Delivering our promise
Better health, for life

Annual Report
2015/16

Imperial College Healthcare NHS
NHS Trust

Contents

Published August 2016

Welcome

Sir Richard Sykes, Chairman

The NHS was consistently in the public eye again this year. And, with real pressure on public finances and growing health demand, it looks set to remain that way.

As one of the largest and most innovative NHS providers, Imperial College Healthcare NHS Trust is right in the midst of the service's biggest challenges. You will see in this annual report how we are responding to all three of the 'gaps' identified by NHS chief executive Simon Stevens in his five year plan for the service – in health and wellbeing; care and quality; funding and efficiency.

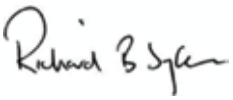
Like many other NHS organisations, we finished the year in financial deficit and we struggled to meet operational performance targets consistently.

But 2015/16 also saw us make big progress – including on our digital strategy, new and stronger partnerships with our local health and social care partners, investment in our people through a new quality improvement programme and a devolved management structure, and a continued commitment to innovation, including in genomics and personalised medicine.

These are the developments that will allow us to close the gaps, becoming a key part of a whole health system that enables everyone to be as healthy as they can be and to get the right care, in the right place, when they need it.

We have endeavoured to make this report a clear and balanced account of our year – where we did well and not so well, and specifically how we performed against our budget, performance targets and our objectives.

Overall, our significant achievements – in both the immediate job of providing the best possible care to all of our patients and the longer term task of evolving to meet changing needs – are a testament to the skill and commitment of our 10,500 staff.



Sir Richard Sykes
Chairman

Performance report

Performance report: 2015/16 overview

Dr Tracey Batten, Chief executive

We have achieved a great deal for our patients and local people during 2015/16 despite a number of significant challenges facing us and the rest of the NHS.

We have provided more care to more people this year – a 6.8 per cent increase in activity compared with last year. This translates to well over a million patient contacts.

We continue to have one of the lowest mortality rates of all NHS trusts in England. And we provide some of the most innovative care and treatment – during the last year alone, we have seen more breakthroughs in fertility treatment, cancer diagnosis and surgical techniques.

Increasingly, our innovation is being directed towards new models of care as well as new treatments. We were the lead provider for a new integrated health and social care service in north west London this year and we have begun to work formally with local GPs to explore accountable care partnership approaches. And the implementation of an electronic patient administration system in 2014/15 is now enabling us to progress our digital strategy at pace.

Following our CQC inspection at the end of 2014 that gave us a 'requires improvement' rating overall, we have put much energy into improving quality consistently across all of our services. This year, we have progressed a major outpatient improvement programme, refreshed our organisational values and behaviours and launched a new quality improvement programme to establish and support a Trust-wide quality improvement methodology.

However, to continue to improve and to innovate, and to do so at scale in order to keep up with changing needs, expectations and technology, we have to get a firmer grip of our operational performance and put our finances on a more sustainable footing.

In 2015/16, while we performed well on the national cancer wait standards, we were not able to meet consistently the national 18 week referral to treatment standard and we only achieved for one month the 95 per cent standard for A&E patients being treated and discharged or admitted within four hours. Pressures on A&E are particularly complex.

There has been an increase in the number of emergency patients we see and in how sick they are when they present. We are also struggling to discharge patients who no longer need specialist, acute care which is reducing our capacity to admit new urgent or emergency patients.

We are not alone in facing these sort of challenges and there is beginning to be real progress in more joined up working across local health systems, including ours, to help patients avoid unnecessary hospital admissions and to get home or into community-based care once they are ready to do so.

A specific contributory factor for our Trust, though, and one that is worsening, is the poor condition of much of our estate. I very much hope we will be able to make progress during the coming year with the estates redevelopment proposals that we set out when we published our clinical strategy, in July 2014.

The Trust was under considerable financial pressure for much of 2015/16. Our plan going in to the year was for an £18.5 million deficit – largely because of the removal of national support for complex specialist care that we had been receiving. However, rather than being in a position ready to move back to financial balance, we have ended the year with a deficit of £47.9 million.

