Trust will continue to need to invest a significant portion of its available capital to meet a very significant programme of backlog maintenance across its estate, and has submitted a request for additional support to achieve this without jeopardising essential investment in other areas of Trust activity. The capital programme has been set at £36 million excluding external donations and financing.

Under Shaping a Healthier Future, the Trust has continued to work with local commissioners and the sector provider trusts in developing business cases which will deliver the very best care for patients across north west London. The Trust continues to actively explore the extent to which funding, commercial and public, can be secured to provide new facilities for patients and would seek to make full use of the recommendations of the Naylor Report if it is fully adopted.

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

We have audited the financial statements of Imperial College Healthcare NHS Trust (the Trust) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 (the 2016-17 GAM) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

This report is made solely to the Board of Directors of the Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of 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 and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying

ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Emphasis of matter – Going concern

We have considered the adequacy of the disclosures made in Note 1.1 in respect of the Trust's ability to continue as a going concern.

The Trust reported a retained surplus of £12.5 million in 2016/17, which included £20.7 million of impairment reversals and £7.2 million net credits in respect of donations and government grants. The financial performance as determined by the Department of Health was a deficit of £15.3 million. Cash outflows before financing, including interest paid and PDC dividend, was £18.6 million and the Trust received net additional borrowing of £15.4 million from the Department of Health and other institutions.

The Trust is projecting a significant deficit for 2017/18 of £41 million, together with a cost improvement plan of £54 million. The Trust has identified that additional funding is likely to be required in the next two years to support the Trust, which is yet to be agreed.

The forecasted deficit and reliance on future funding yet to be agreed indicate the existence of a material uncertainty which may give rise to significant doubt over the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Our opinion is not modified in respect of this matter.

Opinion on other matters

In our opinion:

- the parts of the Remuneration Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception – Use of resources

Auditor's responsibilities

We report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The Trust's outturn position for 2016/17, as reported in the Statement of Comprehensive Income, was a £12.5 million surplus, adjusted to a £15.3 million deficit in respect of the financial performance for the year used by the Department of Health for financial monitoring. The Trust received £25.5 million Sustainability and Transformational funding from NHS Improvement in 2016/17 and had an underlying financial deficit of £41 million.

The Trust and NHS Improvement are currently unable to agree a control total budget position for 2017/18 and therefore no Sustainability and Transformational funding has been assumed. Largely as a consequence of this, the Trust's medium term financial plan shows a deterioration, with a forecast deficit of £41 million for 2017/18. Thus, these issues are evidence of weaknesses in proper arrangements for the financing of sustainable delivery of services.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Matters on which we are required to report by exception – Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 31 May 2017 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust setting a deficit budget for 2017/18 that will cause the Trust to be in cumulative deficit. This is a breach of the Trust's duty to breakeven, taking one year with another, and the medium term financial strategy does not suggest that the Trust will be able to recover this deficit and return to breakeven within a further three years.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's (NHS Improvement) guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of the Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

BDO LLP

Leigh Lloyd-Thomas

For and on behalf of BDO LLP, Appointed Auditor

London, UK

1 June 2017

Financial statements

Statements of accounts

Statement of comprehensive income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	9.1	**(599,980)**	(582,670)
Other operating costs	7	**(470,808)**	(455,378)
Revenue from patient care activities	4	**880,068**	832,193
Other operating revenue	5	**216,507**	187,712
Operating surplus/(deficit)		**25,787**	(18,143)
Investment revenue	11	**104**	200
Finance costs	12	**(1,190)**	(763)
Surplus/(deficit) for the financial year		**24,701**	(18,706)
Public dividend capital dividends payable		**(12,157)**	(11,482)
Retained surplus/(deficit) for the year		**12,544**	(30,188)
Net gain/(loss) on revaluation of property, plant & equipment		**379**	274
Total comprehensive income for the year		**12,923**	(29,914)

Financial performance for the year

Retained surplus/(deficit) for the year	**12,544**	(30,188)
Impairments (excluding IFRIC 12 impairments)	**(20,670)**	(15,533)
Adjustments in respect of donated gov't grant asset reserve elimination	**(7,204)**	(2,158)
Adjusted retained surplus/(deficit)	**(15,330)**	(47,879)

An NHS trust's financial performance is derived from its retained 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.

The notes on pages 95 to 115 form part of this account.

Statement of financial position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets			
Property, plant and equipment	14	**483,432**	447,887
Intangible assets	15	**3,393**	4,792
Total non-current assets		**486,825**	452,679
Current assets			
Inventories	19	**13,674**	14,874
Trade and other receivables	18.1	**97,619**	106,076
Cash and cash equivalents	20	**20,975**	24,204
Total current assets		**132,268**	145,154
Total assets		**619,093**	597,833
Current liabilities			
Trade and other payables	21	**(154,087)**	(157,708)
Provisions	24	**(33,811)**	(37,244)
Borrowings	22	**(126)**	(307)
DH capital loan	22	**(1,226)**	(1,226)
Total current liabilities		**(189,250)**	(196,485)
Net current assets/(liabilities)		**(56,982)**	(51,331)
Total assets ledd current liabilities		**429,843**	401,348
Non-current liabilities			
Provisions	24	**(7)**	0
Borrowings	22	**(886)**	0
DH revenue support loan	22	**(15,805)**	0
DH capital loan	22	**(15,918)**	(17,144)
Total non-current liabilities		**(32,616)**	(17,144)
Total assets employed		**397,227**	384,204
FINANCED BY:			
Public Dividend Capital		**694,844**	694,744
Retained earnings		**(300,373)**	(312,917)
Revaluation reserve		**2,756**	2,377
Total Taxpayers' Equity:		**397,227**	384,204

The notes on pages 95 to 115 form part of this account.

