Imperial College Healthcare NHS
NHS Trust

Annual report
2013/14

Contents

Chairman and chief executive welcome

As one of the biggest NHS trusts in England, we always have much to report in terms of annual developments, challenges and achievements. The past year is no exception, as the report that follows makes clear. In addition to this, 2013/14 has also been an extremely important year in terms of preparation for the future.

Imperial College Healthcare NHS Trust plays a vital role in the lives of the two million people who live in north west London and the many across the UK and overseas who use our specialist services. We're proud to have achieved some of the very best clinical outcomes for them in 2013/14, for example we have one of the lowest mortality rates of all NHS trusts. Our position as one of six academic health science centres in the UK enables us to deliver real innovation through research and education. For example, during the year we were the first globally to use robotic technology to treat fibroids and enable safer and better care for the women this affects.

Through good advanced planning and a massive effort from staff, we also maintained performance throughout the difficult winter period. We consistently met our target to ensure that at least 95 per cent of patients were treated in accident and emergency within four hours, and we did this while delivering £45.8m of savings and achieving a surplus of £15.1m.

To continue to build on our achievements for patients and our wider communities, we have to focus more on raising all of our patient experience measures to match our excellent clinical outcomes. And, with a growing number of people with multiple and long-term health conditions, we have to do more to help people stay as healthy as possible and to increase access to the most effective specialist care, whether that's through outreach into local community clinics or in centralised centres of excellence.

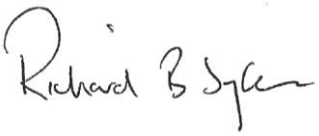
Our transformation programme, just getting underway, is a roadmap for our emerging organisational vision to be a world leader in transforming health through innovation in research, teaching and patient care. It pulls together service improvements with plans for major investment in our facilities and IT, and our preparation in 2013/14 has put us in the best possible position to make that journey.

In October 2013, *Shaping a healthier future*, the long-term strategy for healthcare across north west London led by our eight local NHS clinical commissioning groups, got the go ahead from the Secretary of State for Health. Our vision for our services is very much in keeping with this approach, and effective partnerships and collaboration with our commissioners and other local providers will continue to be vital.

We moved forward with our plans to become a foundation trust – and the local governance this will allow – by completing an important public consultation. We began the first stage of a major IT implementation, to move us to a single electronic patient record system. We strengthened our clinical leadership by organising all of our services into four clinical divisions, each led by senior doctors, and also made some important changes in our leadership team.

We look forward to continuing to work with all of our staff, partners and stakeholders to make sure we achieve our ambition for health and care.

Sir Richard Sykes
Chairman



Dr Tracey Batten
Chief executive

Strategic report

About the Trust

Imperial College Healthcare NHS Trust comprises Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye hospitals, and was formed in 2007. It is one of the largest acute trusts in the country and, in partnership with Imperial College London, the UK's first academic health science centre (AHSC).

The Trust delivers world-leading acute and integrated care services, treating patients at every stage of their lives – with over 55 specialist services for both children and adults.

In 2013/14, there were:

- 1,223,380 patient contacts
- 192,168 inpatient cases
- 1,031,212 outpatient contacts
- 281,990 accident and emergency (A&E) attendances.

The Trust is commissioned to provide a broad range of services by the eight clinical commissioning groups (CCGs) serving a population of nearly two million people in north west London. Very specialist services are commissioned by NHS England and a further 80-plus commissioners from across London and around the country.

Academic health science centre

Together with Imperial College London, the Trust formed the UK's first AHSC in 2009. Imperial College London has a campus on each main Trust site and is closely integrated with all clinical specialties.

Imperial College Healthcare is one of 11 National Institute for Health Research (NIHR) Biomedical Research Centres. 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 Clinical Sciences Centre of the Medical Research Council (MRC) is based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

Our hospitals

There are five hospitals in the Trust. These are:

- **Charing Cross Hospital, Hammersmith**
  Charing Cross is a general hospital providing a range of adult clinical services. It hosts one of eight hyper acute stroke units in London and is a key site for teaching medical students from Imperial College London.
- **Hammersmith Hospital, Acton**
  Hammersmith is a general hospital and home to the heart attack centre for north west London. It is well known for its research achievements; hosting a large community of Imperial College London postgraduate medical students and researchers.

- **Queen Charlotte's & Chelsea Hospital, Acton**
  Queen Charlotte's & Chelsea Hospital provides maternity and women's and children's services. The hospital has extensive high-risk services and cares for women with complicated pregnancies. It also has a midwife-led birth centre for women with routine pregnancies who want a natural childbirth experience.
- **St Mary's Hospital, Paddington**
  St Mary's Hospital is a general acute hospital that diagnoses and treats a range of adult and child conditions. The hospital also provides maternity services and hosts one of the four major trauma centres in London.
- **Western Eye Hospital, Marylebone**
  Western Eye Hospital is dedicated to ophthalmology. It offers the only 24-hour emergency eye care service in west London.

For more information on the Trust, its services and work, please visit the website: www.imperial.nhs.uk

Imperial Private Healthcare

The Trust offers a full range of private healthcare services within dedicated units across the five hospitals. Patients have access to a range of specialised services including critical care, coronary care, state-of-the-art diagnostics and specialist operating theatres. All private healthcare income is reinvested to support NHS services.

Our major developments

The Trust's designation as an academic health science centre with Imperial College London was confirmed for another five years. This was celebrated along with great medical achievements and Trust staff being recognised for their excellent work and commitment to healthcare.

Recognised for safe care

The Trust was recognised as a centre of very safe care. The Dr Foster Hospital Guide 2013 listed the Trust as among the best in the country for Hospital Standardised Mortality Ratios (HSMRs), which measure the expected number of deaths in a hospital against the actual number. It takes into account many details and variables, and is used as a trusted measure to evaluate the safety of a hospital. The Trust is proud that mortality rates were also lower than expected for patients admitted as an emergency, during both weekdays and weekends.

Focus on patient experience

There has been a major focus on ensuring a first-rate experience for every patient and their families. More detail is provided in this annual report on how the Trust is addressing cancer patient experience in particular. Some examples of this work were explained to England's chief nursing officer, Jane Cummings, during her visit to two cancer wards at Charing Cross Hospital in October 2013. While visiting the wards she saw how the Trust is working collaboratively with Macmillan Cancer Support to improve both patient and staff experience.

Award-winning work

Excellent healthcare can only be achieved through talented and engaged staff, and a number were recognised this year with prestigious national awards. In January a team of six midwives won the Lansinoh Team Award from the Royal College of Midwives for their work with vulnerable women at St Mary's Hospital.

The finance team has also been praised for their hard work by scooping the impressive Health Service Journal Efficiency Award of Finance Team of the Year in December 2013. In December 2013, Bill Shields was also named by the Healthcare Financial Management Awards as Finance Director of the Year for developing and delivering his programme of Building World Class Finance.

New cardiac catheter laboratories

The Trust was very proud to host a visit from Professor Sir Bruce Keogh, national medical director of NHS England, to open two new cardiac catheter laboratories in July 2013. Hammersmith Hospital now has a five-lab suite and the £2.5m investment is part of the consolidation of all the Trust's cardiology services into a specialist unit on a single site at Hammersmith Hospital. This dedicated department, named after Augustus Waller, a professor at St Mary's Hospital, will enable better care, research and patient experience along with operational and financial efficiency.

Surgery first

In a world first, interventional radiologists used new robotic technology to treat fibroids, a common condition which affects one in three women. The robotic system means patients can potentially avoid excessive radiation, as it enables more precise treatment and shorter procedure times.

Pioneering brain scan

In December 2013, the Trust became the first centre in the UK to perform a new type of brain scan which can lead to more accurate diagnosis of Alzheimer's disease and other dementia conditions. This marked a significant breakthrough in diagnosis as the test identifies amyloid plaques in the brain, which is one indication of Alzheimer's disease.

Implementing Cerner

In 2013/14, the Trust worked towards the milestone of implementing Cerner, an electronic patient administration system. Careful planning for the switch to the specialist system ensured colleagues were prepared and the process went smoothly. The transfer took place over the 2014 Easter period to take advantage of a lower level of planned activity during the holiday period. The new system will ultimately allow the Trust to improve data quality and patient care.

Progress towards foundation trust status

Significant progress was made on the work to become a foundation trust. Foundation trust status is an endorsement for being well-organised, run and managed. Becoming a foundation trust will support the Trust's continuing work to engage with the people and communities it serves.

Chief executive appointment and leadership team

Work was also done to strengthen the Trust's leadership team. In early April 2014, the Trust welcomed Dr Tracey Batten as chief executive officer. She joined the Trust with over 20 years' experience of working in healthcare and leading large, complex healthcare organisations. Most recently, Tracey was chief executive of St Vincent's Health, Australia's largest charitable hospital group. The Trust also welcomed new executive team members: Cheryl Plumridge, director of governance and assurance, Ian Garlington, director of strategy, and Michelle Dixon, director of communications.

Birth of Prince George

When reflecting on this year, one major highlight will always stand out – the arrival of Prince George at the Lindo Wing at St Mary's Hospital on 22 July 2013. It was a source of pride and joy, especially as his father, Prince William, was also born at the Trust. Despite the worldwide attention and many journalists and camera crews camping outside the Lindo Wing during this exciting time, the Trust was able to function as normal and give all patients the best possible care.

Working with partners

Imperial College London

As a teaching hospital, the Trust works very closely with Imperial College London, its academic partner and one of the world's top universities and medical schools. Trust patients, staff, students and the local population benefit hugely from this relationship as it has enabled many joint working initiatives that focus on research, innovation and better care for patients.

Academic and research partners

In March 2007, the Trust and Imperial College London together created the UK's first academic health science centre (AHSC). This partnership between a healthcare provider and a university means significant medical discoveries and innovations can be made available. Its excellent work in healthcare, research and education was recognised this year when its AHSC status was confirmed for a further five years.

As another avenue to promote the diffusion and adoption of medical innovations into clinical practice, the Trust is a member of Imperial College Health Partners. The partnership is a limited company that formed in June 2012 and brings together healthcare providers, including acute and specialist hospital, mental health and community care services, to work in partnership with Imperial College London.

In March 2013, Imperial College London launched its vision for Imperial West, a new research and translation campus in White City, west London. The centrepiece of the plans for the campus, which is a short walk from Hammersmith Hospital, will be a £150m research and translation hub. The hub will provide state-of-the-art space for academics and business partners that can be adapted to keep pace with the changing demands of scientific discovery and innovation.

More information on the Trust's research work is detailed on page 29.

Our charity partners

Imperial College Healthcare Charity raises and manages charitable funds for research and projects that help improve patient healthcare at the Trust's five hospitals.

Key achievements for the charity in 2013/14 include:

- Being honoured to receive the support of Their Royal Highnesses the Duke and Duchess of Cambridge in celebration of the birth of baby George at St Mary's Hospital in July 2013. The Duke and Duchess suggested well-wishers could consider supporting Imperial College Healthcare Charity if they wanted to make a donation. The money donated is being used for research and equipment to help women whose pregnancies have not been straightforward.
- Launching a new grants programme in November 2013 aimed at funding projects that improve healthcare for London's hard-to-reach communities through partnerships between community groups and local charities working with the Trust.
- Installing artist Jill Berelowitz's 'Core Femme' sculpture in the grounds of Charing Cross Hospital. Standing at over six metres high, it is another striking addition to the charity's growing art collection displayed for the benefit of patients and staff across the Trust.

The Trust also receives valuable support from: COSMIC (Children of St Mary's Intensive Care); Leuka, a leukaemia research charity at Hammersmith Hospital; and the Winnicott Foundation, who raise funds to improve care for premature and sick babies at St Mary's Hospital.

Our commissioners

During 2013/14, the Trust has continued to work closely with commissioners on the strategic health service development programme for north west London – *Shaping a healthier future.* The *Shaping a healthier future* programme is led by the eight CCGs responsible for the commissioning of NHS care for the population of north west London. Following a process of community consultation, review and referral to an Independent Reconfiguration Panel, health secretary Jeremy Hunt announced the changes to healthcare services in October 2013. The Trust's own transformation programme is very much informed by this wider strategic work.

NHS Trust Development Authority

The Trust works with the NHS Trust Development Authority who provides support, oversight and governance to all NHS trusts. The Trust provides them with regular reports on performance, operations and finance, and they are also working closely with the Trust regarding its foundation trust application.

GPs and other primary care providers

Working together with primary care is essential to improving clinical outcomes and to support positive patient experiences. This year the Trust fostered closer working relationships with general practice to support patients and the public to lead healthier lives.

In 2013/14, various initiatives were set up under the Trust's three year primary engagement plan. These include:

- Monthly GP steering group meetings with Trust clinicians and GPs, chaired by the medical director. These meetings have enabled joint discussions on improving services and better communication with primary care professionals.
- GPs now have a single point of access through the GP liaison office for queries regarding the Trust.
- A GP advice service was established where GPs can get advice on specific specialties.
- Through a GP professional development programme, sessions included free study afternoons with medical specialists. Opportunities were designed to reflect the range of learning styles of GPs and meet to accreditation and continuous professional development learning needs.

To ensure that the Trust is listening to the views of GPs and providing opportunities for regular feedback, every quarter the Trust sends out an online GP survey.

Other specialist services

The Trust works in partnership with other hospitals as patients come to the Trust for specialised treatment that isn't available at other acute hospitals. It is home to some of London's specialist acute medicine centres, such as the major trauma centre at St Mary's Hospital, the hyper acute stroke unit at Charing Cross Hospital and the heart attack centre at Hammersmith Hospital.

The specialised paediatrics emergency department at St Mary's Hospital sees 26,000 children and young people per year from across the country. Paediatricians, A&E doctors, emergency nurse practitioners and GPs work in a purpose-built, child-friendly environment, working alongside the adult emergency department.

Our people

The Trust launched a new people and organisation development strategy in 2013 which contains a range of key strategic objectives centred on the Trust's people.

This strategy has four key themes:

- culture and engagement
- talent development
- staff health and wellbeing
- organisation development.

Culture and engagement

There is a clear link between the engagement of the Trust's people and the experience of patients. Engagement with staff is central to the Trust's *Our people and organisation development* strategy.

Quarterly engagement surveys

In 2013 the Trust introduced a new organisation-wide engagement survey. It is designed to provide the Trust with tangible ward and departmental information about how people feel about working at the Trust. A quarter of the Trust's people are surveyed (approximately 2,000 people) every quarter. Results are received back within two weeks, with data available at ward and departmental level.

The survey has enabled divisions and departments to respond with locally owned action plans and actions at department and ward level.

2013 annual NHS staff survey

Every year a selection of Trust staff are asked to take part in the annual national NHS staff survey to collect views about working for the organisation.

The survey's results are reported to the Trust board and used to create key objectives and actions to drive improvement in people's experience.

Results for 2013 were received in March 2014. Overall the Trust engagement score was 3.74, which is 'above average' compared with other acute trusts around the country. The Trust has maintained its position on the Friends and Family Test, with scores which are above average for acute trusts.

Locally owned action plans will seek to address the results of both the annual national survey and the Trust's quarterly surveys. In addition there are a number of corporately owned actions, including:

- further developing internal communication channels with senior managers, including the introduction of web chats with the director of people and a monthly people and organisational development forum to hear and respond to views from across the organisation
- introducing the *Make a Difference* recognition scheme to recognise and reward people who have shown great performance and given great patient care

- transforming the Trust's health and wellbeing services to ensure the 'fitness to work' of all the Trust's people
- introducing a survey of people leaving the Trust, to ensure that the organisation learns from their experience, and introducing a survey for new people who have completed three months in their role to receive insight about their experience as a new starter.

Talent development

The Trust launched five new leadership development programmes in 2013/14 to ensure that it provides support to all leaders in their roles.

The certificate in medical leadership, the first of the new leadership programmes, started in October 2013 and is being run in partnership with Imperial College Business School. It is aimed at the Trust's most senior leaders.

The Trust launched two other leadership programmes for its leaders in October 2013. These are 'Horizons – strategic leadership', a bespoke programme for aspiring top leaders, and 'Aspire – the leadership way'.

For middle managers, the Trust introduced a management programme 'Headstart' and for those in their first management or supervision role, there are 'Foundations'. Over 100 leaders and managers were enrolled on these programmes by the end of March 2014.

Recognition schemes

The Trust runs a number of high-profile recognition schemes which are generously funded and supported by Imperial College Healthcare Charity. Trust and divisional awards are presented to individuals or teams who best embody the Trust's values. These schemes have been in operation since 2008.

In 2013/14, the Trust reviewed the way it recognises people, prepared a new scheme and launched it on 1 April 2014. The scheme is called *Make a Difference* and reflects the impact of people who go the extra mile and the difference this makes to the lives of patients and colleagues. *Make a Difference* integrates instant recognition, divisional awards and Trust awards into a single scheme, and builds on what has worked well in the past.

Staff health and wellbeing

In 2014/15, the Trust will be taking forward staff health and wellbeing in several ways. These include:

- The introduction of a health and wellbeing committee under the chairmanship of the medical director. An overarching health and wellbeing strategy will be presented to the Trust management board to address short- and long-term priorities for health and wellbeing. An immediate goal will be to improve perceptions among the Trust's people about their health and wellbeing at work and, aligned with the *Our people and organisation development* strategy, there is particular reference to improving the engagement of the Trust's people.
- The iMove campaign, which will build on the success in 2013/14 and seek to improve access to gyms and swimming pools within the M25, and encourage people to walk more through the provision of pedometers and the organisation of walking clubs. Cycling will be promoted through bicycle loan and purchase schemes. A website will be created to be the 'go-to' place for information about sporting activity and how to become involved in a wide range of physical activity.
- Re-visiting the Trust's policy on smoking, following the implementation of National Institute for Health and Care Excellence (NICE) guidelines on smoke-free premises, and ensuring that it is implemented rigorously. Smoking is the major preventable cause of

illness and mortality, and the Trust is committed to ensuring that it leads the way in reducing exposure to cigarette smoke of people using its facilities. The Trust will offer support to patients and employees who wish to stop smoking.

Staff profiles

Headcount of employees on 31 March 2014

Age group	Headcount
16-19 years	7
20-29 years	1,747
30-39 years	2,894
40-49 years	2,666
50-59 years	1,760
60 years and over	530
Grand total	**9,604**

Ethnic origin	Headcount
White - British	2,933
White – Irish	329
White - Any other White background	1,117
Mixed - White & Black Caribbean	44
Mixed - White & Black African	60
Mixed - White & Asian	72
Mixed - Any other mixed background	163
Asian or Asian British - Indian	673
Asian or Asian British - Pakistani	133
Asian or Asian British - Bangladeshi	63
Asian or Asian British - Any other Asian background	1,077
Black or Black British - Caribbean	353
Black or Black British - African	806
Black or Black British - Any other Black background	481
Chinese	193
Any other ethnic group	492
Undefined	137
Not stated	478
Grand total	**9,604**

Gender: all staff	Headcount
Female	6,807
Male	2,797
Grand total	**9,604**

Gender: senior managers	Headcount
Female	208
Male	158
Grand total	**366**

Gender: board of directors	Headcount
Female	3
Male	11
Grand total	**14**

Gender: executive team	Headcount
Female	4
Male	7
Grand total	**11**

Equality and diversity policy

Protecting and promoting equality and diversity is a priority for the Trust, and this approach is encompassed in the single equality scheme 2011-2015. The Trust uses the NHS England Equality Delivery System (EDS).

Together with staff, patients and other stakeholders, the Trust undertook a grading event using the EDS in December 2013. The grades in the table below were assigned. This is an improvement on the previous year's gradings, but there is still work to do, particularly in the areas assessed as 'developing'.