Since the autumn, our focus has been on identifying and tackling the root causes of our financial challenges. We have also put in place more robust financial controls. In the last quarter of the year, we undertook a review of our management organisation and ways of working that concluded with proposals for a new, more streamlined structure and clearer accountabilities.

We have been working with staff to put a new structure in place and this remains a key priority as we enter the new financial year. As well as supporting stronger financial management in the short term, the new structure is also intended to empower and support staff to lead the service transformation and improvements that will deliver financial sustainability in the longer term.

I believe we will be supported in our efforts to tackle our immediate operational and financial challenges while putting in place the new models of care and strategic developments to achieve longer term benefits by the move nationally to establish 'place-based' sustainability and transformation plans.

We want to build on the strong relationships we have been forging with partners locally, including with our patients and local communities, to create genuinely integrated approaches to improving health and healthcare.

Dr Tracey Batten
Chief executive

About the Trust

Imperial College Healthcare NHS Trust provides acute and specialist healthcare in north west London for around a million people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with over 10,000 staff.

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

With Imperial College London, we are a designated academic health science centre, supporting rapid translation of research and excellence in education.

Our vision and objectives

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

To enable us to achieve this, our objectives are:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- As an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Our hospitals and services

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

Our five hospitals are:

- **Charing Cross Hospital,** Hammersmith – providing a range of acute and specialist care, it also hosts the hyper acute stroke unit for the region and is a growing hub for integrated care in partnership with local GPs and community providers. Charing Cross has a 24/7 A&E department. Our clinical strategy envisages Charing Cross evolving to become a new type of local hospital, offering a wide range of specialist, planned care as well as integrated care and rehabilitation services for older people and those with long-term conditions.
- **Hammersmith Hospital,** Acton – a specialist hospital renowned for its strong research connections. It offers a range of services, including renal, haematology, cancer and cardiac care, and provides the regional specialist heart attack centre. As well as being a major base for Imperial College, the Acton site also hosts the clinical sciences centre of the Medical Research Council. Under our clinical strategy, the hospital would build further on its specialist and research reputation.
- **Queen Charlotte's & Chelsea Hospital,** Acton – a maternity, women's and neonatal care hospital, also with strong research links. It has a midwife-led birth centre as well as specialist services for complicated pregnancies, fetal and neonatal care. Our clinical strategy sets out a continuing role for both of our specialist hospitals sharing the Acton site, alongside major facilities for Imperial College London.
- **St Mary's Hospital,** Paddington – the major acute hospital for north west London as well as a maternity centre with consultant and midwife-led services. The hospital provides care across a wide range of specialties and runs one of four major trauma centres in London in addition to its 24/7 A&E department. We are proposing a major redevelopment of the St Mary's site to bring together more of our acute care in state-of-the-art facilities.
- **Western Eye Hospital,** Marylebone – a specialist eye hospital with a 24/7 A&E department. We are planning to relocate the whole service to new facilities on the redeveloped St Mary's site.

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

Imperial Private Healthcare is our private care arm, offering a range of services across all of our sites, including at the renowned Lindo Wing at St Mary's Hospital. Income from our private care is invested back into supporting our NHS services.

Research and education

The Trust is one of 11 National Institute for Health Research (NIHR) biomedical research centres (BRC). This designation is given to the most outstanding NHS and university research partnerships in the country, leaders in scientific translation, and early adopters of new insights in technologies, techniques and treatments for improving health. The NIHR Imperial BRC supports more than 600 active research projects across 15 different disease areas. In December 2014, we were designated by NHS England as one of 11 genomic medicine centres, helping to lead innovation in genomics.

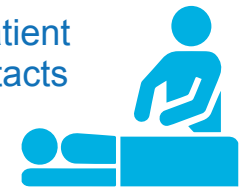
We are a major provider of education and training for doctors, nurses, midwives and allied health professionals including therapists, pharmacists, radiographers and healthcare scientists. In 2015/16, around 900 Imperial College London medical undergraduates trained with us and we are the lead provider for core, specialty and GP medical postgraduate training across north west London. We have around 500 student nurses and midwives in training annually, many of whom gain their first job or qualification with us.