The financial statements on pages 90 to 115 were approved by the Board on 31st May 2017 and signed on its behalf by

Dr Tracey Batten,
Chief executive
Date: 31 May 2017

Statement of changes in taxpayers' equity for the year ending 31 March 2017

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2016	**694,744**	**(312,917)**	**2,377**	**384,204**
Changes in taxpayers' equity for 2016/17				
Retained surplus/deficit for the year		(12,544)		(12,544)
Net gain/(loss) on revaluation of property, plant, equipment			379	379
Temporary and permanent PDC received – cash	100			100
Net recognised revenue/(expense) for the year	**100**	**(12,544)**	**379**	**(13,023)**
Balance at 31 March 2017	**694,844**	**(300,373)**	**2,756**	**397,227**
Balance at 1 April 2015	**697,288**	**(282,729)**	**2,103**	**416,662**
Changes in taxpayers' equity for 2015-16				
Retained surplua/(deficit) for the year		(30,188)		(30,188)
Net gain/(loss) on revaluation of property, plant, equipment			274	274
New PDC received – cash	856			856
PDC repaid in year	(3,400)			(3,400)
Net recognised revenue/(expense) for the year	**(2,544)**	**(30,188)**	**274**	**(32,458)**
Balance at 31 March 2016	**694,744**	**(312,917)**	**2,377**	**384,204**

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. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS trust, is payable to the Department of Health as the public dividend capital dividend.

Retained earnings reserve

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

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.

Statement of cash flows for the year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash flows from operating activities			
Operating surplus/(deficit)		**25,787**	(18,143)
Depreciation and amortisation	7	**34,529**	34,536
Impairments and reversals	16	**(20,670)**	(15,533)
(Increase)/decrease in inventories		**1,200**	(1,416)
(Increase)/decrease in trade and other receivables		**8,413**	16,355
Increase/(decrease) in trade and other payables		**(6,636)**	27,588
Provisions utilised		**(9,981)**	(8,064)
Increase/(decrease) in movement in non cash provisions		**6,555**	4,504
Net cash inflow from operating activities		**39,197**	27,268
Cash flows from investing activities			
Interest received		**104**	200
(Payments) for property, plant and equipment		**(44,793)**	(40,703)
(Payments) for intangible assets		**(150)**	(1,318)
Net cash inflow / (outflow) from investing activities		**(44,793)**	(41,821)
Net cash inflow / (outflow) before financing		**(5,642)**	(1,994)
Cash flows from financing activities			
Gross temporary and permanent PDC received		**100**	856
Gross temporary and permanent PDC repaid		**0**	(3,400)
Loans received from DH – new revenue support loans		**15,805**	0
Other loans received		**1,012**	0
Loans repaid to DH – capital investment loans repayment of principal		**(1,226)**	(1,226)
Other loans repaid		**(307)**	(806)
Interest paid		**(1,190)**	(763)
PDC dividend (paid)/refunded		**(11,781)**	(11,796)
Net cash inflow/(outflow) from financing activities		**2,413**	(17,135)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(3,229)**	(19,129)
Cash and cash equivalents at beginning of the period		**24,204**	43,333
Cash and cash equivalents at year end	**20**	**20,975**	24,204

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounts Manual 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Group Accounting Manual permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going concern

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Financial statements should be prepared on a going concern basis unless there is an intention to cease the Trust's activities or there is no realistic alternative but to do so. The Trust Board has considered the advice in the Department of Health Group Accounting Manual that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. Department of Health bodies should therefore prepare their financial statements on a going concern basis unless informed by the Department of Health of the intention for dissolution without transfer or service or function to another entity.

Assuming there are no changes to the plan during course of 2017/18, at 31 March 2017 the Trust will incur a £41m deficit during the 2017/18 financial year. At the same stand point in time the outline plan for 2018/19 is for a further £32.7m deficit.

The Trust has neither been notified that it services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continued to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate for the foreseeable future. Additionally, Management has a reasonable expectation that the Trust will be provided with adequate resources to continue to service its deficit position and run operational activities in cash terms and it has commitment from NHS Improvement for the level of cash resources needed to deliver its financial and operational plans for the next 12 months despite currently planning on the basis of a deficit. For these reasons, management continue to adopt the going concern basis in preparing the accounts.

However, as the level of the Trust's deficit does not automatically entitle the Trust to Sustainability and Transformation Funding (STF) this level of sustained deficit gives rise to a material uncertainty about the financial viability of the Trust which may cast significant doubt on the Trust's ability to continue as a going concern.

In the context of the wider NHS there are issues for the Trust to address to ensure it's sustainability over a longer time period. However the Board is satisfied that the Trust is sufficiently sighted on these issues and is taking steps to remedy them in conjunction with NHS Improvement.

1.2 Critical accounting judgements and key sources of estimation uncertainty

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 and the estimates and underlying assumptions are continually reviewed. 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.

1.2.1 Critical judgements in applying accounting policies

The Trust has obtained an alternative site valuation report and used this information to account for transactions and balances, rather than estimating site values. The Trust's alternative site valuation is based on land values in the Acton/Hammersmith area of west London and assumes that the Trust has

freehold interests with no encumbrances. The valuation of the properties for alternative use are likely to be materially lower than the fair value, market value with continued use and depreciated replacement cost figures. Reflecting the overall size of the Trust's landholdings, the Trust has applied a 20 per cent reduction to the prevailing land values as a quantum allowance.