NHS EDS Goal	2014/15 Objective	Grade
1. Better health outcomes for all	1.4 The safety of patients is prioritised and assured	Developing
2. Improved patient access and experience	2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised	Developing
	2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently	Achieving
3. Engaged, empowered and well supported staff	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	Achieving
	3.4 Staff are free from abuse, harassment, bullying and violence from both patients and their relatives and colleagues, with redress being open and fair to all	Achieving
	3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	Developing

Our quality focus

2013/14 was an exciting and challenging year for the Trust. It was a year of change both internally and externally as it implemented a new internal structure, consolidated its plans and continued to work in partnership with commissioners and other healthcare partners across north west London.

Although the developments cover a range of areas and partners, all are focused on the core mission to provide the best quality care and treatment to all patients.

Quality strategy

In November 2013, the Trust launched a quality strategy which outlines quality goals it aims to achieve by 2015. It explains the approach to driving improvements, including the governance processes, and how these are set by the vision of safe, high-quality, patient-centred services for patients.

The six principles and goals

The Trust's approach to improving quality is based on Professor Donald Berwick's six principles for improvement. Professor Berwick was commissioned to review the changes needed in the NHS following the Mid Staffordshire Inquiry.

The six principles in the quality strategy are:

1. Safety: our patients will be as safe in our hospitals as they are in their own homes.
2. Effectiveness: our people will minimise the use of ineffective care and maximise the use of evidence-based care.
3. Patient-centredness: our people will respect the individual patient and their choices, culture and specific needs.
4. Timeliness: we will strive to continually reduce waiting times and delays for patients and our people.
5. Efficiency: we will strive to continually reduce waste and thereby cost of care (this includes supplies, equipment, space, capital, ideas and human spirit).
6. Equity: we will seek to ensure that everyone we care for has the same high-quality outcome, regardless of status.

Each of the six principles has a set of objectives and key actions needed which the Trust is working to deliver.

Patient-centred care

Following 2012/13, where the Francis Report facilitated national reflection on patient care and demonstrated that patients must be at the centre of healthcare, 2013/14 has been a year of consolidating plans and fostering cultural change.

Improving patient experience is a top priority for the Trust and the Francis Report into failings at Mid Staffordshire NHS Foundation Trust identified a number of issues related to patient experience which the Trust has taken steps to address through an action plan.

The Trust's work on patient experience is also supported by the Trust's quality strategy. The quality strategy outlines how patient experience is interlinked with processes and Trust staff, and is dependent on all these elements working together effectively.

The Trust's goal is that all staff will respect the individual patient and his or her choices, culture and specific needs. A key component of this goal is to improve the reported experience of patients when compared nationally. In 2013/14, the Trust agreed the five indicators that it will use to track performance:

- Friends and Family Test (FFT): 20 per cent or higher response rate; score of 80 or higher.
- iTrack (Trust real-time patient experience): score of 85 or higher on all core questions.
- National Inpatient Survey: improve on overall position and reduce the number of questions scored below average.
- National Cancer Patient Experience Survey: mid-table within two years and top quartile within three years.
- Staff survey: remain above average with 60 per cent of staff who would recommend the Trust to friends/family needing care.

In addition to agreeing the indicators, the Trust introduced the national FFT for inpatients and A&E, and received an excellent response. Bed headboards were introduced containing key patient information, including the patient's preferred name and details of which doctors and nurses are looking after them.

A major programme of work to ensure the availability of the right levels of nursing staff with the right skills was undertaken. This included consolidating electronic rostering and publishing staffing levels locally.

The Trust acknowledges that there is more work to be done regarding cancer patient experience and has implemented various initiatives to improve this.

For more information on the Trust's patient experience performance, and specifically cancer patient experience, go to page 24.

Quality accounts

The quality accounts report on the quality of services delivered. The Trust is committed to continually improving the quality of the services it provides to its patients and the quality accounts are a report of:

- how well the Trust is doing against the targets set by the Department of Health, CCGs and those it sets itself as an organisation
- how well it is doing when compared with similar healthcare providers
- where it needs to focus to improve the quality of the services it provides.

Trust priorities for 2014/15

Priorities were developed in consultation with senior clinical and management staff across each of the Trust's service delivery areas: patients, members of the public, shadow foundation trust members, Healthwatch, CCGs, and council overview and scrutiny committees. A consultation took place with Trust staff and key stakeholders between December 2013 and February 2014. The priority areas were proposed based on national and local targets, and Trust improvement priorities were based on the quality strategy goals.

Progress against these priorities is measured and reported through the quarterly quality accounts delivery group and reported to the Quality Committee.

Three Trust priority areas are set out in the table below. Further priority improvement targets have been identified for each area.

Patient safety	• To ensure high performance against the safety thermometer. • To reduce healthcare acquired infections. • To be compliant with the Trust anti-infective policy. • To increase reporting of patient safety incidents and reduce those that result in severe or extreme harm. • To have a zero tolerance for Never Events. • To be compliant with the Commissioning for Quality and Innovation (CQUIN) dementia target.
Clinical effectiveness	• To remain better than the national average for mortality rates, as measured by the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR). • To reduce the number of re-admissions to hospital within 28 days of discharge. • To increase patient satisfaction as measured by Patient Reported Outcome Measures (PROMs).
Patient experience	• To meet Trust CQUIN targets for the Friends and Family Test (FFT) for inpatients and A&E. • To implement the FFT for all outpatient departments by October 2014. • To improve on the National Patient and National Cancer Survey results in relation to responsiveness to patient needs. • To implement the staff FFT by June 2014. • To remain above average for staff who would recommend the Trust as a place to work as measured through the National Staff Survey. • To have a zero tolerance for Eliminating Mixed Sex Accommodation (ESMA).

A reporting and learning culture

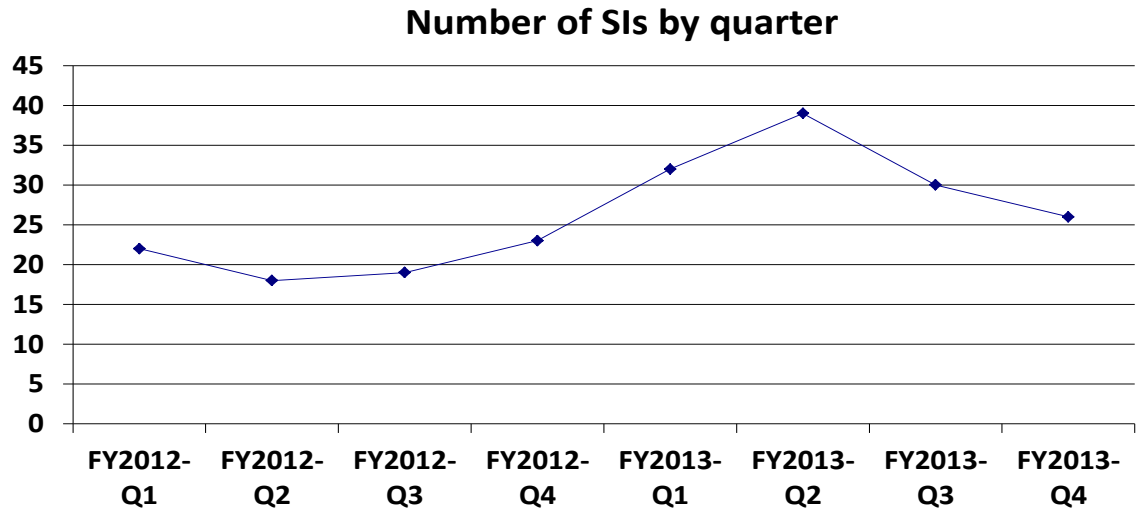
The Trust always strives to improve, and part of delivering safe, effective and quality care is creating a learning culture where the Trust learns from adverse events and incidents. It is important that everybody in the Trust and the organisation as a whole is able to acknowledge mistakes, learn from them, and take action to put things right.

Learning from adverse events[1]

During 2013/14, a number of activities have been undertaken to support this priority, which is also outlined in the quality strategy. The Trust has:

- introduced weekly incident panels, led by the medical director, where all incidents that result in moderate or above harm are reviewed with the divisional director and their top team
- introduced division-based quality and safety teams to provide regular review of incident themes, trends and implementation of action plans ensuring local learning
- upgraded the Datix incident reporting system to provide improved systems and processes for the monitoring, reporting and learning from adverse events
- began linking incident trends and themes to service improvement and junior doctor training.

The rate of identification of externally reportable serious incidents (SIs) increased after the medical director's incident review panel started in 2013/14. The graph below shows the trend in reporting, which is being monitored through the appropriate governance structure.



Serious incident data are not available nationally, so benchmarking is not possible. Using the National Reporting and Learning System (NRLS) to benchmark performance of incidents reported (per 100 bed days) places the Trust as either within or better than their peer group.

The top five themes from reported serious incidents in 2013/14 are:

1. pressure ulcers (grade 3 and above)
2. maternity services
3. delayed diagnosis
4. unexpected death
5. sub-optimal care of the deteriorating patient.

[1] Also see the Annual Governance Statement on page 37.

These five themes will be the priority areas of the Trust's safety improvement programme for 2014/15. This will build on work already underway such as the implementation of a pressure ulcer improvement strategy, led by the director of nursing.

An action plan is implemented following each investigated serious incident. Recent examples of actions taken to prevent issues re-occurring and to improve awareness include:

- modifying the escalation process for emergency theatre access, with escalation now direct to the consultant
- revising step down process for the major trauma ward
- implementing a new process for tracking direct access referrals to diagnostic services in primary care
- appointing seven registrar level doctors into safety champion roles to support feedback to junior doctors and engage them in improvement projects
- introducing monthly 'lessons learned' forums for junior doctors.

The actions from the Trust's serious incident investigations will be audited as part of the clinical audit plan for 2014/15 to ensure compliance.

Falls

Slips, trips and falls are a common cause of accidents and are included as a national reporting requirement for the Trust's Quality Account 2013/14. The Trust continues to report fewer falls than the national average. Reduction in harm is measured using a target based on the previous year's performance, set at the start of each financial year.

Falls results 2013/14

Measure/indicator	Q1	Q2	Q3	Q4	Target 2013/14
Number of falls per 1,000 bed days	3.82	3.78	4.34	3.83	target 2013-14 < 5.6 per 1,000 bed days
Number of patient falls that result in low/minor harm (%)	120 (29.1%)	137 (34.0%)	129 (27.3%)	106 (25.0%)	<33% of total number of falls

Source: Trust Datix incident reporting system

Complaints

The Trust has focused on its complaints management following the Francis Report, and Ann Clwyd MP and Professor Tricia Hart's review into NHS complaint handling.

Patient Advice and Liaison Service (PALS) and the central complaints team reviewed each recommendation to ensure that the Trust implements as many recommendations as possible.

Following an internal restructure, four patient safety managers now lead complaint management in each of the four clinical divisions. This allows the Trust to consider information not only from complaints and PALS, but also claims and incidents, to help ensure that it learns from various forms of feedback.

The management of the central complaints team has been strengthened by the appointment of the Trust's first service quality manager, who works closely with the PALS manager and patient safety leads. This has established a strong foundation which will help ensure the Trust continues to place the patient at the centre of everything it does.

The Trust's current complaints procedure fully reflects the Parliamentary and Health Service Ombudsman's six Principles for Remedy. When the Trust has made a mistake or provided poor service, its response to the complaint is guided by these principles. In 2014/15, the Trust plans to enshrine the principles in its Concerns and Complaints Policy.

During 2013/14, the Trust investigated 884 formal complaints, 93 per cent of which were resolved within the timescale agreed by the patient. PALS dealt with 3,519 informal concerns in the year.

Our performance

The Trust has had an encouraging year, making good progress on challenging targets along with maintaining good performance on key targets. Throughout the year, staff have strived to balance patient safety, quality and efficiency with excellent patient outcomes, whilst maintaining performance against these targets.

The Trust's performance is externally monitored against a range of national standards and targets. In the final quarter of 2013/14 the Trust met all eight cancer waiting times standards. This was the first time in recent years that the Trust has achieved all eight standards for the quarter and the organisation is in a good position to be able to sustain this performance in 2014/15.

This year the Trust has delivered, in all but one month, the three national referral to treatment (RTT) standards. The Trust continues to identify areas for improvement and has put robust plans in place to enable it to meet its targets.

Meeting national targets

Referral to treatment

This year the Trust has continued to work hard so that most of its patients are seen within 18 weeks. The Trust achieved each of the three RTT standards (admitted treatments, non-admitted treatments and for patients waiting for treatment) in every month in 2013/14, except in March for admitted treatments. This includes consistently maintaining having very few patients waiting over 52 weeks for treatment. At the end of the year there were no patients waiting over 52 weeks for treatment.

The Trust recognises that there are some patients who wait longer than 18 weeks for treatment and a comprehensive action plan has been put in place to tackle the longest waits, which are concentrated in a small number of specialist areas.

Accident and emergency

The Trust continues to experience exceptional demand in its A&E departments and has also seen an increase in patients attending with complex needs. Despite these challenges, the Trust consistently met the 95 per cent four hour A&E wait national standard each month in 2013/14.

During the year, the Trust has reviewed how patients move through its emergency department and through the hospital if they need tests or inpatient care, so that it can plan effectively for the future and improve care for its patients.

The Trust has introduced measures to improve the ability of its A&E department to respond at times of peak activity, and to ensure that patients are able to leave hospital safely as soon as they are ready so that beds are available for other patients. These measures include increasing capacity and starting winter planning earlier.

National cancer targets

The Trust continued to see improvements in its performance against the national cancer targets throughout 2013/14. In common with trusts receiving referrals for specialist diagnosis and treatment from other hospitals, the most challenging cancer waiting time standard is the 62-day maximum referral to treatment target.

Over 2013/14, the Trust eliminated its backlog of patients waiting for treatment and improved pathways of care, for example patients having multiple appointments on the same day that previously would have been spread over a number of weeks. The Trust has also worked with hospitals that refer to it to ensure that delays are minimised for patients.

In quarter four of 2013/14, the Trust achieved all eight cancer waiting times standards and is in a position where this performance can be sustained. This means that its cancer patients have a faster pathway from referral to treatment and can expect to have treatment within national guidelines.

Cancelled operations for non-clinical reasons

Since the start of 2014, the rate of cancelled operations for non-clinical reasons has risen above the national standard. This is due to a number of reasons including pressures on bed availability post-operation and theatre capacity. The Trust recognises that this is an important standard for patient experience and is committed to improving its performance in this area in 2014/15. For those patients who are cancelled, the Trust has improved on the rate of patients who are re-booked within 28 days throughout the year.

Infection prevention and control

Infection prevention and antimicrobial stewardship are considered to be core aspects of patient safety. The Trust continues to be committed to preventing and reducing healthcare associated infections, including Meticillin resistant Staphylococcus aureus (MRSA), *C.difficile*, norovirus and surgical site infections.

Since 1 April 2013, the aim and external expectation for any NHS organisation has been for zero MRSA blood stream infections (BSIs). In 2013/14, the Trust had 13 MRSA BSIs allocated to it.

This year, the Trust reduced the number of *C.difficile* infections in its hospitals. It reported 58 cases, against a threshold of 65 cases agreed with the Trust's commissioners.

Over the last year, the Care Quality Commission (CQC) reviewed the Trust's infection control practices in one of their planned inspections. They found the wards they inspected to be clean and that the right systems were in place to prevent and control the risk of infection. The CQC inspection team found many examples of good practice in the care the Trust's teams provide and did not require the Trust to carry out any additional actions.

To continue to reduce this rate and the quality of services, the Trust:

- has implemented the guidance from Public Health England that requires the isolation of patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea
- has reviewed and updated policies and procedures to reflect the above
- closely monitors the time to isolation as a metric of quality
- undertakes monthly multidisciplinary team reviews of all *C.difficile* cases in which risk factors for each case are collated and learning shared with primary care colleagues. The consultant pharmacist has highlighted these issues to GPs (via the GP bulletin newsletter) to help raise awareness and look to mitigate these.

A key priority for the Trust in 2014/15 is embedding into clinical practice the recently published national acute trust toolkit for the early detection, management and control of carbapenem-resistant enterobacteriaceae to meet the emerging risk identified by the chief medical officer of multi-drug resistant carbapenemase-producing organisms.

CQUIN Targets

Commissioners hold the NHS budget for their area and decide how to spend this on hospital care and other health services. The Trust's commissioners set it goals based on quality and innovation, and a proportion of the Trust's income is conditional on achieving those goals. The system is called Commissioning for Quality and Innovation, or the CQUIN payment framework.

Last year, 2.5 per cent of the Trust's clinical income was conditional upon achieving quality improvement and innovation goals agreed with CCGs and NHS England.

Venous thromboembolism (VTE) risk assessment forms one of the Trust's CQUIN schemes. The Trust satisfied the 2013/14 CQUIN VTE target, with more than 95 per cent of patients being assessed for VTE risk within 24 hours of admission to hospital. This is a five per cent improvement compared with 2012/13.

All patients suffering a hospital acquired VTE are identified according to an agreed protocol and are subjected to a formal root cause analysis (RCA) with the responsible clinician. The outcome is reviewed in each case by the VTE lead. The CQUIN targets for RCA for 2013/14 have been met in full.

VTE risk assessment compliance will not be a CQUIN scheme in 2013/14. However, performance against the 95 per cent threshold will be monitored through the contract as it remains a high priority for the Trust to continue to deliver.

CQUIN targets table

	Threshold	Q1	Q2	Q3	Q4
A&E maximum waiting time 4 hours	95%	96.24%	96.68%	95.97%	95.97%
18 weeks referral to treatment – admitted	90%	92.50%	93.35%	93.18%	90.77%
18 weeks referral to treatment – non-admitted	95%	96.85%	96.80%	95.88%	95.28%
18 weeks referral to treatment – incomplete pathway	92%	95.96%	95.96%	95.05%	94.58%
2-week wait from referral to date first seen – all urgent referrals	93%	98.27%	98.37%	98.51%	95.70%
2-week wait from referral to date first seen –breast cancer	93%	97.63%	97.60%	97.28%	95.25%
31 days standard from diagnosis to first treatment	96%	94.43%	96.89%	96.07%	97.95%
31 days standard to subsequent cancer treatment – drug	98%	100%	99.47%	100%	100%
31 days standard to subsequent cancer treatment – radiotherapy	94%	97.50%	98.73%	98.06%	99.60%
31 days standard to subsequent cancer treatment – surgery	94%	96.07%	95.47%	95.42%	95.35%
62-day wait for first treatment from NHS screening services referral	90%	91.27%	95.57%	92.23%	93.00%
62-day wait for first treatment from urgent GP referral	85%	74.27%	74.00%	80.10%	86.2%
C.difficile post-72 hours	65	26	11	10	11
MRSA	0	5	4	2	2
VTE	95%	95.1%	96.1%	96.3%	96.8%
Cancelled operations for non-clinical reasons	0.8%	0.75%	0.73%	0.70%	1.21%
Re-booking non-clinical cancellations within 28 days	5%	8.38%	4.71%	3.35%	2.85%

Patient experience

Sir Robert Francis's report into the failings at Mid Staffordshire NHS Foundation Trust identified a number of issues related to patient experience that Imperial College Healthcare NHS Trust is ensuring are addressed through a specific action plan. A major programme of work to ensure that the right levels of nursing staff with the right skills are available was undertaken, including the consolidation of electronic rostering and local publication of staffing levels. The Trust has also introduced bed head boards containing key patient information, including their preferred name, and details of which doctors and nurses were looking after them.

Friends and Family Test

This year saw the introduction of the national Friends and Family Test (FFT) for inpatients and A&E. The FFT scores are calculated as the proportion of respondents who would be extremely likely to recommend Trust services to friends and family if they needed similar care or treatment minus the proportion of respondents who would not. The mathematical calculation then gives a score of between -100 and +100.