The Trust in numbers 2015/16

Our care

over **one million** outpatient contacts

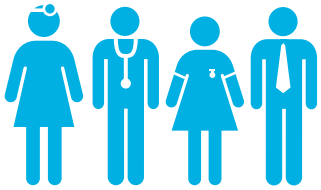
196,000 inpatient contacts



280,000 A&E attendees

9,200 babies born

Our staff



10,500 staff, including

2,300 doctors

4,300 nurses & midwives

600 allied health professionals

1,000 scientists & technicians

120 pharmacists

Our finances

-£47.9m

year end

deficit after adjustment for revaluation of the Trust's estates

Over £1,000m

turnover

Efficiency savings of

£28.9m

for reinvestment in patient care

Invested

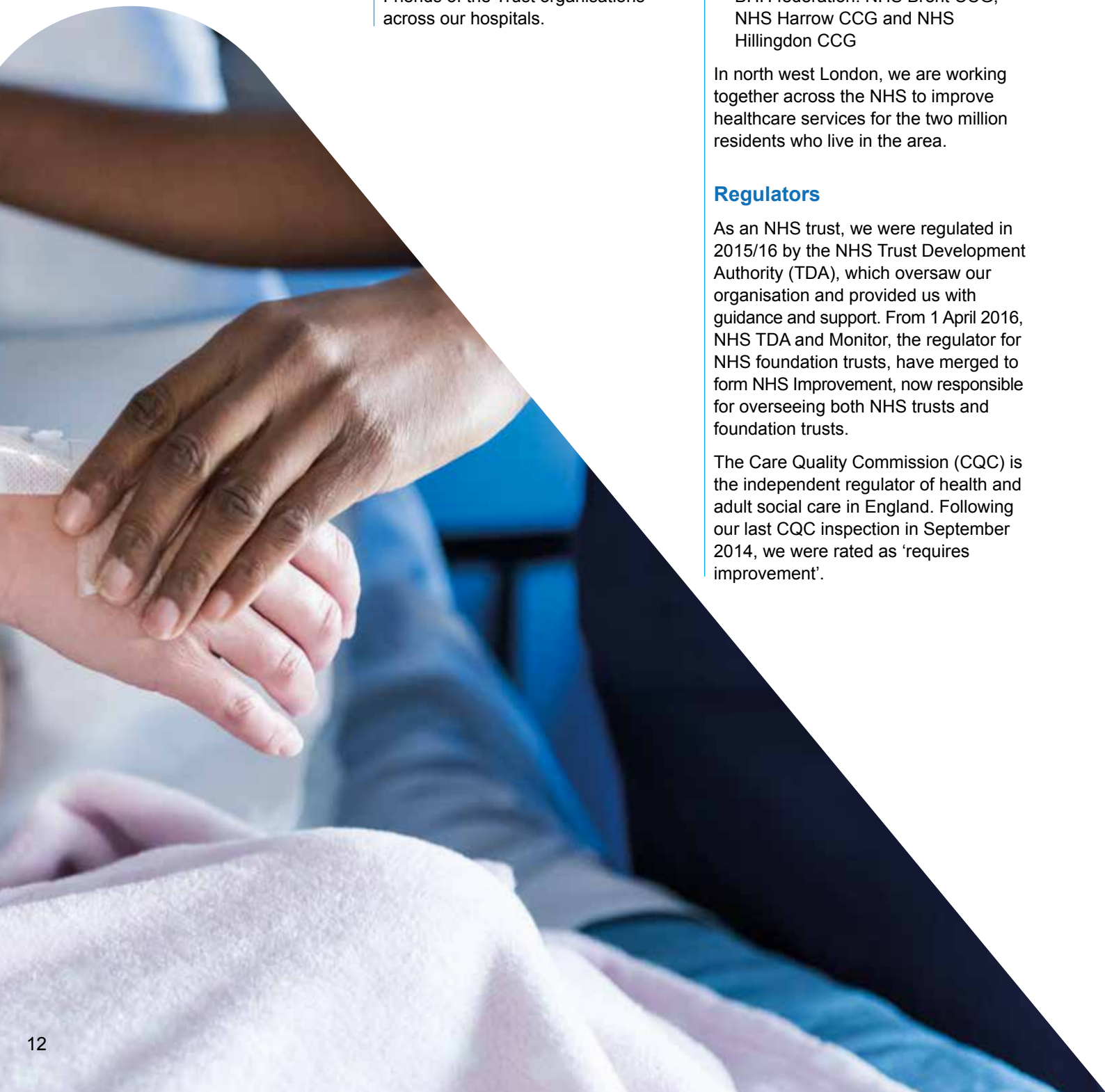
£38.1m

in building and infrastructure projects

Our charities

We work increasingly closely with Imperial College Healthcare Charity, which supports a wide range of initiatives for patients and staff. In 2015/16, the Charity gave £3 million in awards and grants and committed its largest ever strategic investment of £15 million to support major estates improvements.

The Trust also receives generous support from: COSMIC (Children of St Mary's Intensive Care); the Winnicott Foundation, which raises funds to improve care for premature and sick babies at St Mary's Hospital, and the Friends of the Trust organisations across our hospitals.



Our commissioners

Around a third of our care is commissioned by north west London local clinical commissioning groups (CCGs), another third of our work is for CCGs beyond our local area, and the final third comprises specialist services commissioned by NHS England.

The CCGs in north west London have formed two groupings:

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

In north west London, we are working together across the NHS to improve healthcare services for the two million residents who live in the area.

Regulators

As an NHS trust, we were regulated in 2015/16 by the NHS Trust Development Authority (TDA), which oversaw our organisation and provided us with guidance and support. From 1 April 2016, NHS TDA and Monitor, the regulator for NHS foundation trusts, have merged to form NHS Improvement, now responsible for overseeing both NHS trusts and foundation trusts.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Following our last CQC inspection in September 2014, we were rated as 'requires improvement'.

Performance analysis: introduction

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

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

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

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

Assessing performance against our strategic objectives

Assessing progress against our objectives is an important aspect of performance analysis.

All developments within the Trust must be aimed at achieving one or more of our four strategic objectives, listed earlier and overleaf.