1.2.2 Key sources of estimation uncertainty

Road Traffic Accident - The Trust receives income under the NHS Injury Cost Recovery Scheme. During 2016/17 the Trust brought its accounting treatment onto an accruals basis rather than the previous defrayals basis.

Provisions - where the Trust is subject to challenge or outcome on as yet undetermined matter e.g. employment tribunal, redundancy claim, pay claims, etc. the Trust takes a prudent view and provides for such claims within the accounting period in which they arose.

Annual leave accrual - The Trust is required to take account of any annual leave carried into the new financial year by staff as this is an obligation that relates to the previous financial year.

Note 18.1 shows the Trust's trade and other receivables. 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.

Note 24 shows the Trust's provisions. Management undertook a thorough review of provisions based on assumptions concerning the future and other sources of information.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services, private patients, education and research grants. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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 e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme has yearly actuarial valuations.

1.5 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous 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, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

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

- land and non-specialised buildings – market value for existing use basis
- specialised buildings – depreciated replacement cost basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example 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
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

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.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.10 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 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 does not have any finance leases as defined by current accounting standards.

The Trust as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

The Trust as lessor

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 on a straight-line basis over the lease term.

1.12 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.

1.13 Cash and cash equivalents

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

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

1.14 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years.
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.15 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 24.

1.16 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 the NHS Litigation Authority 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 as and when they become due.

1.17 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.18 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

They only type of financial asset owned by the Trust are loans and receivables. Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. Loans and receivables are initially measured at fair value and subsequent measurement is at amortised cost using the effective interest rate method, less any impairment.

At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.19 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

The only type of financial liability owned by the Trust are loans from the Department of Health and trade payables owed to third parties. Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

After initial recognition, all financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 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.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are accounted for as required by the substance of the transaction.

1.22 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Research and development

Research and development expenditure is charged against income in the year in which it is incurred.

1.25 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.26 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.

2. Operating segments

IFRS 8 requires the Chief Operating Decision Maker to consider classes of activities, services or locations that constitute discrete operating segments meriting separate disclosure within the accounts.

As disclosed in notes 3, 4 and 5 the Trust provides services to a range of parties which are reported internally in four divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and children's, and clinical support services; corporate services.

Having considered IFRS 8 requirements, the Board, as the Trust's Chief Operating Decision Maker (defined by the scheme of delegation with regard to budget approval and all major operational decisions), 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 made as regards the statutory accounts with regard to operating segments.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

This included services for private patients to the value of £46m.

The Trust has no other income generation activities whose full cost exceeded £1m or was otherwise material.

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS England	**326,271**	305,281
Clinical Commissioning Groups	**480,278**	456,445
Foundation Trusts	**3,638**	3,748
NHS Trusts	**1,009**	762
Department of Health	**117**	156
NHS Other (including Public Health England and Prop Co)	**540**	0
Additional income for delivery of healthcare services	**0**	3,400
Non-NHS:		
Local Authorities	**7,228**	8,589
Private patients	**46,014**	44,444
Overseas patients (non-reciprocal)	**3,844**	4,095
Injury costs recovery	**7,026**	1,934
Other non-NHS patient care income	**4,103**	3,339
Total Revenue from patient care activities	**880,068**	832,193

5. Other operating revenue

	2016-17 £000s	2015-16 £000s (Restated)
Recoveries in respect of employee benefits	**9,720**	7,384
Education, training and research	**110,393**	113,983
Charitable and other contributions to revenue expenditure – non-NHS	**1,650**	1,808
Receipt of charitable donations for capital acquisitions	**8,318**	3,129
Receipt of Government grants for capital acquisitions	**185**	119
Non-patient care services to other bodies	**32,959**	31,149
Sustainability & Transformation Fund Income*	**25,450**	0
Income generation (other fees and charges)	**3,808**	3,443
Rental revenue from operating leases	**5,102**	7,854
Other revenue	**18,922**	18,843
Total other operating revenue	**216,507**	187,712
Total operating revenue	**1,096,575**	1,019,905

6. Overseas visitors disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**3,844**	4,095
Cash payments received in-year (re receivables at 31 March 2016)	**554**	384
Cash payments received in-year (iro invoices issued 2016-17)	**1,534**	1,239
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**1,081**	1,743
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**1,688**	167
Amounts written off in-year (irrespective of year of recognition)	**1,190**	903

7. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**8,086**	9,708
Services from CCGs/NHS England	**832**	651
Services from other NHS bodies	**10,005**	1,994
Services from NHS Foundation Trusts	**11,516**	9,856
Total services from NHS bodies	**30,439**	22,209
Purchase of healthcare from non-NHS bodies	**12,654**	7,609
Trust chair and non-executive directors	**69**	61
Supplies and services – clinical	**226,074**	224,125
Supplies and services – general	**34,857**	35,325
Consultancy services	**5,541**	3,283
Establishment	**7,297**	8,071
Transport	**13,303**	13,564
Business rates paid to local authorities	**4,099**	4,743
Premises	**43,567**	42,648
Hospitality	**135**	169
Insurance	**440**	528
Legal fees	**546**	879
Impairments and reversals of receivables	**11,616**	11,879
Inventories write down	**959**	495
Depreciation	**33,130**	33,387
Amortisation	**1,399**	1,149
Impairments and reversals of property, plant and equipment	**(20,670)**	(15,533)
Internal Audit Fee	**369**	211
External Audit fee	**164**	164
Other auditor's remuneration	**21**	18
Clinical negligence	**27,575**	25,068
Research and development (excluding staff costs)	**25,146**	23,797
Education and Training	**2,155**	2,475
Other	**9,923**	9,054
Total operating expenses (excluding employee benefits)	**470,808**	455,378
Employee benefits		
Employee benefits excluding Board members	**598,915**	581,286
Board members	**1,065**	1,384
Total employee benefits	**599,980**	582,670
Total operating expenses	**1,070,788**	1,038,048