The Trust opted to collect the responses to this question electronically through the existing iTrack system. In December 2013, over 100 new devices were introduced to make answering the question easier for the patient. This approach has paid off with the Trust achieving excellent response rates which were both well in excess of the required CQUIN targets and those of other similar organisations. In March 2014, the Trust's combined (A&E and inpatient) FFT response rate was 26.7 per cent, compared with the national average of 23.7 per cent. The Trust's FFT scores also appear to be good when benchmarked against peers: the combined FFT score for the Trust was 66, compared with the national average of 63.

Cancer patient experience

The results of the National Cancer Patient Experience Survey, which were published in August 2013, were a less positive story. A programme of work was initiated that focused on strengthening leadership in cancer areas, redesigning cancer pathways and improving communication with patients. Much of this work was led at local level and a series of events ran quarterly throughout the year at which staff could feed back the improvements that have been made. For example, the development of a one-stop clinic for urology patients means that all the key things can be done at one visit. This has been very positively evaluated by patients.

In the cancer wards, an Imperial College Healthcare Charity funded project has focused on implementing behaviours identified in the Macmillan Values Based Standard, which focuses on care and compassion. Again this has been very positively evaluated by patients. In addition, the Trust commissioned quarterly surveys that repeat the national questions to see what improvements are being made. The Trust undertook three of these surveys in 2013/14 and some small improvements are being seen.

Inpatient surveys

The national 2013 Inpatient Survey results showed again that patients are broadly satisfied with the care that they receive at the Trust. The Trust performs above the national average in most areas of this survey. A poster campaign setting out the commitment to making the patient experience better was also launched.

Healthwatch and the patient environment

The Trust has continued to strengthen its partnership working with Healthwatch. Its members are actively involved in the new Patient-Led Assessment of the Care Environment (PLACE) inspections. These inspections have led to a number of changes and improvements to the environment and food. Healthwatch have also conducted dignity champion visits to the St Mary's and Charing Cross sites, both of which have resulted in a number of actions to improve the care of patients, for example revisiting the application of protected mealtimes in the ward areas.

Under PLACE, 24 local patient representatives worked with multidisciplinary teams from the Trust to rate cleaning, catering, the environment, and privacy and dignity. The results are below and the inspections led to a number of changes and improvements to the Trust's environment and catering arrangements.

The Trust achieved good results in the PLACE assessment. Its results for 2013/14 were:

Cleaning	Catering	Environment	Privacy and dignity
99.03%	80.91%	89.22%	88.61%

Achievements in cleaning services

The Trust continues to deliver excellent cleaning standards in partnership with ISS Facilities Services Healthcare. Cleaning standards for 2013/14 were maintained, with the annual PLACE assessment ranking the Trust third highest in London for cleaning services. In addition, Hammersmith Hospital was shortlisted for a national hospital cleanliness award.

Hotel services tender

The Trust started the process of market testing its hotel services (cleaning, catering, porters, and linen and laundry) contract in August 2013 due to the contracts for these services all coming to an end.

All services play a vital role in helping us to improve patient experience, so an extensive process of review and feedback is currently being undertaken to ensure any new contracts deliver the quality of service the Trust's patients expect. The new contracts will be in place by 31 August 2014.

Patient feedback project

The Trust is working with the Patients Association to gather independent feedback from over 800 patients on Trust cleaning, catering and other support services. The project is due to deliver recommendations in April 2014, which will then be adopted by the Trust.

External reviews

The NHS Litigation Authority

The NHS Litigation Authority (NHSLA) provides the Trust with indemnity insurance to cover the cost of claims. As claims cost the NHS in the region of £1 billion each year, the NHSLA offers discounts that are only applied if the Trust can pass certain levels of assessment. The details of the assessments and what the Trust is tested against are set out in the NHSLA risk management standards.

These standards are important because they provide the Trust with the infrastructure to further improve patient safety, develop a highly competent and capable workforce, and ensure the best environment possible for patients and staff across all areas of the organisation. The standards are specifically developed to reflect issues that arise in the negligence claims reported to the NHSLA. They include aspects of care such as blood transfusion, consent to treatment and hand hygiene, as well as the safety and security of the Trust's buildings, corporate and local induction, and how the Trust learns from incidents, complaints and claims. The Trust is currently assessed at the highest rating – level three – for both its maternity and acute services.

The NHSLA has changed the way it monitors standards. From March 2014, it no longer assesses NHS trusts against these standards and the 50 standards will no longer exist. The standards will be available for reference only as archived documents.

The NHSLA will be supporting NHS England to reduce harm by learning from claims. In place of the assessments and standards, the NHSLA will be developing a safety and learning service to provide information and knowledge through sharing best practice. This will be a significant change to the way the Trust will work with the NHSLA over the next financial year.

Care Quality Commission

All health and social care services in England are required to register with the Care Quality Commission (CQC). The Trust is currently registered 'without conditions' to provide services at its five main hospital sites and its seven renal satellite units:

1. Brent Renal Centre
2. Ealing Renal Satellite Unit
3. Hayes Renal Centre
4. Northwick Park Renal Centre
5. St Charles & Hammersmith Renal Centre
6. Watford Renal Centre
7. West Middlesex Renal Centre

Regular leadership walk rounds to review each hospital site against the essential CQC standards are conducted by the Trust. These walk rounds have helped to identify any training and actions required to meet standards, and have been positively received by all areas visited.

The Trust is subject to periodic reviews by the CQC, the last of which was during January 2014 at Charing Cross Hospital when the CQC undertook a themed dementia care inspection as part of a national programme. The inspection took place on 22 January 2014 and the following outcomes were reviewed in the context of dementia care:

- Outcome 4 – care and welfare of people who use services
- Outcome 6 – cooperating with other providers
- Outcome 16 – assessing and monitoring the quality of service provision.

The Trust was found to be compliant with all outcomes with no specific actions requested.

The Trust had a further two planned unannounced inspections at Western Eye and St Mary's hospitals and one mental health themed inspection at St Mary's Hospital. The Trust was found to be compliant with all of the essential standards reviewed.

The Trust is currently preparing for its CQC Chief Inspector of Hospitals inspection which is expected in summer 2014.

Emergency preparedness

A new strategic national NHS Emergency Preparedness, Resilience and Response framework was implemented in April 2013, containing core principles for all NHS organisations. NHS England London assessed the Trust's emergency planning capabilities against the new core standards in August 2013. The Trust was found to be one of the highest performing trusts in London on emergency planning and business continuity arrangements. The assessment also identified a number of areas of best practice which have been shared with other acute trusts in London.

These plans were used during the industrial action by London Underground staff in February 2014 and during the incident at the Apollo Theatre in December 2013. In both instances, the Trust performed well. During the industrial action there was no disruption to the Trust's operational capability despite severe travel disruption and all casualties from the Apollo Theatre received by the Trust were treated within target times and other hospital business continued without disruption.

The emergency planning team have supported, and will continue to support, the Trust's Information and Communication Technology (ICT) department with Cerner (an electronic patient administration system) by ensuring that robust contingency plans are in place to deal with any issues during implementation.

Research and education

Research

Significant scientific advances were made by the Trust in 2013/14 and new investment in clinical research and development (R&D) secured.

The Trust's research strategy is integrated with Imperial College London and greatly influenced by their joint role as an academic health science centre (AHSC) – a designation which was renewed for five years in November 2013.

The Trust also works in partnership with external experts through designated research centres at their hospitals. These include the Medical Research Council, Cancer Research UK, Wellcome Trust and British Heart Foundation.

National Institute for Health Research

The Trust is the largest of the 11 National Institute for Health Research (NIHR) Biomedical Research Centres (BRCs) in the country. This designation is awarded to the most outstanding NHS and university research partnerships, who are leaders in scientific translation and early adopters of new insights in technologies, techniques and treatments for improving health.

In 2013/14, Imperial BRC continued to develop a wide range of novel devices, diagnostics and new therapeutic advances across 15 research themes. Its portfolio of over 600 projects was underpinned by state-of-the-art facilities for gene sequencing, imaging and metabolic analysis, and a biobank.

The NIHR complimented Imperial BRC in 2013/14 on its patient and public involvement and engagement activities within its research themes in 2012/13. Together with other research organisations, it intends to build on this success by developing an integrated approach to patient and public involvement across NIHR programmes in north west London.

New NIHR funding programmes won by the Trust in 2013/14

The Trust attracted further R&D investment from the NIHR for a Diagnostic Evidence Collaborative (DEC). Imperial DEC, one of only four DECs in the country, will focus on bringing diagnosis to the bedside through evaluating new point-of-care diagnostics.

Funding for four new NIHR Health Protection Research Units (HPRUs) – centres of excellence for studying priority areas in public health – was gained. Only 13 HPRUs were granted nationally and the achievement reflects the strong infectious diseases research base across Imperial AHSC. The Imperial HPRUs will focus on respiratory infections, antimicrobial resistance, modelling outbreaks of infectious disease, and the health impact of environmental hazards (with King's College London).

Imperial BRC is collaborating on an initiative which explores integrating and sharing electronic patient data, together with genotypic and phenotypic information from clinical studies.

The NIHR Health Informatics Collaborative brings Imperial BRC together with BRCs at Cambridge, Oxford, University College London, and Guy's and St Thomas' hospitals to link the collection of routine clinical data for research in cardiology, transplantation, cancer, liver disease and critical care.

NIHR Clinical Research Network

In September 2013, the Trust was selected to host the NIHR Clinical Research Network for North West London (NWL CRN). The Trust will receive around £80m to run the NWL CRN for five years. With other NHS providers in the region, the network will increase opportunities for patients to participate in clinical research and ensure studies are efficient.

More than 12,000 patients were recruited into 329 studies in 2013, an increase of over 12 per cent from 2012. And more commercial clinical R&D investment was attracted in 2013 – over 500 patients were recruited across 62 studies (a 50 per cent increase from 2012).

Discovery research: new devices, diagnostics and therapies

Imperial BRC supports more than 600 active research projects across 15 different disease areas. In the last year the Trust's BRC-supported clinical academics published over 450 peer-reviewed articles.

The BRC collaborates with Imperial Innovations, who provide technology commercialisation services, and grant and development funding support, to pilot new studies in the early stages of drug discovery. Through its Therapeutic Primer Fund scheme the BRC is promoting the discovery and development of therapeutics for unmet medical needs such as chronic obstructive pulmonary disease and asthma, thrombosis, breast and ovarian cancer, and malaria. In 2014, this fund will be extended, in partnership with the Royal Marsden NHS Foundation Trust, to identify additional new areas of therapeutic intervention in cancer.

The Imperial Clinical Phenotyping Centre at St Mary's Hospital, which is jointly funded by the BRC and equipment manufacturers (the Waters Corporation and Bruker Spectrospin GmbH), has produced a number of successes. These include diagnosis and staging of colorectal cancer tissue biopsies using high resolution magic angle spinning nuclear magnetic resonance spectroscopy.

The BRC funded studies into pulmonary arterial hypertension, neuroendocrine tumours, immune thrombocytopaenia, thoracic aortic aneurysm, Friedreich's ataxia, Kawasaki disease and astrocytoma. By investing in state-of-the-art imaging, sequencing and metabolic spectroscopy facilities, it is gaining new insights into the diagnostic and therapeutic stratification of these patient groups. This will ultimately lead to more personalised patient care.

The Trust is playing an active role with other major NIHR BRCs in establishing the NIHR BioResource – a national database of consented and genotyped healthy volunteers. It will provide the basis for testing the next generation of personalised medicines.

Education

In September 2013, the Trust became a Lead Provider for additional medical specialties through a competitive process – it now provides 26 specialties with 1,800 trainees.

The Trust is Lead Provider in North West Thames for chemical pathology, rheumatology, genito-urinary medicine (with Chelsea and Westminster), core anaesthetics and acute care, acute internal medicine, higher anaesthetics, emergency medicine, haematology, and core and intermediate paediatric specialties. Across north London, the Trust is Lead Provider for urology and ear nose and throat specialties. For London, the Trust is Lead Provider for paediatrics higher and paediatric surgery (the latter with Chelsea and Westminster) specialties.

The Trust works closely with Shared Services and Health Education North West London and its North West London Local Education and Training Board (who plan the workforce and commission training) to ensure its education provision meets the needs of its providers.

Improvements in education

In 2013/14, the Trust's board made a commitment to transform its approach and performance on education. Education is now a key objective for the organisation and it aims to work towards becoming the first choice training centre for healthcare professionals across all specialties.

In September 2013, the medical director became accountable to the Trust board for education and an independent external review of medical education was commissioned in October 2013. It investigated a number of persistently reported issues including poor reviews and survey results, poor supervision, and bullying and undermining. The review's recommendations were developed into an educational transformation programme, which was launched in April 2014.

Progress already achieved in 2013/14 includes starting a bullying and undermining action project with support from Health Education England; launching Trust-wide trainee forums in December 2013; strengthening local faculty group meetings in divisions; and starting a review of education roles and time commitments.

Achievements in education

The Trust delivered a number of educational achievements in 2013/14. These include:

New appointments:

- the number of teaching fellows was increased
- a new NIHR clinical doctoral fellow in hand therapy was appointed
- two new directors of clinical studies were appointed to enhance the undergraduate experience.

New staff qualifications and awards:

- four pharmacists qualified to become non-medical prescribers
- two pharmacists were awarded the faculty fellow for the Royal Pharmaceutical Society
- two NIHR doctoral fellows in therapy services and one pharmacist were awarded PhDs
- the British Society of Rheumatology best practice award was given for integrating clinical service with education and research.

Research and training:

- the first north west London sector research symposium for nurses, midwives, pharmacists and allied health professionals (AHPs) was held in September 2013
- two quality improvement initiatives, where junior doctors tackled problems from clinical settings with the help of a range of participants, were run with the Royal College of Art
- Trust pharmacy staff led a redesign of the postgraduate diploma in general pharmacy practice for the Joint Programme Board – a collaboration of nine universities in South East, East and South of England
- multidisciplinary simulation training was launched to enhance learning following serious incidents
- new simulation programmes in bronchoscopy, endoscopy and the cardiac catheter lab were started to further increase the research capability of nurses, AHPs, pharmacists and doctors, such as a research nurse training programme
- further developing 'paired learning' – a peer learning initiative.

Sustainability report and data

The Trust strives to operate as a financially and socially responsible organisation. It recognises the need to minimise its impact on the environment in order to deliver the highest quality healthcare to the communities it serves, now and into the future.

The Trust will continue to implement measures to reduce its carbon emission in line with the 2015 NHS target of 25 per cent, and has expanded its work beyond the normal energy-based measures.

Water savings

The Trust recognised the importance of its responsibility to save water, and reduce costs and its carbon footprint. After stringent assessment, ADSM, the government-appointed water efficiency experts, were selected to implement the AquaFund initiative to reduce water consumption.

The AquaFund initiative enables public sector organisations to lower their water consumption and make financial savings without the need for any investment. The initiative aims to reduce water consumption through methods such as installing water saving technologies, reducing tariffs and charges, preventing leaks and promoting water education throughout the organisation. The initiative is self-funding, therefore no capital outlay was required by the Trust.

The Trust is in the first year of the five-year AquaFund initiative and has already made significant achievements:

- savings of over £40,000 – which can be directly invested elsewhere
- identifying and fixing two large consumption issues with estimated savings of 110,000m^3 per annum of water wastage
- total visibility of the Trust's operational, financial and billing data for the entire portfolio
- raised awareness of the need to save water amongst staff and patients, and the positive impact individual actions can have on the environment and society.

The next phase of the AquaFund initiative includes:

- achieving a 30 per cent reduction in water usage by the end of year two of the project
- achieving £120,000 of financial savings by the end of year two of the project
- installing further automatic meter reading and sub-metering to achieve a deeper understanding of the portfolios water usage
- completing feasibility studies on borehole and water recycling from site.

By the time the Trust completes the AquaFund initiative, it will save thousands of litres of water, reduce costs and CO_2, have a future water management plan, and will be fully prepared for the deregulation of the water market.

The Trust also continues to benefit from investments made over the last few years in energy efficiency initiatives. Electricity consumption has gone down by 3.5 per cent and gas consumption has been reduced by an impressive 8.05 per cent compared with 2012/13.

Waste

As a result of the focus on expanding the non-infectious clinical waste stream in 2012/13, the Trust won gold in the prestigious Green Apple Awards for Carbon Reduction (NHS Sector) in 2013/14. Working in partnership with the waste management provider Grundon, the Trust has dramatically reduced its carbon footprint for waste.

The continuing use of this waste stream as a fuel to generate electricity for the national grid has further reduced Trust waste-related carbon emissions by nearly 16,000kg CO_2 in 2013/14. This means the Trust is now sending 47 per cent of its waste for energy recovery and only one per cent straight to landfill.

The Trust reduced the amount of plastic containers used to dispose of its specialist clinical waste streams by changing to cardboard based products where possible. This has saved 1,626kg of CO_2 emissions during 2013/14.

The focus for 2014/15 is encouraging staff to re-home unwanted items to promote and increase re-use as well as recycling.

Travel and transport

In May 2013, the Trust launched iMove – a programme to help give access to facilities, events, support and advice to help all of its staff feel fit, healthy and happy. Attempting to build on the legacy of the London 2012 Olympic Games, iMove offers staff discounts both at internal gyms run by Imperial College and with the Trust's gym partners, Better.

iMove builds on the success of previous cycle and pedometer hire schemes run through the estates department. In 2013/14, 86 bikes were loaned to staff and 40 pedometers were loaned out in the first couple of months.

Regular lunchtime walk clubs have proved popular with staff, particularly at St Mary's Hospital, and included a special Christmas walk club in Hyde Park, which helped raise money for the Trust's charity.

Going forward, the programme plans to introduce yoga classes, cross-site team sports tournaments and more advice on mental health, stopping smoking, and alcohol.

Procurement

Amongst other measures, the Trust's standard terms of contract require suppliers to:

- comply with all environmental laws and regulations
- minimise packaging
- label products with required environmental information
- facilitate recovery, treatment and recycling of electronic equipment (if required under specific contracts).

Specific examples of this include the Trust purchasing paper from Premier Paper (through the NHS Supply Chain), which has a high post-consumer waste content, and all furniture being purchased from Crown Commercial Service (CCS) framework agreements which are Forestry Commission certified.

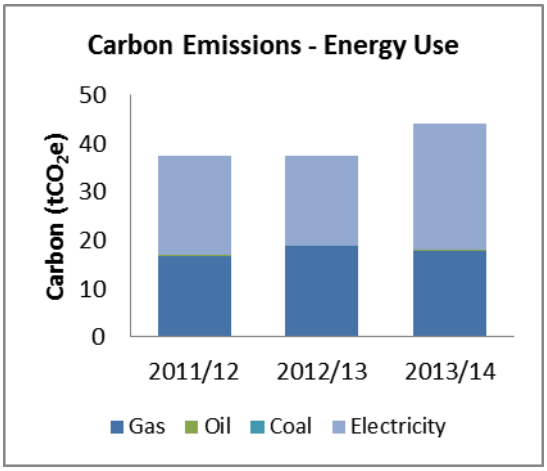
Next steps

As well as taking forward existing measures, in 2014/15 the Trust plans to:

- make use of its building management systems to optimise energy consumption
- re-invigorate energy campaigns, such as turning out lights
- investigate automatic power saving of air conditioning controls
- investigate replacing steam heating at one of the Trust's sites and expanding its medium temperature hot water.