Assessing performance against the five domains of quality

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

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

This performance report draws out the annual performance against key indicators under each domain. A more detailed assessment of performance against all of our quality targets for 2015/16 can be found in our 2015/16 quality account.

Our vision is to be a world leader in transforming health through innovation in patient care, education and research. To enable us to achieve this, the Trust's objectives are:

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- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care
- to pioneer integrated models of care with our partners to improve the health of the communities we serve

Many of our major initiatives in 2015/16 were intended to support more than one of our strategic objectives. However, for ease of reporting, we have set them out in this report under the primary objective to which they relate.

Performance against corporate objectives

Objective: To achieve excellent patient experience and outcomes, delivered efficiently and with compassion

Improving our outpatient services

With over a million outpatient contacts every year, it is vital that we make sure the whole experience is as reassuring and efficient as possible, as well as effective. Our CQC inspection in 2014 highlighted the need for us to do better. So, last year, we launched a programme to improve every aspect of the outpatient experience, from clinic areas to administration systems.

Hundreds of patients took part in a survey looking at how to best improve our facilities. The feedback has shaped plans for a major refurbishment of many of our outpatient clinics, now underway.

Imperial College Healthcare Charity is investing over £7 million in the programme which, as well as supporting the building works, is enabling the creation of a patient service centre to coordinate and manage all appointments and administration and provide a fast, coordinated response to outpatient enquiries. The Charity also supported us to provide 'customer care' training for outpatient staff last year.

Other improvements in 2015/16 included:

- patient letters are now available digitally so paper records are no longer needed – this allows clinicians to have faster access to accurate patient information and reduces waits in clinic
- appointment reminders are now being sent by text to patients' mobile phones which has helped reduce missed appointments

Digital patient records benefit patient care

Notes and observations that clinicians previously wrote in paper health records are now routinely recorded and stored digitally. This hugely reduces our reliance on paper and the secure availability of patient records anywhere and anytime brings real benefits to patient care.