8. Operating leases

8.1. Trust as lessee

	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense				
Minimum lease payments			**7,234**	8,583
Total			**7,234**	8,583
Payable:				
No later than one year	934	775	**1,709**	8,260
Between one and five years	3,575	580	**4,155**	4,254
After five years	1,914	0	**1,914**	3,067
Total	**6,423**	**1,355**	**7,778**	15,581

8.2. Imperial College Healthcare NHS Trust as lessor

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	5,102	7,854
Total	**5,102**	7,854
Receivable:		
No later than one year	1,056	7,654
Between one and five years	2,164	2,164
After five years	1,655	1,655
Total	**4,875**	11,473

9. Employee benefits

9.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**502,005**	497,605
Social security costs	**47,351**	37,366
Employer contributions to NHS BSA – pensions division	**51,363**	49,288
Other pension costs	**19**	14
Termination benefits	**243**	234
Total employee benefits	**600,981**	584,507
Employee costs capitalised	**1,001**	1,837
Gross employee benefits excluding capitalised costs	**599,980**	582,670

9.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**5**	6
	£000s	£000s
Total additional pensions liabilities accrued in the year	**343**	266

9.3 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

10. Better Payment Practice Code

	2016-17 Number	**2016-17 £000s**	2015-16 Number (Restated)	2015-16 £000s (Restated)
Non-NHS payables				
Total Non-NHS trade invoices paid in the year	**164,400**	**518,951**	173,897	480,878
Total Non-NHS trade invoices paid within target	**128,391**	**398,730**	128,519	353,372
Percentage of NHS trade invoices paid within target	**78.10%**	**76.83%**	73.91%	73.48%
NHS Payables				
Total NHS trade invoices paid in the year	**5,967**	**61,199**	5,901	55,597
Total NHS Trade invoices paid within target	**3,205**	**40,271**	2,741	39,076
Percentage of NHS trade invoices paid within target	**53.71%**	**65.80%**	46.45%	70.29%

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 a valid invoice, whichever is later. Prior year figures have been restated to reflect a refined methodology adopted in-year.

11. Investment revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**104**	200
Total investment revenue	**104**	200

12. Finance costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,190**	**763**
Total	**1,190**	**763**

13. External auditors fees

13.1. Auditor remuneration

	2016-17 £000s	2015-16 £000s
Details of fees and remuneration paid to auditors:		
1. Audit of the Trust's accounts	**164**	164
2. Audit-related assurance services	**21**	18
Total	**185**	**182**

13.2. Limitation on external auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

14 Property, plant and equipment

14.1 Property, plant and equipment – current year

2016-17	**Land £000's**	**Buildings excluding dwellings £000's**	**Assets under construction & payments on account £000's**	**Plant & machinery £000's**	**Information technology £000's**	**Furniture & fittings £000's**	**Total £000's**
Cost or valuation:							
At 1 April 2016	59,021	308,495	21,867	147,064	44,148	936	**581,531**
Additions of assets under construction	0	0	32,279	0	0	0	**32,279**
Additions purchased	0	0	0	6,670	174	0	**6,844**
Additions – purchases from cash donations & Government grants	0	0	0	371	0	0	**8,503**
Revaluation	0	379	8,132	0	0	0	**379**
Impairments/reversals charged to operating expenses	4,265	(4,683)	0	0	0	0	**(418)**
At 31 March 2017	**63,286**	**304,191**	**62,278**	**154,105**	**44,322**	**936**	**629,118**
Depreciation							
At 1 April 2016	0	4,476	0	101,261	27,453	454	**133,644**
Impairments/reversals charged to operating expenses	0	(21,088)	0	0	0	0	**(21,088)**
Charged during the year	0	18,048	0	10,472	4,511	99	**33,130**
At 31 March 2017	**0**	**1,436**	**0**	**111,733**	**31,964**	**553**	**145,686**
Net book value at 31 March 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**
Asset financing:							
Owned – purchased	63,286	285,429	54,664	38,597	12,358	383	**454,717**
Owned – donated	0	16,021	7,429	3,303	0	0	**26,753**
Owned – Government granted	0	1,305	185	472	0	0	**1,962**
Total at 31 March 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**

Revaluation reserve balance for property, plant & equipment	**Land £000's**	**Buildings £000's**	
At 1 April 2016	10	1,562	26,466
Revaluation gains	0	379	5,813
At 31 March 2017	**10**	**1,941**	**32,279**

Additions to assets under construction in 2016-17	**Total £000's**
Buildings excl dwellings	**2,377**
Plant & machinery	**379**
Balance as at YTD	**2,756**