Sustainability data

Resource		2011/12	2012/13	2013/14
Gas	Use (MWh)	82068	91911	84486
	tCO_2e	16.7705958	18.78201285	17.92286004
Oil	Use (MWh)	1135.198	628.156	552.656
	tCO_2e	0.361957882	0.200287541	0.176490694
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (MWh)	52431	48643	46634
	tCO_2e	20.2097052	18.5227845	26.11084294
Total energy CO_2e		37.34225888	37.50508489	44.21019367
Total energy spend		£7,753,399.00	£8,256,469.00	£8,713,133.00



Water		2011/12	2012/13	2013/14
Mains	m^3	461951	450823	406294
	tCO_2e	421	411	370
Water and sewage spend		£556,568	£559,773	£594,380

Greenhouse gas emissions: direct, indirect and official business travel emission

CO_2 emissions (tCO_2e)		2007/08	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
	Total	3,804	4,021	3,811	4,000	3,788	3,588	3,501
Direct	Gas	17	17	17	19	15	17	16
	Oil	199	516	292	276	305	169	149
	Coal	0	0	0	0	0	0	0
	Owned vehicles travel	0	0	0	0	0	0	0
	Leased assets (upstream)	0	0	0	0	0	0	0
	Anaesthetic gases	0	0	0	0	0	0	0
Indirect	Electricity	28	23	25	20	18	18	24
	Imported heat/steam	0	0	0	0	0	0	0
Indirect	Waste and water	414	494	307	372	421	411	370
	Business services							
	Capital spend	0	0	0	0	0	0	0
	Construction							
	Food and catering							
	Freight transport							
	Information and communication technologies							
	Manufactured fuels, chemicals and gases							
	Medical instruments /equipment							
	Other manufactured products							
	Other procurement							
	Paper products							
	Pharmaceuticals							
	Travel	3,101	2,866	3,107	3,254	2,966	2,936	2,907
	Commissioning							
	Energy well to tank and transmission	46	104	63	59	63	38	36

Waste minimisation and management

Category	Description	Units	Scope	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Disposal method	Closed loop or open loop	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
Waste recycling	**Most common factor:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Disposal method	Closed loop or open loop	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
Preparing for re-use	**Most common factor:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Refuse	Organic: food and drink waste	tonnes	3	**6.0**	**6.0**		**6.0**	**6.0**	6.0	6.0
	Organic: garden waste	tonnes	3	**6.0**	**6.0**		**6.0**	**6.0**	6.0	6.0
	Organic: mixed food and garden waste	tonnes	3	**6.0**	**6.0**		**6.0**	**6.0**	6.0	6.0
Composted	**Average:**	**tonnes**	**3**	**6.0**	**6.0**		**6.0**	**6.0**	**6.0**	**6.0**
Electrical Items	WEEE - fridges and freezers	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
	WEEE - large	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
	WEEE - mixed	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
	WEEE - small	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
WEEE	**Average:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Disposal method	Combustion	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
High temperature disposal waste with energy recovery	**Most common factor:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Disposal method	Combustion	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
High temperature disposal waste	**Most common factor:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Disposal method	Unknown	tonnes	3	**21.0**	**21.0**		**21.0**	**21.0**	21.0	21.0
Non burn treatment disposal waste	**Most common factor:**	**tonnes**	**3**	**21.0**	**21.0**		**21.0**	**21.0**	**21.0**	**21.0**
Refuse	Municipal waste	tonnes	3	**289.835514**	**289.835514**		**289.835514**	**289.835514**	289.835514	289.835514
	Commercial and industrial waste	tonnes	3	**199.0**	**199.0**		**199.0**	**199.0**	199.0	199.0
Landfill disposal waste	**Ratio weighted average**	**tonnes**	**3**	**244.4177568**	**244.4177568**		**244.4177568**	**244.4177568**	**244.417757**	**244.417757**

Annual Governance Statement

Imperial College Healthcare NHS Trust
Annual Governance Statement 2013/14

1.0 Scope of responsibility

1.1 As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Imperial College Healthcare NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible in accordance with the responsibilities assigned to me.

1.2 I am also responsible for ensuring that the Trust is administered prudently and economically, and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

2.0 Accountability

2.1 In the delivery of my responsibilities and objectives, I am accountable to the board and my performance is reviewed regularly and formally by the Chairman on behalf of the board. The Trust reports to the Trust Development Authority (TDA) under the auspices of the Accountability Framework.

3.0 The purpose of the system of internal control and governance framework of the organisation

3.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Imperial College Healthcare NHS Trust; to evaluate the likelihood of those risks being realised, and the impact should they be realised; and to manage them efficiently, effectively and economically.

3.2 The system of internal control has been in place at Imperial College Healthcare NHS Trust for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts. In July 2013, the Trust board approved a new risk management strategy and Corporate Governance Framework which established a clear system to enable the Trust board and senior managers to review the corporate governance, risk management and internal control framework, and address any weaknesses identified. The strategy set out the types, levels and sources of assurance and established how assurance tools, such as the Board Assurance Framework, assure the board of the effectiveness of the system of internal control and what is being done to address any weaknesses.

3.3 The system of internal control is underpinned by the existence of a number of individual controls that are in place: senior management/executive review; policies and procedures covering important activities; the Standing Orders; Standing Financial Instructions and Scheme of Delegation; the checks and balances inherent in internal and external audit reviews; and board oversight.

3.4 When the revised Corporate Governance Framework was put in place it was modelled on best practice and the Corporate Governance Code ensuring that appropriate assurance could be provided by the processes in place, including the risk framework, the Board Assurance Framework and the work of the board committees.

4.0 The governance framework of the organisation

4.1 The Trust board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable, through its Chairman, to the TDA and the Secretary of State for Health. Its role is largely supervisory and strategic, and it has six key functions:

- to set strategic direction, define objectives and agree plans for the Trust
- to monitor performance and ensure corrective action
- to ensure financial stewardship
- to ensure high standards of corporate and clinical governance
- to appoint, appraise and remunerate executives
- to ensure dialogue with external bodies and the local community.

4.2 In July 2013, the Trust board approved a proposal to reconfigure the Board Committee structure leading to the establishment of a revised Audit, Risk and Governance Committee (AR&GC), a new Quality Committee and a Finance and Investment Committee. In addition it agreed to the closure of the Governance Committee and the Quality and Safety Committee. Cross membership of the committees enables issues to be discussed and raised across the Committee structure from different perspectives for example discussions around Project Diamond and cost improvement programmes.

4.3 The Trust board therefore now operates with the support of five committees: AR&GC, Finance and Investment Committee, Quality Committee, Foundation Trust Programme Board, and Remunerations and Appointments Committee. These committees have been established on the basis of the following principles:

- the need for committees to strengthen the Trust's overall governance arrangements and support the board in the achievement of the Trust's strategic aims and objectives
- the requirement for a committee structure that strengthens the board's role in strategic decision-making and supports the non-executive directors in scrutiny and challenge of executive management actions
- maximising the value of the input from non-executive directors and providing clarity around their role
- supporting the board in fulfilling its role, given the nature and magnitude of the Trust's wider agenda, to support background development work and to perform scrutiny in more detail than is possible at board meetings.

4.4 **Audit Risk and Governance Committee**

The role of the AR&GC is to provide the Trust board with the assurance that adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively. It oversees the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the board.

The committee reviews the work and findings of external audit and provides a conduit through which their findings can be considered by the board. It also reviews the Trust's annual statutory accounts before they are presented to the Trust board, ensuring that the significance of figures, notes and important changes are understood. The committee maintains oversight of the Trust's counter fraud arrangements. It also provides assurance over the Trust's risk process ensuring that risk is dealt with consistently throughout the organisation, seeking additional assurance and liaising closely with the Financial Investment Committee and Quality Committee where required.

4.5 Over the year, the AR&GC were key to developing the new risk management strategy, have taken a lead role in developing the Corporate Risk Register and have performed deep dives into areas including the implementation of Cerner and junior doctor induction.

4.6 **Finance and Investment Committee**

The role of the Finance and Investment Committee (FIC) is to undertake on behalf of the Trust board thorough and objective reviews of financial policy and financial performance issues, reviewing the risks to the financial position. It advises the Trust board on finance issues and investment strategy, including those relating to the Trust's estate. It reviews the Trust's financial performance and identifies the key issues and risks requiring discussion or decision by the Trust board. It also provides an overview of the development of the Trust's medium- and long-term financial models. It conducts post project implementation reviews of significant projects and considers business cases for approval on behalf of the Trust board, up to a capital value of £5m, or whole-life cost of £5m for Information and Communication Technology (ICT) projects. Proposals that exceed these levels, and are therefore beyond Trust delegated powers, or are considered to have contentious issues, are referred to the Trust board for consideration. Otherwise, the Trust board is informed of decisions as a standing item.

4.7 Over the year, the FIC has scrutinised the process for developing the cost improvement plans and has had detailed discussions on areas of development for the foundation trust application including development of the long-term financial model.

4.8 **Quality Committee,**

The role of the Quality Committee is to obtain assurance that high-quality care is being delivered across the Trust, ensuring that the quality strategy is implemented and continuous improvement evidenced. It has been constructed around the six principles for improvement set out by Donald Berwick: "care that is safe, effective, patient-centred, timely, efficient and equitable", which in turn are the key elements of the quality strategy. It ensures that robust clinical governance structures, systems and processes, including those for clinical risk management and service user safety, are in place across all services and are in line with national, regional and commissioning expectations.

4.9 Since its inception, the Quality Committee has continued to develop its agenda, having looked at: risks that specifically affect the four clinical divisions, cancer patient experience and winter pressures.

4.10 **Remuneration and Appointments Committee**
The role of the Remuneration and Appointments Committee is to act on behalf of the Trust board in relation to the appointment, remuneration, terms of service and performance of the executive directors, and to oversee the process for appointing non-executive directors. It also periodically reviews the structure, size and composition of the Trust board. In determining remuneration policy and packages, the committee has regard to the Trust's overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any relevant guidance from the Treasury.

4.11 The Remuneration and Appointment Committee has looked in detail at remuneration for its executive team and approved the remuneration package for the new chief executive.

4.12 **Foundation Trust Programme Board**
The role of the Foundation Trust Programme Board is to lead and monitor all aspects of the foundation trust programme. It provides leadership and direction to the programme, and assurance to the Trust board in ensuring a successful foundation trust application. In particular, it has looked at the membership strategy and foundation trust public consultation and has developed the constitution that will govern the Trust once it becomes a foundation trust, including the size and composition of the council of governors.

4.13 The table below shows details of the meetings that took place during the year 2013/14.

Committee meeting dates in 2013/14						
Audit and Risk Committee	18.4.13	5.6.13	22.7.13			
Audit, Risk and Governance Committee				4.9.13	11.12.13	12.3.14
Governance Committee	17.4.13	15.5.13				
Quality Committee	11.9.13	8.10.13	13.11.13	5.12.13	12.2.14	6.3.14
Finance and Investment Committee	20.6.13	19.9.13	21.11.13	21.11.13	23.1.14	
Foundation Trust Programme Board	17.4.13	16.5.13	20.6.13	16.7.13	29.8.13	20.9.13
	22.10.13	19.11.13	17.12.13	13.1.14	18.2.14	18.3.14
Remuneration and Appointments Committee	26.6.13	26.2.14				

4.14 All meetings were quorate during the year.

4.15 Following the revised governance structure, all board committees' terms of reference were reviewed and amended.

4.16 The chairs of each of the sub-committees routinely present verbal and, where appropriate, written reports to the board, highlighting key issues and decisions at their meetings. Approved minutes of each sub-committee meeting are also presented at board meetings.

4.17 The board met a total of six times in public in 2013/14: May 2013, July 2013, September 2013, November 2013, January 2014 and March 2014. Throughout the year attendance was monitored and full attendance occurred with the exception of the chief executive having one authorised absence and one absence due to illness, and one non-executive director having one authorised absence. In addition, the board met in seminar session: April 2013, June 2013, October 2013, December 2013 and February 2014 with four authorised absences.

4.18 In-year changes to the membership of the board were as follows:

- Non-executive director designate, Dr Andreas Raffel from 6 June 2013
- Acting chief financial officer, Marcus Thorman from 1 October 2013 to 6 April 2014
- Acting medical director, Professor Chris Harrison from 1 October 2013
- Chief financial officer, Bill Shields until 30 September 2013 and from 7 April 2014
- Medical director, Professor Nick Cheshire until 30 September 2013
- Chief executive, Mark Davies until 30 September 2013
- Acting joint chief executive, Bill Shields from 1 October 2013 to 6 April 2014
- Acting joint chief executive, Professor Nick Cheshire from 1 October 2013 to 6 April 2014
- Chief executive, Tracey Batten from 7 April 2014

4.19 As part of its foundation trust application, the Trust completed a Board Governance Memorandum (BGM) for submission to the TDA in January 2014. This assessment highlighted outcomes of an evaluation of the board's effectiveness which had been carried out by Deloitte to both inform and develop the board's development programme. The BGM highlighted the governance review, which was undertaken to review the effectiveness of the assurance framework, and made various recommendations for change which were approved by the board in July 2013. As part of an action plan to deal with any areas where improvements were required, an ongoing review of the effectiveness, based upon Monitor's Code of Governance, is to take place by the anniversary of the changes.

4.20 In April 2013, all board members were asked to sign a declaration of compliance with the NHS Codes of Conduct, Accountability and Openness, and the Trust has not reported any breach of these codes. The Trust's standing orders were adhered to over the course of the year and no suspensions were recorded. The arrangements in place are sufficient and appropriate to discharge compliance with the board's statutory functions and show that the Trust is legally compliant.

4.21 The board's register of interests was updated throughout the year and is an agenda item at each public board meeting. The register of gifts, hospitality, consultancies, sponsorship and support for travel, education and training covering board members and divisional directors was presented to the board in May 2013. The board is satisfied that there are appropriate and sufficient arrangements in place to show that it complies with the Corporate Governance Code and that any areas of non-compliance are detailed within the Annual Governance Statement.

5.0 Capacity to handle risk

5.1 The Trust implemented a revised risk management strategy in July 2013 which sets out the Trust's philosophy for the management of risk and individual responsibilities and accountabilities in this regard. Operationally, responsibility for the implementation of risk management has been delegated to executive directors as follows, but the accountable officer retains overall responsibility:

- The director of governance and assurance has delegated authority for the risk management framework including training, and is the lead for maintaining the Board Assurance Framework and its supporting processes. The director of governance and assurance is also responsible for the overall performance of corporate governance functions, including monitoring the system of internal control which includes the system and supporting processes for risk registers.
- The chief financial officer has responsibility for financial governance and associated financial risk.
- The medical director and director of nursing have joint responsibility for quality. In addition, the medical director has responsibility for clinical governance, clinical risk, serious incidents, patient safety and effectiveness. The director of nursing has responsibility for patient centredness, equity, nursing and midwifery professional practice, standards, education, and research.
- The chief operating office has responsibility for the executive leadership for the clinical/operational divisions, together with the performance management for the operational services.
- The chief information officer is the Senior Information Risk Owner (SIRO) for the Trust and has responsibility for information governance and data security risks.

5.2 A range of risk management training is available to staff based on the nature of their role and position within the organisation. This includes risk awareness training which is provided to all new staff as part of their corporate induction programme, and risk modules on the senior management training.

5.3 The risk management strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as mechanisms to highlight areas that they believe require improvement.

6.0 Risk assessment

6.1 The risk management strategy sets out an integrated approach to the management of risk across the organisation. The aim is to encourage considered risk taking, including experimentation and innovation within authorised limits, but to reduce those risks that impact on patient and staff safety, and have an adverse effect on the Trust's reputation as well as its financial and operational performance.

6.2 The risk management strategy also defines how risks are linked to one or more of the Trust's objectives. Once the risk has been identified, it is then described, and it is assigned an owner. At this stage, key controls that are to be taken to reduce the likelihood of the risk happening, or reducing its impact, are identified.

6.3 The Trust's risk assessment process covers all of its activities – clinical services, clinical support services and business support functions. Each division and directorate is responsible for maintaining its own risk register in accordance with the procedures described in the risk management strategy. These risk registers are reviewed regularly by directorate and divisional forums, and risks are escalated, where appropriate, for inclusion on the Corporate Risk Register.

6.4 The Board Assurance Framework provides the mechanism for the board to monitor risks, controls and the outputs of its assurances processes. It is monitored by the Trust management and the AR&GC, and is used as a strategic tool to provide assurance that controls are in place and effective. The framework identifies the Trust's strategic objectives and links the risks to achieving those objectives, clearly identifying areas that lack appropriate assurance, and identifies action plans to achieve better control.

6.5 Throughout the year, the Trust has monitored its compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 against the 16 CQC Essential Standards of quality and safety. The Quality and Risk Profile (QRP) tool, which aggregates a wide range of information on each provider of health and social care registered with the CQC, did not highlight any areas of serious concern. The QRP was discontinued in August 2013 and replaced by the Intelligence Monitoring Report. This is a publicly available document and includes a new risk banding score. The Trust is currently banded at level 4, with 1 being high risk and 6 being low risk. This is published approximately every quarter and all elevated and amber risks are followed up with the division or relevant leads. Regular updates on the risk estimates reported within the tool, and the drivers behind any changes, are provided to the Quality Committee.

6.6 In 2013/14, the Trust had four CQC inspections.

6.6.1 A themed mental health inspection was conducted at St Mary's Hospital on 4 July 2013. This inspection focused on domains of care, not the outcomes, and found that staff were knowledgeable and skilled in caring for patients with mental health issues.

6.6.2 A routine unannounced inspection was conducted at St Mary's Hospital on 30 July – 1 August 2013. This inspection looked at the following outcomes:

- Outcome 1 – Respecting and involving people who use services
- Outcome 4 – Care and welfare of people who use services
- Outcome 7 – Safeguarding
- Outcome 8 – Cleaning and infection control
- Outcome 12 – Staffing requirements
- Outcome 14 – Supporting workers
- Outcome16 – Assessing and monitoring the quality of service provision
- Outcome 21 – Records.

The Trust was found to be compliant against all outcomes reviewed, with no specific actions required.

6.6.3 A routine unannounced inspection was undertaken at Western Eye Hospital on 3 October 2013. This inspection looked at the following outcomes:

- Outcome 2 – Consent to care and treatment
- Outcome 4 – Care and welfare of people who use services
- Outcome 13 – Staffing
- Outcome 21 – Records.

The Trust was found to be compliant, without any specific actions requested. It was noted that the A&E department was very busy with limited seating, but that patients reported a positive experience at the hospital.

6.6.4 A national unannounced themed inspection focusing on dementia care was undertaken at Charing Cross Hospital on 22 January 2014. The following outcomes were reviewed in the context of dementia care:

- Outcome 4 – Care and welfare of people who use services
- Outcome 6 – Cooperating with other providers
- Outcome16 – Assessing and monitoring the quality of service provision.

The Trust was found to be compliant with all outcomes, with no specific actions requested.

6.7 All new employees are required to attend corporate induction which includes Information Governance (IG) training using the independently audited Trust Information Governance Training Programme. All temporary staff are required to complete IG training using the Department of Health provided IG training toolkit prior to commencing their assignment in the Trust. All educational institutions that provide students to the Trust for placement are required to ensure their students have received approved IG training prior to commencing their placement with the Trust.

6.8 All employees must undertake annual mandatory IG training. This is provided using the Trust's independently audited online Information Governance Training Programme provided on the Trust intranet. Temporary employees are required to re-fresh Information Governance training on an annual basis. The requirement set by the Department of Health is 95 per cent of staff must undertake approved IG training on an annual basis. The Trust achieved 97.6 per cent compliance with the metric.

6.9 Information security incidents are reported via the Trust's incident reporting system, Datix. From 1 October 2013, incidents were also separately recorded in the Department of Health-provided IG SIRI (Serious Incidents Requiring Investigation) database. This was overseen by the IG team.