Following successful pilots in gynaecology and care of the elderly wards at St Mary's Hospital last year, online clinical documentation and prescribing and administration of medications was introduced in our A&E units, outpatient areas, theatres and wards across all of our sites.

Our digital patient records are based on Cerner software purchased through the National Programme for IT. That contract ended in 2015 and this made it possible for us to upgrade to the latest version of the software. This will allow us to introduce further improvements to the system over the coming year.

Leading improvements in dementia care

Our dementia team built on successful work in 2014/15 which introduced carers' passports and a raft of initiatives to improve care for patients with dementia, their carers and families – both through specialist dementia services and supporting people using other Trust services.

In 2015/16 key developments, all supported by Imperial College Healthcare Charity, included:

- A ward specifically designed to support patients with dementia opening at St Mary's Hospital. Witherow ward has been designed to reduce confusion for patients with dementia and help them feel safe and secure, for example, by using specialist lighting to mimic changes in natural light, painting a dining area orange to stimulate appetite, and enabling patients to choose a picture for above their bed to help with wayfinding.
- Improving nutrition and hydration of patients with dementia in hospital by providing specialised support tailored to their needs with an innovative pathway known as NoSH, developed in partnership with Sodexo. All patients admitted to medical wards with a diagnosis of dementia are placed on the first level of the programme, their weight is monitored regularly and their food and fluid intakes recorded. They are given 'bento boxes' with snacks providing them access to nutritious foods on demand. For patients who require a little more support the 'enhanced' and 'intensive' levels of the programme include goals and different menus designed for people with dementia.
- Developing a specialist cubicle at St Mary's A&E to support patients with dementia – as busy A&E departments can be particularly distressing for people with dementia and their carers and families. The cubicle has dementia friendly décor, activities, music and a heated 'trolley' to help keep patients warm.

Transforming our services to meet changing needs

Our clinical strategy, published in July 2014, is focused on:

- creating more local and integrated services, to improve access and help keep people healthy and out of hospital
- concentrating specialist services where necessary, to increase quality and safety
- ensuring better organised care, to improve patient experience as well as clinical outcomes
- developing more personalised medicine, capitalising on advances in genetics and molecular medicine

In 2015/16, we established our clinical strategy implementation programme to help initiate and support major service developments aimed at achieving our clinical vision and delivering high quality services, seven days a week.

Each project within the programme is clinician-led and employs a structured process to scope requirements and options and to involve staff, patients, GPs and other stakeholders in the development and implementation of proposals. The first four projects, which got underway in autumn 2015, were:

- a review of acute medicine – to help make sure that patients who need urgent or emergency care are assessed as quickly as possible and transferred to the most appropriate specialist care, as required
- streamlining the care pathway for patients with acute chest pain – to enable more patients to benefit from direct access to the specialist heart assessment centre at Hammersmith Hospital
- developing our ambulatory emergency care strategy – allowing more urgent and emergency patients to be assessed and treated without needing to be admitted to hospital
- a review of vascular surgery services – to determine the best configuration of services across our sites

Stroke service co-location

In the autumn of 2015/16, following supportive feedback from patients, carers, local residents and other stakeholders, the Trust's inpatient stroke services were brought together at Charing Cross Hospital.

The integrated stroke service is designed to improve the service to meet best practice, enabling patients to have the fullest and speediest recovery possible. We created an expanded stroke unit with improved gym facilities alongside the existing hyper-acute stroke unit – 'HASU' – together on one floor of Charing Cross Hospital, which enables the Trust to offer seven-day senior clinical review and therapy services to all stroke patients.

This new service model is expected to be in place at Charing Cross for a period of approximately five years, during which time the St Mary's Hospital site is due to be redeveloped and modernised so that the whole integrated stroke service can be re-located there in new facilities, as set out in the Trust's clinical strategy.