14.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	53,637	308,146	10,193	135,707	38,454	899	**547,036**
Additions of assets under construction	0	0	14,472	0	0	0	**14,472**
Additions purchased	0	5,405	0	8,548	5,095	37	**19,085**
Additions – purchases from cash donations & Government grants	0	352	1,353	1,543	0	0	**3,248**
Reclassifications	0	1,309	(3,770)	1,325	599	0	**(537)**
Disposals other than for sale	0	0	(381)	(59)	0	0	**(440)**
Revaluation	2	272	0	0	0	0	**274**
Impairment/reversals charged to reserves	5,382	(6,989)	0	0	0	0	**(1,607)**
At 31 March 2016	**59,021**	**308,495**	**21,867**	**147,064**	**44,148**	**936**	**581,531**
Depreciation							
At 1 April 2015	0	4,237	0	89,508	23,292	360	**117,397**
Impairments/reversals charged to operating expenses	0	(17,140)	0	0	0	0	**(17,140)**
Charged during the year	0	17,379	0	11,753	4,161	94	**33,387**
At 31 March 2016	**0**	**4,476**	**0**	**101,261**	**27,453**	**454**	**133,644**
Net book value at 31 March 2016	**59,021**	**304,019**	**21,867**	**45,803**	**16,695**	**482**	**447,887**
Asset financing:							
Owned – purchased	59,021	286,851	21,867	42,243	16,695	482	**427,159**
Owned – donated	0	15,883	0	3,246	0	0	**19,129**
Owned – Government granted	0	1,285	0	314	0	0	**1,599**
Total at 31 March 2016	**59,021**	**304,019**	**21,867**	**45,803**	**16,695**	**482**	**447,887**

14.3 Property, plant and equipment asset lives

The Trust uses the following lives for each class of asset

Property, plant and equipment	Minimum life	Maximum life
Building excl dwellings	25	60
Plant & machinery	5	15
Information technology	5	8
Furniture and fittings	10	10

Freehold land, properties under construction, and assets held for sale are not depreciated.

The Trust had its estate valued by an independent RICS Chartered Surveyor, GVA Grimley Ltd, on a modern equivalent asset basis as at 31 December 2016.

The Trust has discussed movements in relevant indices to 31 March 2017 with GVA Grimley Ltd and does not consider a further update is required at year end.

15. Intangible non-current assets

15.1. Intangible non-current assets

2016-17	Total £000's
At 1 April 2016	**8,775**
Additions purchased	**0**
At 31 March 2017	**8,775**
Amortisation	
At 1 April 2016	**3,983**
Charged during the year	**1,399**
At 31 March 2017	**5,382**
Net book value at 31 March 2017	**3,393**
Asset financing: Net book value at 31 March 2017 comprises:	
Purchased	**3,393**
Total at 31 March 2017	**3,393**

15.2. Intangible non-current assets prior year

2015-16	Total £000's
Cost or valuation:	
At 1 April 2015	**6,920**
Additions – purchased	**1,318**
Reclassifications	**537**
At 31 March 2016	8,775
Amortisation	
At 1 April 2015	**2,834**
Charged during the year	**1,149**
At 31 March 2016	3,983
Net book value at 31 March 2016	**4,792**

15.3. Intangible non-current assets lives

The Trust amortises intangible assets over a period of five years.

16. Analysis of impairments and reversals recognised in 2016-17

	Total
Impairments and reversals taken to SoCI	**£000s**
Total impairments of property, plant and equipment changed to SoCI	**(20,670)**
Donated and Gov granted assets, included above	**£000s**
PPE – donated and Government granted asset impairments: amount charged to SOCI – DEL	**(928)**

The reversal of impairment this year (above) is as a result of the valuation of the Trust's property portfolio as at 31 December 2016 by an independent IRCS chartered surveyor, GBA Grimley Ltd, on a modern equivalent asset value basis.

17. Commitments

Contracted capital commitments at 31 March 2017 not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**8,673**	5,679

18 Trade and other receivables

18.1. Trade and other receivables

	31 March 2017	31 March 2016
	£000s	£000s
NHS receivables - revenue	**25,973**	43,555
NHS prepayments and accrued income	**39,814**	25,916
Non-NHS receivables - revenue	**33,496**	37,701
Non-NHS receivables - capital	**332**	0
Non-NHS prepayments and accrued income	**25,212**	19,415
PDC Dividend prepaid to DH	**77**	453
Provision for the impairment of receivables	**(33,886)**	(25,820)
VAT	**4,711**	3,230
Interest receivables	**6**	4
Other receivables	**1,884**	1,622
Total	**97,619**	106,076

The great majority of trade is with CCGs and NHS England, as commissioners for NHS patient care services. As CCGs and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**15,993**	20,312
By three to six months	**8,589**	18,694
By more than six months	**25,609**	11,313
Total	**50,191**	50,319

18.3. Provision for impairment of receivables

	2016-2017	2015-2016
	£000s	£000s
Balance at 1 April 2016	**(25,820)**	(19,024)
Amount written off during the year	**3,550**	5,083
(Increase)/decrease in receivables impaired	**(11,616)**	(11,879)
Balance at 31 March 2017	**(33,886)**	(25,820)

The impairment of receivables provision is based on assumptions concerning the future and other sources of information about the age and recoverability of the debt. Categories include non-NHS receivables, overseas visitors and private patients. For each category, the Trust provides against receivables on a percentage basis, depending on the assessed risk profile based on type, age and status.