Metric	No.
Cumulative number of level 1 IG SIRIs (internally reported) from 1 October 2013	13
Cumulative number of level 2 SIRIs (from 1 April 2013)	0

Summaries of the 13 incidents are set out in the following table:

Date of incident	Breach type	Summary of Incident
26-Jan-14	Lost or stolen hardware	Theft of laptops from pathology and immunology
10-Jan-14	Other	Unauthorised filming by patients of other Trust patients within Trust premises
19-Dec-13	Other	Failure of physical security – removal of door during building works allowing temporary open access to an area containing clinical records
19-Dec-13	Lost or stolen paperwork	Theatre list containing 23 names was found outside the Lindo Wing: Investigating Officer
02-Dec-13	Disclosed in error	Email addressed to a consultant in the Trust was sent instead to a namesake at our academic partner (Imperial College London)
29-Nov-13	Disclosed in error	The patient was sent the medication record of another patient enclosed
27-Nov-13	Disclosed in error	A list containing the personal identifiable information and brief clinical information was sent to a patient in error
26-Nov-13	Disclosed in error	Letters of 65 children who attend the A&E Department at St Mary's in November were sent by post to Brent CCG. The letters were sent en masse instead of being individually addressed to the appropriate recipient
25-Nov-13	Lost or stolen hardware	Three Trust laptops were stolen from the E6 Charing Cross chemotherapy day care unit
14-Nov-13	Other	A member of the clinical team took photocopies of the records of two patients and removed them from the ward to her home without any authorisation
11-Nov-13	Disclosed in error	Envelopes filled with incorrect information (RIS/PACS)
21-Oct-13	Corruption or inability to recover electronic data	Numerous PICU staff payslips found abandoned in the car park (Acrow) at St Mary's Hospital
27-Sep-13	Disclosed in error	Five pages of the dialysis diary containing the personal identifiable information of 28 patients was enclosed in an envelope in error and posted to a patient as part of a complaint response

Incidents are reviewed by the Information Security Committee and, where appropriate, referred to the Caldicott and Clinical Records Committee or discussed for consideration for addition to the ICT Risk Register. The Caldicott Guardian is provided with a weekly update of incidents which will also be reported in the Information Governance Annual Report. No incidents were reported to the Information Commissioner.

6.10 The Trust's IG assessment report overall score for 2013/14 was 72 per cent and was graded 'satisfactory'. This maintains the 'satisfactory' rating achieved last year. The IG Toolkit return was subject to an independent audit that was undertaken in two stages, firstly in October 2013 to review the IG interim return, and finally in March 2014 to independently audit the final annual submission. The outcome of the audit was substantial assurance.

7.0 The risk and control framework

7.1 Risk management is embedded within the organisation in a variety of ways. All staff have a duty to report on incidents, hazards, complaints and near misses in accordance with the relevant policies. During the course of the year, the Trust upgraded the Datix web-based incident reporting system which will provide staff with a simpler method for reporting incidents in real time. It is expected that this will lead to a rise in the number of incidents reported, providing all staff with more learning opportunities. It will also enable the Trust to better link incidents to complaints, claims, locations, service groups etc, thereby enabling it to profile and identify trends effectively reducing potential risk areas. Following an internal re-structure, the Trust has four patient safety managers who lead complaint management in each of the four clinical divisions, strengthening the links between complaints and the Patient Advice and Liaison Service (PALS), claims and incidents, but also enables better integration with the work on serious incidents (SIs) to help ensure that the Trust continues to place the patient at the centre of everything that it does. The Trust is now in the process of reviewing the Corporate Risk Register with a view to ensuring that it is more strategic and all-encompassing.

7.2 The rate of identification of externally reportable SIs increased after the Medical Director's incident review panel commenced in 2013/14, with a total of 135 SIs reported in 2013/14, compared with 74 in 2012/13.The trend in reporting is being monitored through the appropriate governance structure.

7.3 The top five themes from reported SIs in 2013/14 are:

- pressure ulcers (Grade 3 and above)
- maternity services
- delayed diagnosis
- unexpected death
- sub-optimal care of the deteriorating patient.

These five themes will be the key priority areas of the Trust's safety improvement programme for 2014/15. This will build on the work already underway, for example the pressure ulcer improvement strategy which the director of nursing is implementing. An action plan is implemented following each investigated SI to prevent issues re-occurring and to improve awareness. These actions will be audited as part of the clinical audit plan for 2014/15 to ensure compliance.

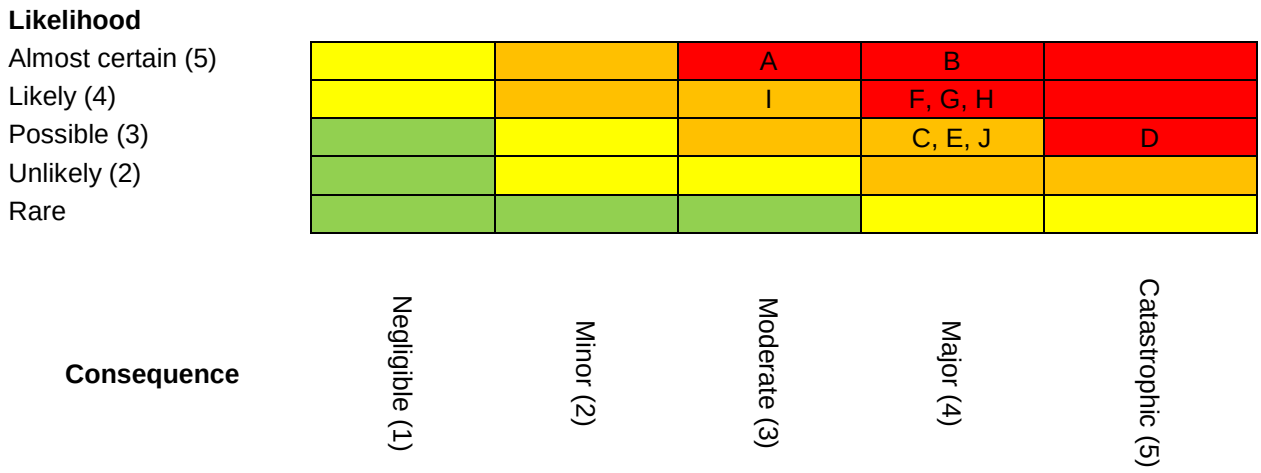
Never Events are a subset of SIs and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. The Trust works to the definitions in the Never Events list 2013/14 update published by NHS England.

One incident has occurred in the last 12 months which met the criteria and was reported as a Never Event. This was categorised as wrong site surgery. A second case has been reported as a Never Event and was under investigation at the time of writing this statement. The Trust anticipates this case will be downgraded from a Never Event to a serious incident as the patient did not experience long-term harm (Never Event definition). This case was a misplaced nasogastric tube.

The Trust is also investigating two incidents where packs deliberately left in place to prevent further bleeding after suturing of childbirth tears were not removed before the patients went home. These events do not appear to meet the national criteria for Never Events, but are being investigated as serious incidents.

Action plans following Never Events are monitored by the medical director until they are evidenced to be delivered. The action plan is not closed with the commissioners until the Trust has provided assurance that all actions have been implemented.

7.4 As at 31 March 2014, the Trust's risk profile was:



No	Description	Risk history
A	Failure to maintain operational performance	Ongoing
B	Increased potential for healthcare associated infections	Ongoing
C	Failure to successfully implement the new electronic patient record system (Cerner)	Ongoing
D	Failure to deliver Cost Improvement Programmes (CIPs)*	Ongoing
E	Inability to achieve Shaping a Healthier Future activity changes due to failure to deliver associated estate change	New
F	Insufficient historic and current investment in the estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably	New
G	Paediatric Intensive Care Unit (PICU) risk to patient – transmission of a multi-drug resistant infection between patients resulting in colonisation from VIM-resistant pseudomonas isolated on PICU, which carries up to 75 per cent mortality with bacteraemia	New
H	Insufficient level 2 beds on the Hammersmith Hospital site.	New
I	Potentially poor reported patient experience via 2014 National Cancer Patient Experience Survey	Future
J	Failure to achieve corporate objectives for medical education	Future

NB The risks set out above relate to the high-level risk description and need to be read in conjunction with the Corporate Risk Register presented to the March 2014 Trust board, which is available on the Trust's website.
**Consequence scoring is now reduced to a major consequence.*

7.5 The Trust has retained its Level 3 accreditation status against the NHSLA Risk Management Standards for Trusts.

7.6 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with

the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

7.7 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met with updated objectives forming part of the Trust's Equality Delivery Scheme for 2012–16. A stakeholder Equality Delivery System grading event took place in December 2013 and reviewed three service-focused outcomes. These outcomes and the applied grading were:

- Safety – developing
- Patient experience – developing
- Complaints – achieving.

In addition, the Trust has recently appointed an inclusion and vulnerability lead to oversee equality, diversity and human rights legislation.

7.8 Control measures are in place to ensure that patients, the public and staff with physical and sensory impairments are able to access buildings on all the Trust's sites. All new estates schemes, as well as refurbishments or ad hoc improvements, are assessed to ensure that they meet the requirements of the Disability Discrimination Act (DDA) as far as practically possible. Issues identified through patient feedback, complaints or PALS contacts are used to inform priorities for estates improvements, alongside periodic DDA surveys. These priorities are reinforced through the PLACE (Patient-Led Assessment of the Care Environment) steering group, which reports to the Patient Centredness Board. The generic Trust-wide investment criteria include patient safety and quality of experience as factors in prioritising expenditure.

7.9 The Trust has reviewed, and continues to monitor, the systems in place to care for people with learning disabilities. One of the requirements of Monitor's Compliance Framework is that trusts are compliant with the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in *Healthcare for All* (Department of Health, 2008). In addition, the Trust has recently appointed an inclusion and vulnerability lead to oversee the care received by people with learning disabilities.

7.10 The Trust has undertaken risk assessments and a carbon management plan is in place to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

8.0 Review of economy, efficiency and effectiveness of the use of resources

8.1 The Trust has well-developed systems and processes for managing its resources. The annual budget setting process for 2013/14 was approved by the board before the start of the financial year and was communicated to all managers in the organisation. The chief financial officer and his team have worked closely with divisional and corporate managers throughout the year to ensure that a robust annual budget was prepared and delivered. In 2013/14, the Trust achieved 95 per cent of its agreed cost improvement programme target and it generated its adjusted retained surplus after impact of impairments and adjustments in respect of donated and government grant asset reserve elimination for the year of £15m.

8.2 Monthly financial and operational performance reports are presented to the performance boards, the Trust management and bi-monthly to the board. The Trust makes use of both internal and external audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits, the internal audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed, such that action plan priorities are agreed with Trust management for implementation. All action plans are monitored and implementation is reviewed regularly and reported to the AR&GC as appropriate.

8.3 The FIC receives and reviews financial performance information and has had detailed discussions about cost improvement plans and the effective use of resources, and will request further information where required.

8.4 As part of their annual audit, the Trust's external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. Their reports setting out the areas of audit focus and their findings from the work undertaken are provided to the AR&GC.

8.5 In addition to routine internal audits, the Trust commissions assurance reviews from internal audit on issues which the Trust has identified as requiring strengthening and performance improvement, or where new arrangements have been implemented. In 2013/14, this included consideration of the robustness of the Gateway review process for the Cerner implementation project.

8.6 Action plans have been agreed to address all internal audit recommendations and the Trust has agreed actions to make the necessary improvements. Ongoing monitoring is in place to ensure identified weaknesses are addressed.

9.0 Annual Quality Report

9.1 The Trust board is required under the Health Act 2009 and the National Health Service (quality accounts) Regulations 2010 to prepare quality accounts for each financial year. Guidance has been issued to trusts on the form and content of the annual quality accounts, which incorporate the above legal requirements and requisite external assurance arrangements.

9.2 The engagement process for 2013/14 has been completed, involving patients, staff and stakeholders in a number of meetings. People were given the opportunity to comment on the format of the accounts and the indicators chosen. The indicators have been agreed at the management board and presented to the Trust board, and the draft report is in progress.

9.3 The Trust met the following quality accounts priorities that were agreed for 2013/14. These were to:

- reduce avoidable harm by ensuring that patients are assessed for a risk of venous thromboembolism (VTE)
- ensure high performance against the NHS Safety Thermometer
- increase awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened and have access to specialist assessments as needed (as measured through the Dementia CQUIN)

- be in the top 10 trusts in the country for below the national average for Standardised Hospital-level Mortality Indicators (SHMI) rates
- improve responsiveness to inpatient needs
- remain above average for staff who would recommend the Trust to friends or family needing care
- achieve the Department of Health (DH) target of 15 per cent response rate for the Family and Friends Test (patient perspective).

9.4 The Trust partially met the following priorities:

- *To reduce healthcare associated infections*
    - The Trust reported 58 *Clostridium difficile* cases during 2013/14 against a limit of 65 as set by the DH.
    - The Trust reported 13 Meticillin resistant Staphylococcus aureus (MRSA) blood stream infections (BSI) during 2013/14, against a zero tolerance target as set by the DH.
    - The Trust has put a number of actions in place to try and reduce the rate of MRSA blood stream infections, including reviewing the Trust policies and screening processes; increasing scrutiny of each case with actions being put in place; increasing its vascular access resources and re-launching the trust-wide vascular access committee.
- *To create a culture of openness and learning through patient safety incident reporting*
    - The Trust has increased the numbers of patient safety incidents that are reported as compared with last year, but did not meet the locally agreed target to be 10 per cent above the national average for reporting patient safety incidents. Over the last year, the Trust has changed how patient safety incidents are reviewed, with the introduction of the weekly incident panel meeting that is chaired by the medical director. This has increased consistency in how the Trust grades incidents.
    - The Trust has recently upgraded the Datix incident reporting system, which will improve the reporting process and ensure staff receive feedback.
- *To have caring and compassionate staff*
    - The Trust achieved the locally agreed indicator for Q1–Q3, but this was not measured in Q4.
    - In order to reflect specific feedback from the Chief Inspector of Hospitals inspections, the Trust reviewed the local patient questionnaire at the end of Q3. In order to maintain a survey of optimum length, a number of existing questions had to be removed, including the one related to this indicator.

9.5 The Trust partially met the locally agreed target for the following priority:

- *To increase compliance with anti-infective prescribing*
    - The Trust has seen improvements in two of the three indicators included in this measurement; however the Trust needs to improve on the documentation of STOP dates. The Trust has increased the frequency of these audits and used a combination of new policies with new technology to support staff to continue to improve against this target.

9.6 The Trust did not meet the locally agreed target for the following priority:

- *To reduce the number of emergency re-admissions to hospital within 28 days of discharge*
    - The Trust almost met this target and is taking the following actions to continue to improve on this target by: working closely with general practitioners and community teams to review patients who have been re-admitted so that specific actions for these patients can be agreed; establishing an older persons assessment clinic to ensure access to rapid ambulatory assessment and planned care; and extending the hours of the discharge team to provide support in the evenings and at weekends.

9.7 The Trust did not report against the outpatient indicator as it was anticipated that this information would be reported from the National Outpatient Survey, but this was not conducted during 2013/14.

9.8 The Trust measures the participation rates for Patient Reported Outcome Measures (PROMs) for hip, hernia, varicose vein and knee surgery. The Trust did not meet the target for this indicator and will focus on improving this by ensuring that each PROM has a clinical lead to regularly review the scores at service level.

9.9 In terms of monitoring, the quality accounts Delivery Group, chaired by Dr Kevin Fox, monitors the quality accounts' indicators each quarter. Regular updates of the Trust's progress against the quality accounts priorities are provided to the Quality Committee via the governance quarterly report and the Trust board. External assurance of aspects of the quality accounts has been provided by the Trust's external auditors.

10.0 Review of effectiveness of risk management and internal control

10.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors, clinical audit, and the executive and divisional directors within the Trust that have responsibility for the development and maintenance of the internal control framework. I have also relied on the content of the Quality Account accompanying this Annual Report and other available performance information. This review is also informed by comments made by the external auditors in their management letter; the head of internal audit opinion and other reports. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Based on the internal audit reviews undertaken in 2013/14 the head of internal audit has provided a significant assurance opinion on the system of internal control in the Trust. In reaching this opinion, particular focus was given to:

- an assessment of the design and operation of the underpinning assurance framework and supporting processes
- an assessment of the range of individual opinions arising from risk-based audit assignments taking account of the relative materiality of these areas and management progress in respect of addressing control weaknesses identified.

10.2 There was a comprehensive handover of the accountable officer responsibilities to me when I took on this responsibility, which was further assisted by the interim accountable officer being in post throughout the period covered by this Governance Statement.

10.3 The year has seen significant changes to the manner in which the Trust manages risk with the development of a new framework for both managing risk but also for providing

assurance to the board that the system is effective. The changes in particular have enabled the Trust to better articulate risk using the tools of cause, effect and impact which allows the Trust to identify commonality amongst risks, thereby enabling it to effect greater change with a bigger impact.

10.4 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the AR&GC, the FIC and the Quality Committee.

10.5 The effectiveness of the system of internal control has been reviewed by the Trust board via its sub-committees and individual management responsibilities at executive and divisional director level. I am satisfied that this Annual Governance Statement describes a system and approach which remained robust for the period from 1 April 2013 to 31 March 2014, and supports preparation of the Annual Accounts on a going concern basis.

10.6 Regular reports have been received from sub-committees or individual senior managers in relation to all of the key risks. Annual reports have been received by the board of directors relating to all important areas of activity and ad hoc reports in-year wherever these were required. Assurance was also obtained from two external reviews carried out during the year:

- The Grant Thornton led review initiated by the Trust in preparation for its application for foundation trust status.
- A Monitor-appointed KPMG review considering foundation trust readiness.

11.0 Significant issues

As identified through the Trust's risk management processes, the significant issues to report and corresponding actions taken to address key risk issues are outlined below:

11.1 Significant issues for 2013/14

11.1.1 Cerner implementation

The Trust has taken a rigorous approach to the management of risk associated with the implementation of the Cerner patient administration system and maternity functionality. This was evidenced by the very thorough testing of the Cerner system that has been undertaken, which identified issues with the workflow used for booking diagnostic tests. This along with challenges with data migration and reporting led to the decision being taken to delay the 'go live' to April 2014. In light of the delay to the 'go live' date, Deloitte performed a review of the procedures to manage the Cerner implementation as part of their procedures to assess value for money. A number of recommendations were identified from this work which the Trust has now implemented.

11.1.2 Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

The Trust has undertaken several actions in response to the Mid Staffordshire NHS Foundation Trust Inquiry Report, which was published in February 2013. Of the 290 recommendations, approximately 20 per cent were considered to be of direct relevance to the Trust and these were captured in an action plan, and assigned to executive and corporate leads. The action plan is now part of a wider integrated quality governance work plan aligned to the principles (safety, effectiveness, patient centredeness, equity, timeliness and efficiency) in the Trust's quality strategy 'QG15'.

All of the actions have either been completed or are now part of a work plan for each QG15 principle.

The Trust board has received an update on progress against the actions at its meetings in March, July and November 2013. An annual report summarising progress against the Mid Staffordshire NHS Foundation Trust Inquiry (2013) recommendations and actions will be presented to the Trust board in May 2014.

11.1.3 Engaging with new commissioners

Commissioning across England fundamentally changed in April 2013 to a GP-led model configured in clinical commissioning groups (CCGs), which replaced primary care trusts (PCTs). The Trust has sought to regularise and strengthen its relationships with its new commissioners to ensure consistency and quality of its engagement with them. The Trust has appointed a substantive director of strategy with responsibility for developing these relationships, in terms of supporting the wider health economy in the delivery of system-wide reform and ensuring that the Trust is recognised as a system-wide enabler for the delivery of sustainable, high-quality healthcare in acute and out of hospital settings.

11.1.4 Cost improvement plans

During 2013/14, the Trust introduced a revised process for quality assuring and managing the quality impact assessments (QIA) for cost improvement programmes (CIP) as under delivery could affect the financial plan for the Trust. All CIP QIAs are captured in a bespoke electronic system (StratPro). The medical director and director of nursing undertake a review of the CIP QIAs with each division/area (on a regular basis) to ensure that the impact on quality has been robustly considered and any risks identified have been mitigated. The review also considers the ongoing monitoring of QIAs post-implementation of a scheme. Where an adverse impact has been identified and it is felt the risk to quality is too high, schemes have not been implemented. Outputs from the reviews are formally reported to the Quality Committee and to the Trust board through the director of nursing's report. An annual summary report will be presented to the Trust board in May 2014.