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

Creating a shared vision and values

In 2015, staff came together from across the Trust to refresh our values and ensure we have a clear and shared understanding of who we are, what we want to achieve and how we should behave to our patients and each other.

Through workshops, interviews and online feedback, around 4,000 staff were involved in the initiative. There was a lot of great discussion and a coming together of ideas. We tested out emerging findings about what should drive and shape us with patient groups and other partners and arrived at a combination of kind, expert, collaborative and aspirational for our core values, see pages 18-19.

Since the autumn, we have been working to ensure our values and ethos guide everything we do. They are at the heart of our new quality improvement programme and we are using them to develop improved ways of recruiting and appraising staff, for example. There's much more to do but, critically, we now have strong foundations in place.

Making quality improvement everyone's business

As a key component of our quality strategy published in 2015, we launched a new programme to encourage and enable all staff to make improvements in their own areas.

The quality improvement (QI) programme offers:

- a range of training and resources for staff based on a new, Trust-wide quality improvement model – plan, do, study, act
- the QI hub – a dedicated team providing practical support and expertise to staff leading improvement projects

The QI programme is grounded in the Trust's new values and, in particular, has a strong commitment to ensuring quality improvement initiatives are co-designed with patients, GPs and local residents.

In the first six months of the programme, over 4,500 staff participated in QI awareness sessions. By March 2016 the QI hub was supporting over 50 improvement projects. The projects' aims include improving hospital discharge, staff recruitment, outpatient administration, hand hygiene and safety, including preventing patient falls while in hospital.

Safer surgery for all

We strengthened our Safer Surgery programme in response to a small number of 'never events' – serious, patient safety incidents that should not occur if the available preventative measures have been implemented. Our never events in 2015/16 all related to practices in surgery. The Safer Surgery programme aims to make safety front of mind for everyone working in invasive procedures.

It includes:

- a revised invasive procedures policy to ensure compliance with the newly published national standards
- a communications programme to support the roll-out of the new policy
- a team-based simulation training programme to promote better team functioning in all theatres, endoscopy and interventional radiology
- an online mandatory training module, which includes a video made by a consultant involved in one of the never events giving a real life experience
- an observational audit process to assess compliance and support training

We have seen improved compliance with the World Health Organization surgery checklist, and will be expanding the programme further in 2016/17 to ensure that it is fully embedded into practice.

Improving medical education

With our medical education transformation programme we set out to ensure educational needs are met in a positive, supportive working environment, making the following improvements:

- a restructure of the education team and improved governance and processes
- a pilot buddy system for medical students, pairing them with a trainee for mentoring – this will now be rolled out
- better faculty training for new consultants, education and clinical supervisors
- a new annual programme of specialty education reviews, underpinned by 12 work streams to drive further improvement

In November 2015, we hosted two visits, one from Higher Education North West London to review postgraduate training, and one from Imperial College, to review undergraduate education. The feedback we had from both was largely positive, with recognition of the great deal of work undertaken. We have action plans to respond to issues identified which will be implemented throughout 2016/17.

Progress has particularly been made in ophthalmology where three training placements have been reinstated at the Western Eye Hospital following a specialty quality visit in March 2016.

Trust-wide multi-professional education strategy: a five year plan

We developed a multi-professional education strategy and five year plan to create a culture of continuous learning, supporting our workforce to deliver the highest possible quality of care to patients.

By investing in our people through education we want to improve staff experience and engagement within the Trust and so support improved patient experience. The strategy recognises and supports the contribution of the whole multi-professional team in delivering safe, effective and compassionate care.