19. Inventories

	Drugs	Consumables	Energy	**Total**
	£000s	£000s	£000s	**£000s**
Balance at 1 April 2016	4,219	10,422	233	**14,874**
Additions	126,210	39,681	208	**166,099**
Inventories recognised as an expense in the year	(124,528)	(41,630)	(182)	**(166,340)**
Write-down of inventories (including losses)	(246)	(713)	0	**(959)**
Balance at 31 March 2017	5,655	7,760	259	**13,674**

20. Cash and cash equivalents

	31 March 2017	31 March 2016
	£000s	£000s
Opening balance	**24,204**	43,333
Net change in year	**(3,229)**	(19,129)
Closing balance	**20,975**	24,204
Made up of		
Cash with Government banking service	**20,864**	24,111
Commercial banks	**82**	62
Cash in hand	**29**	31
Cash and cash equivalents as in statement of financial position and statement of cash flows	**20,975**	24,204
Third party assets – bank balance	**0**	0
Third party assets – monies on deposit	**59**	60

21. Trade and other payables

	31 March 2017	31 March 2016
	£000s	£000s
NHS payables – revenue	**10,234**	9,030
NHS payables – capital	**0**	177
NHS accruals and deferred income	**8,629**	10,396
Non-NHS payables – revenue	**13,840**	30,045
Non-NHS payables – capital	**11,257**	8,065
Non-NHS accruals and deferred income	**91,283**	79,156
Social security costs	**6,922**	5,643
Accrued Interest on DH loans	**30**	32
Tax	**2,298**	6,013
Other	**9,594**	9,151
Total	**154,087**	157,708
Included above:		
to buy out the liability for early retirements over 5 years	**0**	0
number of cases involved (number)	**0**	0
outstanding pension contributions at the year end	**7,518**	6,961

22. Borrowings

	Current		Non-current	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**1,226**	1,226	**31,723**	17,144
Loans from other entities	**126**	307	**886**	0
Total	**1,352**	**1,533**	**32,609**	**17,144**
Total other liabilities (current and non-current)	**33,961**	**18,677**		

Borrowings / loans – repayment of principal falling due in:

	31 March 2017		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0 - 1 years	1,226	126	**1,352**
1 - 2 years	1,226	126	**1,352**
2 - 5 years	19,483	760	**20,243**
Over 5 years	11,014	0	**11,014**
Total	**32,949**	**1,012**	**33,961**

23. Deferred income

	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April	**26,793**	22,095
Deferred revenue addition	**8,344**	7,673
Transfer of deferred revenue	**(10,807)**	(2,975)
Current deferred income at 31 March 2017	**24,330**	26,793

Deferred income is reported within trade and other payables in note 21.

24. Provisions

	Total £000s	Comprising: Legal claims £000s	Other £000s
Balance at 1 April 2016	**37,244**	120	37,124
Arising during the year	**7,040**	1	7,039
Utilised during the year	**(9,981)**	0	(9,981)
Reversed unused	**(485)**	(12)	(473)
Balance at 31 March 2017	**33,818**	**109**	**33,709**
Expected timing of cash flows:			
No later than one year	**33,811**	109	33,702
Later than one year and not later than five years	**0**	0	0
Later than five years	**7**	0	7

Amount included in the provisions of the NHS Litigation Authority in respect of Clinical Negligence Liabilities (£000s):	
As at 31 March 2017	305,678
As at 31 March 2016	258,979

25. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
NHS Litigation Authority legal claims	(71)	(56)

26. Financial instruments

26.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, 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. Trust treasury activity is subject to review by the Trust's internal auditors.

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 exposures as at 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note. At the 31st March 2017 the main customer debts totaled £27.7m for which the Trust feels it has made adequate provision.

Liquidity risk
The Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources The Trust is not, therefore, exposed to significant liquidity risks.

26.2. Financial assets

	Total £000s
Receivables - NHS	**55,700**
Receivables - non-NHS	**26,547**
Cash at bank and in hand	**20,975**
Total at 31 March 2017	**103,222**
	(restated)
Receivables – NHS	63,411
Receivables – non-NHS	27,184
Cash at bank and in hand	24,204
Total at 31 March 2016	114,799

26.3. Financial liabilities

	Total £000s
NHS payables	**21,681**
Non-NHS payables	**93,485**
Other borrowings	**33,961**
Total at 31 March 2017	**149,127**
NHS payables	11,696
Non-NHS payables	98,656
Other borrowings	18,677
Total at 31 March 2016	129,029

27. Related party transactions

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.

The Department of Health is regarded as a related party. During the year 2016/17 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 detailing income and expenditure for the year along with the debtor and creditor as at 31 March 2017.

2016/17	Creditor £000s	Debtor £000s	Income £000s	Expenditure £000s
Department of Health	23	211	47,172	0
NHS England	408	31,149	360,540	48
NHS Foundation Trusts including:				
Chelsea and Westminster	1,864	2,628	20,065	3,182
CCGs including:				
Brent	938	1,611	61,113	0
Camden	88	669	8,060	0
Central London (Westminster)	640	3,973	56,615	375
Ealing	1,181	2,963	76,522	0
Hammersmith and Fulham	733	5,449	86,183	400
Harrow	124	670	12,568	0
Hillingdon	139	600	12,890	0
Hounslow	171	1,430	33,753	0
Richmond	157	93	9,947	0
West London (Kensington & Chelsea & Qpp)	493	3,173	72,507	9
NHS Trusts	4,329	4,319	4,950	8,437
Other NHS Bodies including:				
Health Education England	95	1,166	60,208	9
NHS Litigation Authority	10	0	54	28,098
HM Revenue and Customs	9,220	4,711	0	47,351
NHS Pension Scheme	7,517	0	0	51,363
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	106	15	405	7,326

The Trust has also received revenue and capital payments from a number of charitable funds.