The Trust delivered £45.8m of CIP in 2013/14 or 93 per cent of the target for the year. The under-recovery on CIP was offset by additional income, meaning the Trust achieved its financial plan target and generated its adjusted retained surplus after impact of impairments and adjustments in respect of donated and government grant asset reserve elimination of £15m surplus. The main area of under-recovery was the medicine division, although all divisions had a slow start to the year due to the reconfiguration of the operational management from clinical programme groups to the divisional structure.

11.2 Significant issues for 2014/15

11.2.1 Cerner implementation

The Trust took the Cerner patient administration system and maternity functionality into live operation in April 2014. With the implementation of a new patient administration system there is a risk to data quality as users adjust to a new system and new workflows. This can impact on patient safety and income recovery. The Trust has a well-developed risk mitigation plan which has involved ensuring that a very high percentage of staff have been trained; have available a wide range of support materials including standard operating procedures, quick reference guides and crib sheets; and are supported through a network of Cerner champions and floorwalkers. In addition to

this, a wide range of data quality performance indicators have been produced and are being actively managed to ensure that data quality is maintained.

11.2.2 Estates maintenance

The condition and age of some of the facilities that the Trust runs its patient services from continues to be a risk and is clearly articulated on the corporate risk register. Within the confines of a reduced capital programme, the Trust will focus the delivery of a multi-million pound package of works throughout the year to support frontline services. This will range from infection control works at ward level to engineering solutions to ensure safe and appropriate conditions within the theatre suites. From detailed work on risk profiling and improved management information systems, the Trust will also ensure that the budget deployed on estate maintenance has the greatest possible impact on operational risk, as well as ensuring that patient satisfaction and quality of experience are maintained as high as possible in the general appearance of the Trust's hospitals.

11.2.3 Shaping a Healthier Future

Following on from the Independent Review Panel (IRP) decision in October 2013, some elements of service change within Shaping a Healthier Future (SaHF) were called for implementation without undue delay. For the Trust this is the closure of emergency services at the Hammersmith Hospital site, which are to be replaced by a 24/7 Urgent Care Centre that will provide more appropriate care for patients presenting to that unit; this will be supported within the health economy, with A&E services continuing to be provided at St Mary's for self-presenting and ambulance attendances and it is expected that some patients will choose to go to other units, primarily The North West London Hospitals NHS Trust. The Trust is working with health partners to finalise the design of these services with plans to take them into operational use ahead of winter 2014.

Significant for the coming year will be the completion of the outline business case for the Trust's investments in its infrastructure to remodel its buildings and its workforce to reflect the challenges of the SaHF public consultation. This will represent a significant investment by the Trust and will require all aspects of the north west London health and social care economy to work as a single community in order to deliver what will be one of the most fundamental changes to the delivery of healthcare in a generation. If approved by the Trust board, work will take place to produce the full business case.

Supporting the changes within SaHF, north west London also gained pioneer status during 2013/14 as one of 14 pioneers across the country looking at true 'whole systems integration', bringing health and social care together, trialling capitated budgets and working in truly patient-centric ways. This work will be an extremely exciting area for the coming year and the Trust's clinicians are fully engaged as the Trust seeks to support the very best innovative models of care.

11.2.4 Financial issues – Project Diamond and CIPs

Alongside the other members of the Project Diamond cohort of trusts, the Trust, over the last three years, received funding from NHS London and the Department of Health. This funding was specifically to cover the additional costs for more complex patients over and above that derived from the average tariff.

Historically, the Trust has received two streams of Project Diamond funding. For 2013/14 this amounted to:

- market forces factor on research and development to the value of £10.1m
- a second income stream for the higher acuity work of £7.7m.

Ownership of the Project Diamond funding steam has now moved to NHS England and the National Institute for Health Records (NIHR) and, whilst it has honoured the allocation of funds for 2013/14, the NIHR have made it clear that the second stream of funding will not be available in 2014/15. In addition, NHS England has stated their funding needs to be agreed on a local basis. Both of these issues were notified after plans for 2014/15 had been initially set and the Trust has had no ability to prepare for this reduction in income. The Project Diamond group of trusts has strongly opposed this decision and has held several meetings with senior members of both funding organisations in order to resolve the issue. However, to date, this has not been resolved and therefore remains a significant issue for 2014/15.

As in 2013/14 achievement of the CIPs is key to delivering a successful financial plan. Each of the divisions and non-clinical directorates has put forward their plans for 2014/15 and these will be monitored through the StratPro online tool. Ongoing reporting of delivery will be managed through the governance structure of the Trust to the board.

11.2.5 National Cancer Patient Experience Survey (NCPES)

In the 2013 NCPES the Trust performed poorly when benchmarked against other Trusts. The Trust scored 69/100 overall, compared with the national average of 76/100. Much focused work has begun to improve patient experience in cancer care at the Trust and the national annual survey is being repeated quarterly along with Trust wide implementation of the Friends and Family Test (FFT). The Trust has seen small improvements in the national survey score undertaken quarterly and improving FFT scores. Performance on cancer waiting times has improved and each tumour group is redesigning pathways to reduce duplication and improve experience. In May 2014, the Trust will launch the SMILE campaign, which focuses on aspects of care that patients say will make a big difference to their experience. The Trust has built an excellent partnership with Macmillan Cancer Support, who are supporting a number of programmes of improvement. The Trust has established a cancer steering board chaired by the medical director to oversee the improvement plans. It is anticipated that these improvements will have a positive impact on the patient's experience of care. The patient sample for the 2014 survey was taken in the autumn of 2013, so the changes may not have taken effect for the 2014 results.

11.2.6 Medical education

The Trust has recently received the results of an external review of its postgraduate medical education. This, together with the results of General Medical Council (GMC) surveys of postgraduate medical trainees and local surveys of undergraduate medical students, confirm that improvements are needed to address concerns about the outcomes of training and about bullying and undermining of trainees. In addition to an ongoing project to address bullying supported by Health Education North West London, the Trust is reviewing how medical education is reflected in consultant job plans to ensure that trainers have sufficient support and training, changing the leadership model for medical education under the direction of the medical director, and bringing about greater individual accountability for education through job plans and appraisals. The board will be receiving regular updates on progress, with further detailed scrutiny through the quality and audit, risk and governance committees.

11.2.7 Management of Infection Prevention and Control (IP&C)

A significant issue for the Trust is increased potential for healthcare associated infections (HCAI). The Trust has had a case of MRSA blood stream infection allocated to it since 1 April 2014. The aim and external expectation is for zero MRSA blood stream infections. The provision of appropriate patient pathways with patient isolation is a key component in preventing infection transmission and acquisition. It is also necessary to address the increasing challenges of antimicrobial resistance and its spread. The demand for isolation capacity is increasing, yet the current estate is limiting.

The Trust has a corporate, multidisciplinary IP&C service, which is now an integral component of the medical director's Directorate. It is underpinned by an active hospital epidemiology programme and extensive use of data for surveillance, feedback and quality improvement. An annual programme of activities for IP&C and associated action plans is in place and is monitored by the Trust and management boards. The divisional governance structures have IP&C central to their quality agenda and provide progress on actions to performance review meetings and Trust-level committees. Antibiotic stewardship is also a key activity within the IP&C programme, to address the increasing threat of antimicrobial resistance, minimise risks associated with antibiotic exposure and to optimise the treatment and management of infection. Some core, cross-divisional committees have been redefined to ensure strong engagement with senior clinicians, and to drive some Trust-wide quality improvement and patient safety initiatives, there are also senior clinical IP&C leaders in each division. The applied research in IP&C at the Trust and the integrated working model with the service will continue to benefit patients and will be enhanced next year with further NIHR funding, closer working with patient groups and with primary care, and as issues are increasingly considered from a whole healthcare economy perspective. The business planning rounds for 2014/15 contain a number of proposed developments to support and resource important quality improvement strategies. Capital development work will also continue to acknowledge the Trust's ongoing commitment to minimising the risk associated with its estate.

12.0 Conclusion

12.1 Subject to the matters outlined in this statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives, and that those control issues have been, or are being, addressed.

Signed 

Dr Tracey Batten, Chief Executive **Date: 3 June 2014**

Directors' report

The Trust was set up by its Establishment Order No 2755 dated 2007 as a National Health Service Trust for the purposes of Section 25(a) of the National Health Service Act 2006. The accounts direction under which the Trust is reporting is the NHS Act 2006 and Accounts Direction as issued by the Department of Health.

Details of directors and board members

Board members

The Trust board is responsible for setting the strategic direction of the organisation.

The board met a total of six times in public in 2013/14: May 2013, July 2013, September 2013, November 2013, January 2014 and March 2014.

Chairman: Sir Richard Sykes
Non-executive director and vice-chairman: Sir Thomas Legg
Non-executive director: Sir Gerald Acher
Non-executive director: Dr Rodney Eastwood
Non-executive director: Jeremy Isaacs
Non-executive director: Professor Sir Anthony Newman Taylor
Non-executive director: Sarika Patel
Non-executive director designate: Dr Andreas Raffel (from 6 June 2013)
Chief executive officer: Mark Davies (until 30 September 2013)
Acting joint chief executive officer: Bill Shields (from 1 October 2013)
Acting joint chief executive officer: Professor Nick Cheshire (from 1 October 2013)
Chief financial officer: Bill Shields (until 30 September 2013)
Chief financial officer: Marcus Thorman (from 1 October 2013)
Chief operating officer: Steve McManus
Medical director: Professor Nick Cheshire (until 30 September 2013)
Acting medical director: Professor Chris Harrison (from 1 October 2013)
Director of nursing: Professor Janice Sigsworth

Audit and Risk Committee and Audit, Risk and Governance Committee membership

Following a review of the corporate governance structure, the Audit and Risk Committee became the Audit, Risk and Governance Committee with the role to provide the Trust board with the assurance that adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively.

The Audit and Risk Committee met three times in 2013/14: April 2013, June 2013 and July 2013. The Audit, Risk and Governance Committee met three times: September 2013, December 2013 and March 2014.

The following non-executive directors were members of the Audit and Risk Committee during this period.

Non-executive director and chair: Sir Gerald Acher
Non-executive director and vice-chairman: Sir Thomas Legg
Non-executive director: Professor Sir Anthony Newman Taylor
Non-executive director: Sarika Patel

The following non-executive directors were members of the Audit, Risk and Governance Committee during this period.

Non-executive director and chair: Sir Gerald Acher
Non-executive director and vice-chairman: Sir Thomas Legg
Non-executive director: Professor Sir Anthony Newman Taylor
Non-executive director: Sarika Patel
Non-executive director designate: Dr Andreas Raffel

Others are/can be invited throughout the year, such as the medical director, director of nursing, director of information and communication technology (ICT), and local counter fraud specialist (who is a regular attendee).

Finance and Investment Committee

Non-executive director: Sarika Patel (Chair)
Non-executive director: Jeremy Isaacs
Non-executive director: Dr Andreas Raffel

Foundation trust programme board

Non-executive director: Dr Rodney Eastwood (Chairman)
Non-executive director: Sir Thomas Legg
Non-executive director: Professor Sir Anthony Newman Taylor

Quality Committee

Non-executive director: Professor Sir Anthony Newman Taylor (Chair)
Non-executive director: Sir Thomas Legg
Non-executive director: Dr Rodney Eastwood
Non-executive director: Sir Gerald Acher

Remuneration and Appointments Committee

The Remuneration and Appointments Committee determines whether the criteria for performance payment have been met. It met twice, on 20 June 2013 and 26 February 2014.

The following non-executive directors have acted as members of the remuneration committee:

Non-executive director: Jeremy Isaacs (chair)
Non-executive director: Sir Thomas Legg
Non-executive chairman: Sir Richard Sykes

Executive and clinical division directors

The executive team and the executive board members manage the Trust and are responsible for its performance.

Chief executive officer: Mark Davies (until 30 September 2013)
Acting joint chief executive: Bill Shields (from 1 October 2013)
Acting joint chief executive: Professor Nick Cheshire (from 1 October 2013)
Chief financial officer: Bill Shields (until 30 September 2013)
Chief financial officer: Marcus Thorman (from 1October 2013)
Chief information officer: Kevin Jarrold
Chief operating officer: Steve McManus
Acting director of communications: John Underwood (until 23 February 2014)
Director of communications: Michelle Dixon (from 24 February 2014)
Director of governance and corporate affairs: Cheryl Plumridge (from 1 July 2013)
Director of infection prevention and control: Professor Alison Holmes
Director of nursing: Professor Janice Sigsworth
Director of people and organisation development: Jayne Mee (from 1 March 2013)
Director of strategy: Ian Garlington (from September 2013)
Medical director: Professor Nick Cheshire (until 30 September 2013)
Acting medical director: Professor Chris Harrison (from 1 October 2013)
Divisional director medicine: Professor Tim Orchard
Divisional director surgery and cancer: Professor Jamil Mayet
Divisional director women's and children's: Mr TG Teoh
Divisional director investigative sciences and clinical support: Dr Julian Redhead

Register of interests: March 2014

Chairman: Sir Richard Sykes

Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
Chairman, UK Stem Cell Foundation since 2004
Member, Bristol Advisory Council since 2006
President, Institute for Employment Studies since 2008
Chairman, Careers Research Advisory Centre since 2008
Non-Executive Chairman of NetScientific
Non-Executive Director of ContraFect since 2012
Chairman of Royal Institution of Great Britain
Chancellor Brunel University

Senior independent director: Sir Thomas Legg

Imperial College Healthcare Trust Charity Trustee

Non-executive director: Sir Gerald Acher

Deputy Chairman, Camelot Group Plc
Vice Chairman, Motability
Trustee, Motability 10 Anniversary Trust

Chairman, Littlefox Communications Ltd

Non-executive director: Dr Rodney Eastwood

- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy (secondary school)
- Consultant, Mazars
- Trustee of the London School of ESCP Europe (a pan-European Business School)
- Member of the Editorial Advisory Board of HE publication

Non-executive director: Jeremy Isaacs

- Director, JRJ Group Limited
- Director, JRJ Jersey Limited
- Director, JRJ Investments Limited
- Director, JRJ Team General Partner Limited
- Director, Food Freshness Technology Holdings Ltd
- Director, Kytos Limited
- Director, Support Trustee Ltd
- Director/Non-executive Director Chairman, Marex Spectron Group Limited
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust

Non-executive director: Professor Sir Anthony Newman Taylor

- Chairman, Colt Foundation
- Trustee, Rayne Foundation
- Chairman, Independent Medical Expert Group, Armed Forces Compensation Scheme, Ministry of Defence
- Member, Bevan Commission, Advisory Group to Minister of Health, Wales
- Trustee, CORDA, Preventing Heart Disease and Stroke
- Rector's Envoy for Health, Imperial College
- Head of Research and Development, National Heart and Lung institute (NHLI)
- Member Advisory Board, Royal British Legion Centre for Blast Injury Studies (CBIS), Imperial College

Non-executive director: Sarika Patel

- Board, Centrepoint
- Board, Royal Institution of Great Britain
- Partner, Zeus Capital
- Board, London General Surgery
- Board, 2020 Imaging Ltd

Designate non-executive director: Dr Andreas Raffel

- Executive Vice Chairman, Rothschild
- Member, Council of Cranfield University
- Trustee, Beyond Food Foundation
- Member, International Advisory Board of Cranfield School of Management

Chief executive: Professor Nick Cheshire

- Hansen Medical, Scientific advisory board member (Endovascular Robotics programme)
- Hansen Medical, Department level research support
- Member of Medical Directors Advisory Group, McKinsey Company
- Medtronic Inc, Scientific advisory board member (Branch AAA stent programme), Institution level grant support
- Shareholder (0.5 per cent), Veryan Medical (IC spin out)
- Member of TOPIC Selection Committee, National Institute for Health and Care Excellence
- Cook (UK) Speakers Bureau
- Member, Organising Committee of the Multidisciplinary European Endovascular Therapies Conference (MEET) Rome, Italy
- Member, Scientific Advisory Committee of the Controversies and Updates in Vascular Surgery (CACVS) conference, Paris, France
- Organiser and speaker, Medtronic University course
- Gore Company, Consulting agreement for advanced endovascular therapies

Cook, Medtronic and Gore are endovascular equipment suppliers to the Trust. Hansen Medical manufactures the only commercially available endovascular robot and supplies hardware and disposable robotic equipment to the Trust.

Mark Davies, chief executive

- Wife is managing director and owner of Redlands Equestrian Ltd and works as a freelance consultant for the NHS
- Director of Shelford Health Roundtable (Shelford Group)

Chief Executive: Bill Shields

- Honorary Colonel, 243 (Wessex) TA Field Hospital
- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Board member, NHS Shared Business Services

Medical director: Professor Chris Harrison

- Non-Executive Director, CoFilmic Limited
- Director, RSChime Limited
- Vice Chair, London Clinical Senate Council

Chief operating officer: Steve McManus

- Chair, National Neurosciences Managers Forum
- Chair of governors, Tackley Primary School

Director of nursing: Professor Janice Sigsworth

- Honorary professional appointments at King's College London, Bucks New University and Middlesex University
- Trustee of the Foundation of Nursing Studies

Chief Financial Officer: Marcus Thorman

- Nil

Additional disclosures

Charges for information

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

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

Audit information

It is confirmed there is no relevant audit information of which the company is unaware and directors have taken all steps that they ought to as a director to make themselves aware of any relevant audit information and to establish that the company's auditor is aware of the information.

Accountable officer: Dr Tracey Batten

Organisation: Imperial College Healthcare NHS Trust

Signature:  Date: 3 June 2014

Remuneration report

Imperial College Healthcare NHS Trust for 2013/14

Salaries and allowances	Salary	Other remuneration	Bonus payments	Expense payments (taxable)	Exit packages	Pension-related benefits	Total remuneration	Total remuneration excl. pension-related benefits
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(total to nearest £00)		(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
Name	**£000**	**£000**	**£000**	**£00**	**£**	**£000**	**£000**	**£000**
Sir Richard Sykes, Chairman	20 - 25	0	0	0	0	n/a	20 - 25	20 - 25
Sir Thomas Legg, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Jeremy Isaacs, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sir Gerald Archer, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Rodney Eastwood, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Prof Sir Anthony Newman Taylor, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sarika Patel, Non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Andreas Raffel, Associate non-executive director[1]	0 - 5	0	0	0	0	n/a	0 - 5	0 - 5
Mark Davies, Chief executive[2]	140 - 145	80 - 85	0	0	148,200	Left	375 - 380	375 - 380
Bill Shields, Chief financial officer/Chief executive[3]	220 - 225	0	10 - 15	2	0	60 - 62.5	295 - 300	235 - 240
Steve McManus, Chief operating officer	165 - 170	0	0	211	0	180 - 182.5	365 - 370	185 - 190
Prof Nick Cheshire, Medical director/Chief executive[4]	85 - 90	160 - 165	0	0	0	60 - 62.5	310 - 315	250 - 255
Prof Janice Sigsworth, Director of nursing	155 - 160	0	0	0	0	22.5 - 25	180 - 185	155 - 160
Prof Chris Harrison, Medical director[5]	35 - 40	75 - 80	5 - 10	0	0	New board member	115 - 120	115 - 120
Marcus Thorman, Chief financial officer[6]	75 - 80	0	5 - 10	0	0	New board member	85 - 90	85 - 90

Pension benefits	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	Total accrued lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2014	Cash equivalent transfer value at 31 March 2013	Real increase in cash equivalent transfer value
Name	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Sir Richard Sykes, Chairman	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas Legg, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Isaacs, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Gerald Archer, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Rodney Eastwood, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pr Sir Anthony Newman Taylor, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarika Patel, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Andreas Raffel, Associate Non-executive director[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Davies, Chief executive[2]	Left	Left	Left	Left	Left	Left	Left
Bill Shields, Chief financial officer/Chief executive[3]	2.5 - 5	10 - 12.5	60 - 65	180 - 185	1,028	939	89
Steve McManus, Chief operating officer	7.5 - 10	25 - 27.5	50 - 55	160 - 165	910	743	167
Prof Nick Cheshire, Medical director/Chief executive[4]	2.5 - 5	10 - 12.5	50 - 55	155 - 160	1,011	919	92
Prof Janice Sigsworth, Director of nursing	0 - 2.5	5 - 7.5	65 - 70	200 - 205	1,251	1,182	65
Prof Chris Harrison, Medical director[5]	New board member	New board member	50 - 55	160 - 165	1,076	New board member	New board member
Marcus Thorman, Chief financial officer[6]	New board member	New board member	30 - 35	95 - 100	445	New board member	New board member

1 Dr Andreas Raffel joined the board as associate non-executive director on 6 June 2013.
2 Mark Davies left the board on 30 September 2013. Other remuneration represents salary paid for three months after leaving the board.
3 Bill Shields became joint chief executive on 1 October 2013.
4 Professor Nick Cheshire became joint chief executive on 1 October 2013.
5 Professor Chris Harrison joined the board as medical director on 1 October 2013.
6 Marcus Thorman joined the board as chief financial officer on 1 October 2013.