Our behaviours

Kind

To be kind:
- we put people first
- we listen, notice and respond
- we see things from others' point of view

In practice:
- notice when someone needs help
- make eye contact and smile
- introduce ourselves by name and role
- actively listen and respond to others
- make time for meaningful interactions

Expert

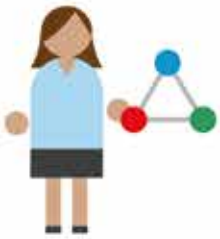
To be expert:
- we're informed and up to date
- we're reliable
- we're responsible

In practice:
- keep our practice up to date
- do what we say we will do
- be sure of our facts and the limitations of our knowledge
- use money, time and other resources efficiently
- seek solutions to problems and secure help if we can't resolve them ourselves

Collaborative

To be collaborative:
- we work as a team
- we're open and approachable
- we're adaptable

In practice:
- involve others in the development of ideas and plans from the start
- actively build partnerships
- share information and knowledge, openly and honestly
- respect others' time and contributions
- be willing to change our mind



Aspirational

To be aspirational:
- we strive for excellence
- we embrace innovation
- we champion better care

In practice:
- always look for ways to improve what we do
- make time for reflection and learning
- recognise and celebrate achievements
- not be afraid to challenge or be challenged
- enable and support others to learn and develop

Our values

Kind

We are considerate and thoughtful, so you feel respected and included.

Expert

We draw on our diverse skills, knowledge and experience, so we provide the best possible care.

Collaborative

We actively seek others' views and ideas, so we achieve more together.

Aspirational

We are receptive and responsive to new thinking, so we never stop learning, discovering and improving.

Our ethos

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

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

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

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

Imperial College Healthcare NHS
NHS Trust

Delivering our promise
Better health, for life

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

Mapping the genetics of cancer and rare diseases

We are the lead for the West London Genomic Medicine Centre, one of 11 centres that began work last year as part of the government's 100,000 Genomes Project. We are helping to map the whole genetic make-up of patients with rare diseases, and their families, as well as patients with common cancers.

Working closely with our partners, Chelsea & Westminster Hospital NHS Foundation Trust, Royal Brompton & Harefield NHS Foundation Trust and Royal Marsden NHS Foundation Trust, we are gathering samples and medical information to build up a bank of anonymised data in order to better understand the role that genes play in disease.

The project has the potential to transform the future of healthcare by improving our knowledge of the influence of genetics on disease, how other people can be helped with similar diseases in the future, and how different types of tests can be developed to detect changes beyond the genome.

In addition to these long-term benefits, we hope some participating patients will benefit in the short-term as a conclusive diagnosis may be reached for a rare or inherited disease more quickly, or a treatment for cancer may be targeted at the particular genetic change that is present in the cancer.

Earlier diagnosis of oesophageal and gastric cancer

A breath test that can help doctors diagnose the early signs of oesophageal and gastric cancer in minutes, and so potentially improve survival rates, has been developed by researchers at the Trust and College. Last year, the test produced encouraging results in a study with Trust patients and is now being used in a larger trial.

Researchers analysed breath samples of 210 patients using the test. They found it can discriminate between malignant and benign oesophageal cancer in patients for the first time. It is faster and easier to perform than other methods and provides results in minutes, rather than four to six hours. The test can also be applied to detect gastric (stomach) cancer tumours.

New fertility treatment reduces complications

A clinical trial at Hammersmith Hospital is investigating the use of the hormone kisspeptin in IVF with women who are at risk of developing complications. Following a successful trial in 2013 showing that kisspeptin can stimulate egg maturation leading to a healthy pregnancy, last year saw the start of a trial of kisspeptin with women who are at risk of developing ovarian hyperstimulation syndrome (OHSS), a potentially life-threatening condition.

Results of the trial so far are very positive with a 77 per cent pregnancy rate at six weeks and a 62 per cent live birth rate.

OHSS can be a result of standard IVF where the treatment acts very powerfully for a long period of time directly on the ovaries. Instead, kisspeptin, a naturally occurring hormone, works through an area in the brain stimulating a woman's natural reproductive hormones. Kisspeptin is unable to over stimulate the ovaries because it acts via the woman's own indigenous hormones.

Vaccine reminder during pregnancy

Researchers and clinicians from the College and the Trust developed a new app to guide and remind pregnant women about vaccines recommended during pregnancy.

The Maternal Immunisations (MatImms) app is aimed at pregnant women to guide them about infections that could be harmful to them and their baby, such as flu and whooping cough, and which could be prevented by getting vaccinated in pregnancy.