During the course of the year Dr Julian Redhead became a voting Board member of the Trust, and a Trustee of the Imperial College Healthcare Charity. Trust balances with Imperial College Healthcare Charity for the period were as follows:
Debtors at 31 March 2017 were £496k
Creditors at 31 March 2017 were £0k
Income for the 12 months to 31 March 2017 was £7,757k
Expenditure for the 12 months to 31 March 2017 was £627k

The Trust works in partnership with Imperial College London as an Academic Health Science Centre.
Trust balances with Imperial College London for the period were as follows:
Debtors at 31 March 2017 were £916k
Creditors at 31 March 2017 were £2,537k
Income for the 12 months to 31 March 2017 was £7,677k
Expenditure for the 12 months to 31 March 2017 was £1,975k

27. Related party transactions (cont)

2015/16	Creditor £000	Debtor £000	Income £000	Expenditure £000
Department of Health	0	407	50,054	0
NHS England	1,936	21,299	315,797	232
NHS Foundation Trusts including:				
Chelsea and Westminster	1,736	3,864	17,681	3,710
CCGs including:				
Brent	855	4,447	57,114	0
Camden	107	52	7,432	0
Central London (Westminster)	416	6,322	55,468	0
Ealing	1,065	4,267	71,724	0
Hammersmith and Fulham	941	8,727	85,379	400
Harrow	120	930	10,940	0
Hillingdon	116	833	11,623	0
Hounslow	169	571	30,962	0
Richmond	42	941	10,314	0
West London (Kensington & Chelsea & Qpp)	551	6,181	69,862	0
Other NHS Bodies including:				
Health Education England	0	1,248	64,594	3
NHS Litigation Authority	0	0	82	25,582
HM Revenue and Customs	11,656	3,230	0	37,366
NHS Pension Scheme	7,106	0	0	49,288
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	0	5	429	6,815

28. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	2,217,129	395
Special payments	54,066	104
Total losses and special payments and gifts	2,271,195	499

The total number of losses cases in 2015-16 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	1,900,055	421
Special payments	133,517	104
Total losses and special payments	2,033,572	525

29. Events after the end of the reporting period

There are no events after the end of the reporting period that warrant disclosure in these accounts.

30. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

30.1. Breakeven performance

	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s
Turnover	838,148	839,328	900,234	920,256
Retained surplus/(deficit) for the year	12,750	12,025	9,102	(1,909)
Adjustment for:				
Adjustments for impairments	0	0	0	7,055
Adjustments for impact of policy change re donated/government grants assets				
Break-even in-year position	**12,750**	**12,025**	**9,102**	**5,146**
Break-even cumulative position	**12,750**	**24,775**	**33,877**	**39,023**

	2007-08 %	2008-09 %	2009-10 %	2010-11 %
Materiality test (I.e. is it equal to or less than 0.5%):				
Break-even in-year position as a percentage of turnover	1.52	1.43	1.01	0.56
Break-even cumulative position as a percentage of turnover	1.52	2.95	3.76	4.24

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	941,690	971,274	979,312	1,000,614	1,019,905	1,096,575
Retained surplus/(deficit) for the year	(20,479)	(39,955)	(102,576)	(109,269)	(30,188)	12,544
Adjustment for:						
Adjustments for impairments	12,060	48,379	117,142	123,818	(15,533)	(20,670)
Adjustments for impact of policy change re donated/government grants assets	0	601	562	856	(2,158)	(7,204)
Break-even in-year position	**(8,419)**	**9,025**	**15,128**	**15,405**	**(47,879)**	**(15,330)**
Break-even cumulative position	**30,604**	**39,629**	**54,757**	**70,162**	**22,283**	**6,953**

	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):						
Break-even in-year position as a percentage of turnover	-0.89	0.93	1.54	1.54	-4.69	-1.40
Break-even cumulative position as a percentage of turnover	3.25	4.08	5.59	7.01	2.18	0.63

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

30.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	18,653	14,644
Cash flow financing	18,613	14,553
Under/(over) spend against EFL	**40**	91

30.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	47,626	38,123
Less: book value of assets disposed of	0	(440)
Less: capital grants	(185)	(119)
Less: donations towards the acquisition of non-current assets	(8,318)	(3,129)
Charge against the capital resource limit	**39,123**	34,435
Capital resource limit	39,123	35,480
(Over)/underspend against the capital resource limit	**0**	1,045

Appendix 1: List of internal audits completed in 2016/17, and relevant assurance level

Title	Assurance Level
Complaints management	Substantial
Sodexo contract	Substantial
Professional registration for nurses and midwives	Substantial
Income, commissioning and service level agreements	Substantial
Infection control	Substantial
Imaging – escalation protocol	Substantial
Financial ledger	Substantial
Treasury management	Substantial
Water management	Substantial
Linen and laundry	Reasonable
DHL contract – patient transport	Reasonable
Compliance against WHO checklist	Reasonable
Deprivation of liberty (DoLs)	Reasonable
Outpatients score card	Reasonable
Safe nurse staffing	Reasonable
Risk management	Reasonable
Fire safety	Reasonable
ICT – project review: Xerox	Reasonable
Safeguarding children	Reasonable
Budgetary monitoring	Reasonable
ICT – information governance toolkit part 2	Reasonable
Subject access requests	Limited
MSSE – business planning	Limited
Discharge management	Limited
CBRE hard FM contract review	Limited
Serious incidents – action plans	Limited

A number of further reviews were undertaken where it an assurance level was not appropriate /required:

- ICT – application review: System One
- ICT – information governance toolkit return
- Corporate records
- Clinical audit
- Cancer
- Quality of nursing documentation within both sample of acute wards and maternity unit
- Quality accounts.