Imperial College Healthcare NHS Trust for 2012/13

Salaries and allowances	Salary	Other remuneration	Bonus payments	Expense payments (taxable)	Exit packages	Pension-related benefits	Total remuneration	Total remuneration excl. pension-related benefits
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(total to nearest £00)		(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
Name	**£000**	**£000**	**£000**	**£00**	**£**	**£000**	**£000**	**£000**
Sir Richard Sykes, Chairman	20-25	0	0	0	0	n/a	20-25	20-25
Sir Thomas Legg, Non-executive director	5-10	0	0	0	0	n/a	5-10	5-10
Jeremy Isaacs, Non-executive director	5-10	0	0	0	0	n/a	5-10	5-10
Ellen Schroder, Non-executive director[1]	0-5	0	0	0	0	n/a	0-5	0-5
The Honorable Angad Paul, Non-executive director[2]	0-5	0	0	0	0	n/a	0-5	0-5
Sir Gerald Archer, Non-executive director[3]	5-10	0	0	0	0	n/a	5-10	5-10
Dr Rodney Eastwood, Non-executive director[4]	5-10	0	0	0	0	n/a	5-10	5-10
Dr Martin Knight, Non-executive director[5]	5-10	0	0	0	0	n/a	5-10	5-10
Prof Sir Anthony Newman Taylor, Non-executive director[6]	0-5	0	0	0	0	n/a	0-5	0-5
Sarika Patel, Non-executive director[7]	0-5	0	0	0	0	n/a	0-5	0-5
Mark Davies, Chief executive	255 - 260	0	0	0	0	Not available	255 - 260	255 - 260
Bill Shields, Chief financial officer	215 - 220	0	0	70	0	0	220 - 225	220 - 225
Steve McManus, Chief operating officer[8]	95 - 100	0	0	104	0	New board member	105 - 110	105 - 110
Prof David Taube, Medical director[9]	35 - 40	40-45	0	0	0	Left	80 - 85	80 - 85
Dr David Mitchell, Medical director[10]	20 - 25	40-45	0	0	0	Left	65 - 70	65 - 70
Prof Nick Cheshire, Medical director[11]	25 - 30	50-55	0	0	0	New board member	80 - 85	80 - 85
Prof Janice Sigsworth, Director of nursing	155 - 160	0	0	0	0	27.5 - 30	185 - 190	155 - 160

Pension benefits	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Total accrued lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real increase in cash equivalent transfer value
Name	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Sir Richard Sykes, Chairman	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas Legg, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Isaacs, Non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ellen Schroder, Non-executive director[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
The Honorable Angad Paul, Non-executive director[2]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Gerald Archer, Non-executive director[3]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Rodney Eastwood, Non-executive director[4]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Martin Knight, Non-executive director[5]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Prof Sir Anthony Newman Taylor, Non-executive director[6]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarika Patel, Non-executive director[7]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Davies, Chief executive	Not available	Not available	85-90	265-270	1,812	Not available	Not available
Bill Shields, Chief financial officer	(2.5-5)	(12.5-15)	55-60	165-170	939	985	(46)
Steve McManus, Chief operating officer[8]	New board member	New board member	45-50	135-140	743	New board member	New board member
Prof David Taube, Medical director[9]	Left	Left	Left	Left	Left	Left	Left
Dr David Mitchell, Medical director[10]	Left	Left	Left	Left	Left	Left	Left
Prof Nick Cheshire, Medical director[11]	New board member	New board member	45-50	145-150	919	New board member	New board member
Prof Janice Sigsworth, Director of nursing	0-2.5	5-7.5	65-70	195-200	1,182	1,114	68

1 Ellen Schroder left the board on 30 April 2012.
2 The Honorable Angad Paul left the board on 30 September 2012.
3 Sir Gerald Archer joined the board on 1 April 2012.
4 Dr Rodney Eastwood joined the board on 1 April 2012.
5 Dr Martin Knight joined the board on 1 April 2012 and left the board on 1 March 2013.
6 Professor Sir Anthony Newman Taylor joined the board on 1 October 2012.
7 Sarika Patel joined the board on 1 January 2013.
8 Steve McManus joined the board on 20 August 2012.
9 Professor David Taube left the board on 31 August 2012.
10 Dr David Mitchell joined the board on 1 September 2012 and left the board on 30 November 2012.
11 Professor Nick Cheshire joined the board on 1 December 2012.

Median pay

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director of the Trust in the financial year 2013/14 was £252,500 (2012/13 – £257,500). This was 7.33 times (2012/13 – 6.72) the median remuneration of the workforce, which was £34,430 (2012/13 – £38,320).

In 2013-14, one (2012/13 – 1) employee received remuneration in excess of the highest paid director. Remuneration was £261,924 (2012/13 – £260,765).

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.

Financial summary

Chief Financial Officer's review

The Trust has once again successfully met the key income and expenditure targets. The table below summarises the Trust's performance against its key financial duties as required by the Department of Health (DH). The Trust achieved a surplus of £15.1m (after adjusting for impairments and donated assets) and delivered savings of £45.8m, demonstrating the continued financial improvement made. This needs to be sustained to deliver the long-term financial plan.

Delivery of the Cost Improvement Programme (CIP) was challenging and, although the Trust did deliver £45.8m of savings in the full 12 months to 31 March 2014, it fell short of its planned savings target for the year by £3.4m.

Total net capital expenditure for the period was £30.2m, across a variety of schemes. The programme sought to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk, investing in information technology (IT) and improving the patient experience.

Statutory financial duties

Duty	Requirement	Achievement
1. Breakeven duty	To ensure total expenditure does not exceed income	Achieved – surplus of £15.1m
2. External Financing Limit	To remain within the DH borrowing limit	Achieved – cash outflow of £2.1m
3. Capital absorption rate of 3.5%	To pay a dividend of 3.5% to the DH	Achieved
4. Capital Resource Limit (CRL)	To ensure capital expenditure is within the limit set by the DH	Achieved – net spend of £30.2m

Income and expenditure

The Trust's total operating income was £979.3m, compared with £971.2m for the previous year. The Trust received more income from commissioners than planned as activity management plans failed to deliver to the extent anticipated. Consequently, the Trust undertook significant levels of unplanned clinical activity.

The total operating expenditure was £1,081.9m including an impairment of £117.1m and donated asset adjustment of £0.6m. After adjusting for the impairment, overall expenditure has remained constant when compared with the previous year. The Trust has, however, had to manage a range of inflationary and other cost pressures, including national pay awards, incremental drift, pension auto enrolment, costs of new medicines/medical technology, increases in patient transport and implementation of a new patient administration system (Cerner).

In 2013/14, the Trust commissioned independent professional valuers to undertake a valuation of the estate. The revaluation exercise established a robust methodology to inform the valuation of premises for inclusion within the annual accounts. The 2013/14 valuation has resulted in an overall net reduction of £115m in the value of the Trust asset base, including an in-year impairment of £117.1m. This impairment has no cost or cash impact and is excluded from the DH's assessment of the Trust's breakeven duty.

The Trust planned for savings in excess of five per cent of turnover, of which £45.8m were delivered over the year; £3.4m less than planned. These efficiencies were carefully planned and implemented through the Transformation Board, where any potential risks to patient safety and patient experience were rigorously assessed to ensure that no CIP had a detrimental impact on quality. Key themes of the efficiency programme in 2013/14 were: clinical pathway redesign; medicines management; negotiating better prices with suppliers and reviewing supply chain arrangements; exploiting commercial opportunities to increase income; and reducing overheads.

Capital expenditure

The Trust continues to invest in capital infrastructure to help achieve its strategic service objectives. During 2013/14, the Trust invested £30m to modernise its estate, deal with the backlog maintenance issues, purchase new and replacement medical equipment, and upgrade IT equipment and infrastructure. Significant schemes in 2013/14 included:

- Endoscopy suite at St Mary's Hospital (£4.8m)
- Backlog maintenance (£3.7m)
- Medical equipment (£7.9m)
- IT investment (£6.5m)

Liquidity, cash and working capital

The Trust maintained a strong cash position throughout the year and remained within its external financing limit, with a year-end cash position of £50.4m; £10m less than the level anticipated when the cash plan was developed at the start of the financial year. In August, the cash forecast was revised to £50.3m to take into account delays in the receipt of cash due to reorganisation within the NHS and the subsequent delays in agreeing contracts with commissioners. The revised forecast also included additional advance payments to suppliers to obtain discounts greater than the interest yield on investments. Working capital – current assets (excluding cash) less current liabilities – improved by £39.6m, strengthening the Trust's liquidity position.

The financial outlook

The Trust has been able to show it can deliver a strong financial performance in a challenging environment. The expectation is that the demand for health services will continue to increase, but there will be very limited additional resources. There must be continued focus on reducing costs without compromising quality, in addition to the willingness to work with local healthcare partners and commissioners to address changes to service provision to deliver the Quality, Innovation, Productivity and Prevention (QIPP) programme.

The 2014/15 key financial issues and challenges are as follows:

- Impact of changes to national and local tariff – the overall net reduction in tariff is 1.3 per cent.
- Impact of QIPP – the Trust is working with commissioners to introduce clinical care pathway improvements
- Commissioning for Quality and Innovation (CQUIN) – failure to achieve the required contractual operational and quality standards will result in reduction in the contract value agreed with commissioners.
- Delivery of the CIP of £49.2m.
- Planned Project Diamond funding for 2014/15 amounts to £17.2m. Ownership of the Project Diamond funding stream moved to NHS England and the National Institute for Health Research (NIHR) and whilst allocation of funds for 2013/14 has been honoured, there has been no guarantee that funding will be received this year. The Project Diamond group of trusts has held several meetings with senior members of both organisations in an attempt to resolve this issue.
- *Shaping a Healthier Future* – the Trust has worked with local commissioners and the sector provider trusts in developing a business case which will deliver the very best care for patients across north west London. The outline business case is still to be approved and has significant financial challenges for the Trust in future years.
- Capital expenditure – the condition and age of some of the Trust's facilities continues to be a risk. Within the confines of available capital resources, the Trust will focus the delivery of a multi-million pound package of works throughout the year to minimise backlog maintenance risks, support clinical services and invest in IT.
- Cerner implementation – the Trust successfully implemented the Cerner patient administration system in April 2014. A detailed risk mitigation plan has been put in place to ensure a successful deployment and to support the ongoing risk management of the new system as it becomes embedded within the Trust.
- Foundation trust status – the Trust's long-term financial plan is still on track, which will provide the essential financial conditions to enable the Trust to achieve foundation trust status in 2015.

The Trust's primary aim in 2014/15 is to capitalise and build on the financial strength established over the last few years and to continue to meet its objective of being a high performing care provider. The current business model and ways of providing clinical services will be continuously challenged to minimise waste, maximise efficiencies and harness opportunities to ensure a sound and strong financial future.

Independent auditors' statement to the members of Imperial College Healthcare NHS Trust

We have examined the summary financial statements contained within the Strategic Report for the year ended 31 March 2014, which comprise the Summary Statement of Comprehensive Income, the Summary Statement of Financial Position, the Summary Statement of Changes in Taxpayers' Equity, the Summary Statement of Cash Flows and related notes 1 to 9.

The report is made solely to the board of directors ("the boards") of Imperial College Healthcare NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Audit work has been undertaken so that we might state to the boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the boards, as a body, for this report, or for the opinions we have formed.

Respective responsibilities of director and auditor

The directors are responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the Annual Report with the full annual financial statements.

We also read the other information contained in the Annual Report as described in the contents section and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the summary financial statements.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the Trust's full annual financial statements describes the basis of our audit opinion on those financial statements, the Directors' Remuneration Report, the Strategic Report and the Directors' Report.

Opinion

In our opinion the summary financial statements contained within the Annual Report are consistent with the full annual financial statements of the Trust for the year ended 31 March 2014.

Deloitte LLP
St Albans
3 June 2014

Statement of accounts

Statement of comprehensive income for year ended

31 March 2014	NOTE	**2013-14 £000**	2012-13 £000
Gross employee benefits	3	**(526,157)**	(522,485)
Other operating costs	3	**(536,127)**	(466,159)
Revenue from patient care activities	1	**774,430**	752,725
Other operating revenue	2	**204,882**	218,549
Operating deficit		**(82,972)**	(17,370)
Investment revenue		**202**	287
Other gains and (losses)		**(171)**	(13)
Finance costs		**(857)**	(1,791)
Deficit for the financial year		**(83,798)**	(18,887)
Public dividend capital dividends payable		**(18,778)**	(21,068)
Deficit for the year		**(102,576)**	(39,955)

Other comprehensive income	**2013-14 £000**	2012-13 £000
Impairments and reversals taken to the Revaluation Reserve	**(3,545)**	0
Net gain/(loss) on revaluation of property, plant and equipment	**5,929**	31,423
Net gain/(loss) on revaluation of intangibles	**0**	0
Total comprehensive income for the year*	**(100,192)**	(8,532)

Financial performance for the year		
Retained surplus/(deficit) for the year	**(102,576)**	(39,955)
Impairments (excluding IFRIC 12 impairments)	**117,142**	48,379
Adjustments in respect of donated and gov't grant asset reserve elimination	**562**	601
Adjusted retained surplus	**15,128**	9,025

* A trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but is adjusted for impairments to property, plant, equipment and stock as impairments are not considered part of the organisation's operating position.

Statement of financial position as at

31 March 2014	NOTE	**31 March 2014 £000**	31 March 2013 £000
Non-current assets:			
Property, plant and equipment	9	**595,639**	715,616
Intangible assets		**1,413**	1,681
Trade and other receivables		**0**	0
Total non-current assets		**597,052**	717,297
Current assets:			
Inventories		**14,214**	17,652
Trade and other receivables		**96,256**	65,462
Cash and cash equivalents		**50,449**	55,326
Total current assets		**160,919**	138,440
Non-current assets held for sale		**0**	0
Total current assets		**160,919**	138,440
Total assets		**757,971**	855,737
Current liabilities			
Trade and other payables		**(128,280)**	(127,930)
Provisions		**(25,091)**	(37,353)
Borrowings		**(1,475)**	(1,833)
Capital loan from Department		**(1,226)**	(1,226)
Total current liabilities		**(156,072)**	(168,342)
Net current assets/(liabilities)		**4,847**	(29,902)
Non-current assets plus/less net current assets/liabilities		**601,899**	687,395
Non-current liabilities			
Trade and other payables		**0**	0
Provisions		**(17,149)**	0
Borrowings		**(1,113)**	(2,540)
Capital loan from Department		**(19,596)**	(20,822)
Total non-current liabilities		**(37,858)**	(23,362)
Total assets employed:		**564,041**	664,033

FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital (PDC)	**696,288**	696,088
Retained earnings	**(175,475)**	(72,899)
Revaluation reserve	**43,228**	40,844
Total taxpayers' equity:	**564,041**	664,033

Statement of changes in taxpayers' equity for the year ended 31 March 2014

	Public dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2013	**696,088**	**(72,899)**	**40,844**	**664,033**
Changes in taxpayers' equity for 2013-14				
Retained surplus/(deficit) for the year	**0**	**(102,576)**	**0**	**(102,576)**
Net gain/(loss) on revaluation of property, plant and equipment	**0**	**0**	**5,929**	**5,929**
Impairments and reversals	**0**	**0**	**(3,545)**	**(3,545)**
New PDC received – cash	**200**	**0**	**0**	**200**
Net recognised revenue/(expense) for the year	**200**	**(102,576)**	**2,384**	**(99,992)**
Balance at 31 March 2014	**696,288**	**(175,475)**	**43,228**	**564,041**
Balance at 1 April 2012	**694,918**	**(32,944)**	**9,421**	**671,395**
Changes in taxpayers' equity for the year ended 31 March 2013				
Retained surplus/(deficit) for the year	0	(39,955)	0	(39,955)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	31,423	31,423
New PDC received	1,170	0	0	1,170
Net recognised revenue/(expense) for the year	**1,170**	**(39,955)**	**31,423**	**(7,362)**
Balance at 31 March 2013	**696,088**	**(72,899)**	**40,844**	**664,033**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 MARCH 2014	2013-14 £000	2012-13 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating surplus/(deficit)	**(82,972)**	(17,370)
Depreciation and amortisation	**36,346**	37,053
Impairments and reversals	**117,142**	48,379
Donated assets received credited to revenue but non-cash	**(562)**	(80)
Government granted assets received credited to revenue but non-cash	**0**	0
Interest paid	**(859)**	(1,835)
Dividend (paid)/refunded	**(18,317)**	(21,472)
(Increase)/decrease in inventories	**3,438**	(1,385)
(Increase)/decrease in trade and other receivables	**(31,258)**	(10,125)
Increase/(decrease) in trade and other payables	**(618)**	17,854
Provisions utilised	**(3,271)**	(1,223)
Increase/(decrease) in provisions	**8,158**	25,685
Net cash inflow/(outflow) from operating activities	**27,227**	75,481
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**205**	285
(Payments) for property, plant and equipment	**(30,381)**	(20,705)
(Payments) for intangible assets	**(123)**	(1,494)
Proceeds of disposal of assets held for sale (PPE)	**1,006**	3
Proceeds of disposal of assets held for sale (intangible)	**0**	0
Net cash inflow/(outflow) from investing activities	**(29,293)**	(21,911)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(2,066)**	53,570

CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	**200**	1,170
Other loans received	**64**	1,979
Loans repaid to DH – capital investment loans repayment of principal	**(1,226)**	(22,826)
Other loans repaid	**(1,849)**	(1,541)
Capital grants and other capital receipts (excluding donated/government granted cash receipts)	**0**	0
Net cash inflow/(outflow) from financing activities	**(2,811)**	(21,218)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(4,877)**	32,352
Cash and cash equivalents (and bank overdraft) at beginning of the period	**55,326**	22,974
Cash and cash equivalents (and bank overdraft) at year end	**50,449**	55,326

Notes to the summarised financial statements

1. Revenue from patient care activities

	2013-14 £000	2012-13 £000
NHS trusts	**651**	723
NHS England	**299,878**	0
Clinical commissioning groups (CCGs)	**418,367**	0
Primary care trusts	**0**	700,202
Strategic health authorities	**0**	5,746
NHS foundation trusts	**3,881**	4,097
Department of Health	**938**	4,529
NHS other (including Public Health England and Prop Co)	**0**	0
Non-NHS:		
Local authorities	**9,327**	0
Private patients	**34,331**	30,477
Overseas patients (non-reciprocal)	**2,282**	1,802
Injury costs recovery	**1,641**	1,361
Other	**3,134**	3,788
Total revenue from patient care activities	**774,430**	752,725

Injury costs recovery income reflects actual rates of collection.