The following audit reports remained in draft at time of publication:

- Imaging
- Maternity activity data review
- Procurement to payments
- Registration authority.

Appendix 2: Trust board declarations of interest

Sir Richard Sykes – chairman

- Director, EDBI Pte Ltd
- Chairman, Singapore Biomedical Sciences International Advisory Council
- Chairman, UK Stem Cell Foundation
- Non-Executive Chairman of NetScientific plc
- Chairman of Royal Institution of Great Britain
- Chancellor Brunel University
- Chairman PDS Biotechnology Corporation.

Sir Gerald Acher – non-executive director

- Vice Chairman of Motability
- President of Young Epilepsy
- Chairman Brooklands Museum Trus;
- Chairman Cobham Community Bus CIC
- Chairman Cobham Conservation and Heritage Trust
- Trustee of Motability 10 Anniversary Trust
- Trustee of KPMG Foundation.

Professor Andy Bush – non-executive director

- Chair of the Publications Committee of the European Respiratory Society, so will sit on the Executive and Steering Committees
- Senior Investigator – NIHR
- Research Grants: (For a full list please see the Trust website)
  - NIHR Career Development Fellowship, “Use of molecular profiling to determine optimal management for moderate to severe preschool wheeze”, ref: CDF-2014-07-019 £770,661awarded to Dr Sejal Saglani, Research Support Professors Deborah Ashby, Andy Bush, Clare Lloyd.
  - COST Action BM1407: “Translational research in primary ciliary dyskinesia: bench, bedside and population perspectives”, €550,000 over 4 years, PIs AB and Dr Jane Lucas.
  - Wellcome Strategic Award, November 2015, “Pulmonary epithelial barrier and immunological functions at birth and in early life – key determinants of the development of asthma?”, £4.64 million (Institutional support and BLF >£0.5 million), AB Principal Applicant; additional funding £210,000 for two PhD studentships from British Lung Foundation, £200,510 from Northern Ireland HSC R&D Division and five other PhD studentships.
  - MRC-Asthma UK Centre for Mechanisms in Allergic Asthma third renewal, 2015 for 5 years, £2.6 million, AB Co-applicant.
  - Action for A-T Clinical Fellowship, Jan 2016, “The natural history of ataxia telangiectasia”, £210,725, AB Collaborator.
  - From Asthma UK, AUK-PHD-2016-372 Gene-environment interactions mediating preschool wheeze: the role of 17q21, farmyard microbes and innate cytokines £100,000 AB co-investigator.

Dr Rodney Eastwood – non-executive director

- Member of the Board of Trustees of the RAF Museum
- Chairman, Audit Committee, Royal Society of Biology
- Visiting Fellow in the Faculty of Medicine of Imperial College
- Trustee of the London School of ESCP Europe (a pan-European Business School).

Peter Goldsbrough – non-executive director

- Non-executive director of R J Young (Properties) Ltd
- Non-executive director Jenkinsons Holding Ltd
- Senior Advisor, The Boston Consulting Group
- Visiting Professor, Institute of Global Health Innovation, Imperial College London
- Spouse is non-executive director of NHS England.

Sarika Patel – non-executive director

- Board – Royal Institution of Great Britain
- Partner – Zeus Capital
- Board – London General Surgery
- Commissioner – Board of the Gambling Commission.

Dr Andreas Raffel – non-executive director

- Senior Adviser at Rothschild
- Deputy Chair of Council of Cranfield University (to end 30 May 2017)
- Member of the International Advisory Board of Cranfield School of Management
- Trustee, Bristol University (Awaiting Approval December 2017)
- Trustee and board member Change Grow Live (CGL).

Nick Ross – non-executive director

- Member: RCP Committee on Ethical Issues in Medicine
- Trustee: UK Stem Cell Foundation
- Chairman: Wales Cancer Bank Advisory Board
- Affiliate: James Lind Alliance
- President: HealthWatch
- Trustee: Sense About Science
- Trustee: Crimestoppers
- Vice President: Institute of Advanced Motorists
- President: The Kensington Society
- Trustee: Imperial College Hospital Charity Board
- Director: ICH Charity Ltd
- Chairman: UCL Jill Dando Institute of Crime Science.

Victoria Russell – non-executive director

- Partner: Fenwick Elliott LLP
- Deputy Chairman; Livery Committee
- Trustee and Committee Member: Sulgrave Club for Young People.

Dr Tracey Batten – chief executive

- Trustee of The Point of Care Foundation
- Spouse appointment Non-Executive Director of BUPA Board (12th January 2016).

Richard Alexander – chief financial officer

- Non-Executive Director of HDI – Health Data Insights
- Ex Oracle employee and current shareholder.

Dr Julian Redhead – medical director

- Trustee – Royal Society for the Prevention of Accidents
- Director – Stadium Doctors Ltd
- Shareholder – Fortius Clinic
- Medical Director – Fortius Clinic
- Inspector – Care Quality Commission
- Major Incident Doctor – London Ambulance Service
- Doctor – Chelsea Football Club.

Professor Janice Sigsworth – director of nursing

- Honorary professional appointments at King's College London, Bucks New University and Middlesex University
- Trustee of the General Nursing Council Trust
- Clinical adviser to the NMC review of pre-registration nursing standards
- Chair of the Shelford Chief Nurses Group.

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Full accounts

If you require a set of our full accounts, please contact the Trust company secretary, imperial.corporate.governance@nhs.net

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