2. Other operating revenue

	2013-14 £000	2012-13 £000
Recoveries in respect of employee benefits	**6,240**	6,439
Education, training and research	**119,482**	122,743
Charitable and other contributions to revenue expenditure – non-NHS	**68**	29
Receipt of donations for capital acquisitions – NHS charity	**809**	747
Receipt of government grants for capital acquisitions	**26**	42
Non-patient care services to other bodies	**37,512**	33,093
Income generation	**4,427**	6,011
Rental revenue from operating leases	**6,096**	5,593
Other revenue	**30,222**	43,852
Total other operating revenue	**204,882**	218,549
Total operating revenue	**979,312**	971,274

3. Operating expenses	2013-14	2012-13
	£000	£000
Services from other NHS trusts	**8,872**	8,601
Services from CCGs/NHS England	**1,729**	0
Services from other NHS bodies	**313**	872
Services from NHS foundation trusts	**6,639**	6,205
Services from primary care trusts	**0**	2,707
Total services from NHS bodies*	**17,553**	18,385
Purchase of healthcare from non-NHS bodies	**3,497**	2,980
Trust Chair and Non-executive Directors	**66**	64
Supplies and services – clinical	**199,404**	183,421
Supplies and services – general	**37,905**	37,035
Consultancy services	**16,778**	16,212
Establishment	**7,208**	8,042
Transport	**11,692**	9,628
Premises	**39,518**	40,193
Hospitality	**46**	0
Insurance	**578**	0
Legal fees	**188**	0
Impairments and reversals of receivables	**4,633**	553
Inventories write down	**771**	874
Depreciation	**35,955**	36,641
Amortisation	**391**	412
Impairments and reversals of property, plant and equipment	**117,142**	47,505
Audit fees	**261**	231
Other auditor's remuneration	**58**	8
Clinical negligence	**13,251**	12,827
Research and development (excluding staff costs)	**17,235**	16,711
Education and training	**2,000**	2,439
Other	**9,997**	31,998
Total operating expenses (excluding employee benefits)	**536,127**	466,159

Employee benefits		
Employee benefits excluding board members	**524,507**	521,307
Board members	**1,650**	1,178
Total employee benefits	**526,157**	522,485
Total operating expenses	**1,062,284**	988,644

*Services from NHS bodies does not include expenditure which falls into a category below.

Other auditor's remuneration includes £2k for property-related non-audit services; £10k for Cerner implementation non-audit services; and £46k for board and quality governance support non-audit services.

4. Staff numbers	**2013-14**			2012-13
	Total number	**Permanently employed number**	**Other number**	Total number
Average staff numbers				
Medical and dental	**1,717.9**	1,694.3	23.6	1,686
Administration and estates	**2,177.1**	1,861.0	316.1	2,243
Healthcare assistants and other support staff	**1,186.5**	1,169.1	17.4	1,057
Nursing, midwifery and health visiting staff	**3,540.1**	3,469.6	70.5	3,439
Nursing, midwifery and health visiting learners	**0.0**	0.0	0.0	0
Scientific, therapeutic and technical staff	**1,369.2**	1,274.6	94.6	1,344
Other	**0.0**	0.0	0.0	0
TOTAL	**9,990.8**	**9,468.6**	**522.2**	9,770
Of the above – staff engaged on capital projects	**9.7**	6.9	2.8	10

5. Staff sickness absence

	2013-14 number	2012-13 number
Total days lost	55,958	62,691
Total staff years	8,657	8,943
Average working days lost	6.46	7.01

The staff sickness figures above are supplied by the Department of Health and are based on the 2013 calendar year.

The Department of Health considers the resulting figures to be a reasonable proxy for financial year equivalents.

6. Exit packages agreed in 2013/14

Exit package cost band (including any special payment element)	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed	2013-14 Total number of exit packages by cost band	2012-13 *Number of compulsory redundancies	2012-13 *Number of other departures agreed	2012-13 Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	3	8	11	4	12	16
£10,000-£25,000	7	8	15	8	28	36
£25,001-£50,000	9	4	13	12	24	36
£50,001-£100,000	6	6	12	7	6	13
£100,001 - £150,000	1	1	2	6	1	7
£150,001 - £200,000	0	1	1	1	0	1
>£200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost)	**26**	**28**	**54**	39	71	110
Total resource cost (£000s)	**1,050,871**	**1,056,184**	**2,107,055**	2,234,524	1,942,292	4,176,816

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme and the local Mutually Agreed Redundancy Scheme (MARS). 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. The expenses associated with these departures may have been recognised in part or in full in a previous period.

7. Exit packages – other departures analysis

	2013-14 Agreements Number	2013-14 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
MARS contractual costs	19	538
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	3	254
Exit payments following employment tribunals or court orders	7	264
Non-contractual payments requiring HMT approval*	0	0
Total	**29**	**1,056**

This disclosure reports the number and value of exit packages agreed in the year. The expenses associated with these departures may have been recognised in part or in full in a previous period.

As single exit packages can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in note 6, which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

8. Better Payment Practice Code – measure of compliance

	2013-14 Number	2013-14 £000	2012-13 Number	2012-13 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**138,068**	**326,576**	141,159	305,986
Total non-NHS trade invoices paid within target	**128,594**	**311,626**	129,754	291,626
Percentage of NHS trade invoices paid within target	**93.14%**	**95.42%**	91.92%	95.31%
NHS payables				
Total NHS trade invoices paid in the year	**3,450**	**24,779**	3,745	40,881
Total NHS trade invoices paid within target	**2,923**	**24,393**	3,408	40,205
Percentage of NHS trade invoices paid within target	**84.72%**	**98.44%**	91.00%	98.35%

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.

9. Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
at 1 April 2013	**207,278**	**439,635**	**2,200**	**1,807**	**117,639**	**29,082**	**792**	**798,433**
Additions of assets Under construction	**0**	**0**	**0**	15,404	0	0	0	**15,404**
Additions purchased	0	6,619	0	0	7,802	1,212	41	**15,674**
Additions donated	0	0	0	0	562	0	0	**562**
Additions Government granted	0	25	0	0	248	0	0	**273**
Reclassifications	0	1,113	0	(1,113)	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(3,198)	(89)	0	**(3,287)**
Revaluation	3,617	(128,888)	730	0	0	0	0	**(124,541)**
Impairments charged to reserves	0	(3,545)	0	0	0	0	0	**(3,545)**
Reversal of impairments charged to reserves	0	0	0	0	0	0	0	**0**
At 31 March 2014	**210,895**	**314,959**	**2,930**	**16,098**	**123,053**	**30,205**	**833**	**698,973**

Depreciation								
at 1 April 2013	**0**	**0**	0	0	66,343	16,281	193	**82,817**
Reclassifications	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(2,107)	(3)	0	**(2,110)**
Revaluation	479	(130,907)	(42)	0	0	0	0	**(130,470)**
Impairments charged to operating expenses	0	118,441	0	0	0	0	0	**118,441**
Reversal of impairments charged to operating expenses	(479)	(820)	0	0	0	0	0	**(1,299)**
Charged during the year	0	17,392	55	0	15,164	3,266	78	**35,955**
At 31 March 2014	**0**	**4,106**	**13**	**0**	**79,400**	**19,544**	**271**	**103,334**
Net book value at 31 March 2014	**210,895**	**310,853**	**2,917**	**16,098**	**43,653**	**10,661**	**562**	**595,639**
Asset financing:								
Owned – purchased	210,895	292,901	2,917	16,098	40,874	10,661	562	**574,908**
Owned – donated	0	16,530	0	0	2,722	0	0	**19,252**
Owned – government Granted	0	1,422	0	0	57	0	0	**1,479**
Total at 31 March 2014	**210,895**	**310,853**	**2,917**	**16,098**	**43,653**	**10,661**	**562**	**595,639**

The financial statements were approved by the board on 28 May and signed on its behalf by Dr Tracey Batten, Chief Executive, Imperial College Healthcare NHS Trust, on 3 June 2014.

Dr Tracey Batten
Chief Executive Officer
Imperial College Healthcare NHS Trust

Off-payroll contractors

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	12
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	3
for between two and three years at the time of reporting	1
for between three and four years at the time of reporting	3
for four or more years at the time of reporting	2

The Trust confirms 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. The Trust has contracts with limited companies and not with private individuals.

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	20
Number of new engagements which include contractual clauses giving Imperial College Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance *will be* requested	11 (as 9 have left)
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	0

Appendices

Glossary of terms

Adjusted retained surplus
This is the surplus excluding impairment charges against which the Trust's financial performance is judged (see 'Statement of Comprehensive Income' of the accounts).

Employee benefits
Includes all pay expenditure.

Finance costs
Interest payable to suppliers due to the late payment of commercial debt, interest payable on loans taken out by the Trust and unwinding of discount for future payment included in the calculation of pensions due to former staff as required by the NHS accounting policy.

Gains on revaluations
Gains made due to the revaluation of assets.

IFRS
International Financial Reporting Standards.

Impairments
A decrease in the value of assets due to a revaluation.

Intangible assets
Fixed assets other than property, plant and equipment assets, e.g. computer software licences.

Investment revenue
Interest on the Trust's cash balances throughout the year, including investments in the National Loans Fund.

Net current assets/(liabilities)
The Trust's net total of cash, stocks, debtors and creditors

Operating expenses
All expenditure except for those items shown separately – includes all, clinical and general supplies, and building and premises costs including depreciation.

Other operating costs
Income for all other activities including funding support for education, training and research, and non-patient care services provided, e.g. pathology to other hospitals and services to staff and visitors.

Payables
Monies owed by the Trust as at 31 March 2014.

Provision
Provisions for liabilities where the amount and timing are uncertain but a payment at a future date is anticipated.

Property, plant and equipment
Land, buildings and plant, and medical, information technology and general equipment.

Public capital dividends payable
The cost of capital payable to the Department of Health at 3.5 per cent of the average value of net assets.

Public dividend capital
The value of the Trust's assets at the formation of the Trust plus additional capital received in year to finance capital schemes.

Receivables
Monies owed to the Trust as at 31 March 2014,

Retained earnings
The value of the cumulative income and expenditure deficit.

Revenue from patient care activities
Income from the provision of patient services from NHS bodies including primary care trusts, plus private and overseas patients and injury cost recovery for treatment arising from road traffic accidents.

Revaluation reserve
Represents the total revaluation of assets since the formation of the Trust.

Statement of cash flows
Summarises the sources of cash received and expended by the Trust.

The statements included in this Annual Report are merely a summary of the information in the full accounts, which are available on demand from:

The Financial Service Department
Imperial College Healthcare NHS Trust
Sixth floor, Salton House
St Mary's Hospital
Paddington
London W2 1NY

Telephone: 020 3312 7159

Commissioning for Quality and Innovation (CQUIN) for North West London

Goal number	CQUIN scheme	Description of goal	Goal weighting (% of CQUIN scheme available)	Quality domain (safety, effectiveness, patient experience or innovation)
Goal 1	Friends and Family Test (FFT)	FFT aims to provide timely feedback around patient experience.	5%	Patient experience
Goal 2	NHS Safety Thermometer	NHS Safety Thermometer aims to reduce harm by allowing frontline teams to measure the safety of services and to deliver improvements locally.	5%	Safety
Goal 3	Dementia	NHS Dementia CQUIN aims to help incentivise: • identification of patients with dementia and other sources of cognitive impairment • prompt, appropriate referral and follow up after leaving hospital • hospitals delivering high-quality care to people with dementia.	5%	Effectiveness
Goal 4	Venous thromboembolism (VTE)	NHS VTE CQUIN aims to incentivise reduction of avoidable death, disability and chronic illness resulting from VTE.	5%	Safety
Goal 5	Supporting care outside of hospital	• Reduce inappropriate NEL admissions ensuring that alternative provision is effectively utilised by all providers. • Reduce inappropriate A&E usage by ensuring that the Trust actively supports alternative provision and use of CCG commissioned community services.	30%	Effectiveness
Goal 6	Real-time information	Immediate (within 24 hours) and quality real-time electronic information available to primary care.	15%	Innovation
Goal 7	Secondary Care Quality Standards	Commissioning for quality, not compromising on quality. Focus on clinical quality outcomes.	20%	Effectiveness
Goal 8	Integrated formulary	Utilisation of drug formulary.	10%	Integrated formulary
Goal 9	Increased access to diagnostics	Increased access to GP requested diagnostics and pathology tests (and specification for pathology cloud).	5%	Patient experience
		Total	100%	

Commissioning for Quality and Innovation (CQUIN) for NHSE

Goal number	CQUIN scheme	Description of goal	Goal weighting (% of CQUIN scheme available)	Quality domain (safety, effectiveness, patient experience or innovation)
Goal 1	VTE risk assessment	To reduce avoidable death, disability and chronic ill health from VTE.	5%	Safety
Goal 2	Friends and Family Test (FFT)	To improve the experience of patients in line with domain four of the NHS Outcomes Framework. The FFT will provide timely, granular feedback from patients about their experience. The 2011/12 national inpatient survey showed that only 13 per cent of patients in acute hospital inpatient wards and A&E departments were asked for feedback.	5%	Patient experience
Goal 3	Dementia care	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions; to prompt appropriate referral and follow up after they leave hospital; and to ensure that hospitals deliver high-quality care to people with dementia and support their carers.	5%	Safety, clinical effectiveness, patient experience
Goal 4	NHS Safety Thermometer	To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.	5%	Patient experience
Goal 5	Quality dashboards	Provide quarterly progress on data collection, completeness and assurance in the areas of clinical quality from Annex 4 of the NHS standard contract, plus, continue to provide clinical information on 2012/13 clinical dashboard.	10%	Safety, clinical effectiveness, innovation
Goal 6	Highly specialised	Highly specialised services clinical outcome collaborative audit workshop.	10%	Safety, clinical effectiveness
Goal 7	Radiotherapy	Increased access to image guided radiotherapy (IGRT).	10%	Safety, clinical effectiveness
Goal 8	Adult neurosurgery	To reduce the number of shunt revisions within 30 days of insertion due to infection.	10%	Patient experience, safety

Goal 9	Fetal medicine	90 per cent of newly suspected /diagnosed lethal or major fetal abnormalities or other life-threatening fetal disorders referred to the fetal medicine centre that are seen within three working days.	10%	Clinical effectiveness, safety, patient experience
Goal 10	Bone marrow transplant	Understanding of, and improvement in, a number of processes used to identify unrelated donors.	10%	Patient experience
Goal 11	HIV	To increase the role of primary care in the care of HIV patients.	10%	Clinical effectiveness, safety
Goal 12	Major trauma	Improving outcomes in major trauma orthopaedic injuries.	10%	Safety, clinical effectiveness patient experience
		Total	2.4% of contract plan	

Health and safety performance

In 2013/14, the Trust's Health and Safety Committee was reorganised in line with the organisation's new divisional structure. Reports received by the committee included trends identified from 52 health, safety and management of risk inspections, and 218 fire risk assessments carried out as part of the rolling programme.

Through the Trust's health and safety training programme, 275 sessions were provided covering health, safety and fire. Through these sessions, 76 new departmental safety co-ordinators (DSCs) and 63 new fire wardens were trained.

The Trust's health and safety policy and several of its subordinate policies have been reviewed, ratified by the Health and Safety Committee and sent to governance for approval. Compliance with these will ensure continued compliance with the relevant legislation. This is measured during the management of risk inspections and local inspections carried out by the DSCs.

The Trust has continued to work in partnership with Imperial College London on their joint safety arrangements. The memorandum of understanding between the Trust and the College has been reviewed and 22 of the 28 associated safety arrangements have been completed (via the joint safety group). There have also been four new clinical trials approved through the joint clinical research safety committee.

Alternative formats for the annual report

Annual report publication and alternative formats
This document is available on www.imperial.nhs.uk or contact the communications directorate on 020 3312 2168 for further details.

This document is also available in other languages, large print and audio format

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Este documento encontra-se também disponível noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Dokument ten jest na życzenie udostępiany także w innych wersjach językowych, w dużym druku lub w formacie audio.

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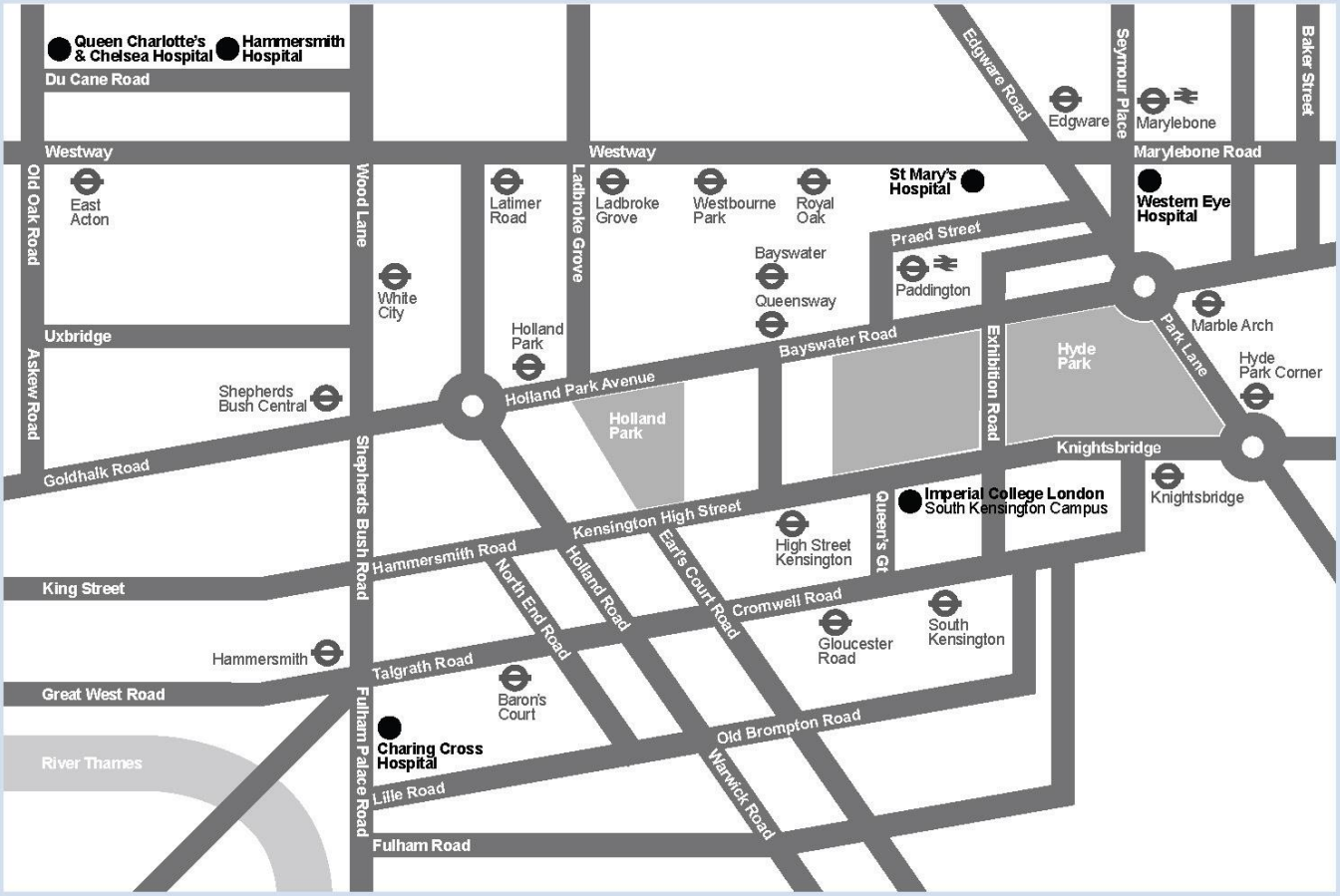
Sipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madhe dhe në formë dëgjimore.

Contact us and map of Trust sites



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