The app's developers were inspired to create MatImms because of the low uptake of the vaccine against whooping cough identified during their research.

The app includes a personalised vaccination schedule based on the woman's due date, which can be synced to her phone's calendar, with reminders about when to get her own vaccines and when to vaccinate her baby during the first year of life.

The app also tackles concerns about vaccinations with information on their ingredients and safety records, and it contains links and videos to other websites for further information.

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

Improving cancer care with Macmillan Cancer Support

We continue to work with Macmillan Cancer Support to deliver a better experience for people affected by cancer across north west London thanks to our joint 'supporting you through our cancer care' programme. With almost £3 million investment from Macmillan, the partnership has already delivered eight new cancer nurse specialists and established a Macmillan navigator service.

Delivering the Macmillan navigator service was a big achievement in 2015/16 as it was key to improving patient experience. The team of Macmillan navigators are a single telephone contact for all cancer patients and those supporting and caring for them. The navigators help guide each person with cancer through their health service journey from detection, to diagnosis, through treatment and beyond.

There are lots of different professionals involved in treating someone who has cancer. The navigators work really closely with the whole multidisciplinary team to help make everything a little more seamless for our patients.

Macmillan funding, together with support from Imperial College Healthcare Charity, has also enabled Schwartz Rounds to take place which offer staff from all disciplines an opportunity to reflect on the emotional aspects of their work. Research into their effectiveness shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture.

The next phase of the Macmillan partnership is looking at how to support people once they have completed their main hospital-based treatment. There are plans for in-depth engagement with patients, carers, local people and health, social and community care staff to understand and co-design the support needed by people who are living with or beyond cancer.

Care Information Exchange

Sharing knowledge, better care

Care information exchange

With healthcare records going digital, we have the potential to link up patient information securely online so that our clinicians, patients, carers, GPs and professionals in other health and social care providers can have up-to-date and comprehensive information at their fingertips.

This will allow a step change in joint care planning and partnership working with patients to improve health and wellbeing. With £3m funding committed by Imperial College Healthcare Charity, we are leading a major initiative for north west London – the care information exchange – to do just that.

The goal is to improve care and help patients feel more in control of their own health. Patients will be able to access their information whenever and wherever they are, on their computer or smartphone. And they can choose to share it as they wish with their health and care professionals, relatives and carers. There will be educational resources, appointment information, test results and care plans, and patients can record information about their health in an online journal.

By the end of 2015/16, we had built the technical infrastructure for the care information exchange, using Patients Know Best as the core platform, and established robust information governance processes.

We are now working with small groups of patients and professionals to pilot the use of the care information exchange in supporting a number of different healthcare projects.

Community independence service

The Trust was appointed lead health provider for a newly integrated community independence service covering the boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster from April 2015.

The service provides coordinated health and social care to vulnerable people helping them avoid unnecessary time in hospital or institutional care and helping them to get better at home after hospital discharge.

The Trust worked hard with a range of partners, particularly Central London Community Healthcare NHS Trust and adult social care teams, to dissolve organisational boundaries and work as one team.

This was not without its challenges – in terms of different organisations' IT systems, ways of working, policies and procedures and locations. But intense focus on all of these areas pushed the project forwards and meant more people could be supported in their own homes.

Partnership working with local GPs

The Trust and Hammersmith & Fulham GP Federation established a formal relationship in 2015/16 to explore a new model of integrated care for the population of the borough.

The evolving model of care is in line with national policy development and includes consideration of 'an accountable care partnership' approach – when healthcare providers comes together to offer joined-up care to a whole population across primary and secondary care.

Over time, we will be looking to work with other partners and to build on the successes of initiatives such as the community independence service.

Involving patients, carers and local people

Integrating patient and public involvement (PPI) into all levels of the Trust's services and work was agreed as a key priority by the Trust board in November 2015, with support for a new approach. The approach sets out four key areas for involvement:

- informing strategy, policy and planning, for example through lay representation on programme and project boards
- improving services, for example through experience-based co-design activities
- supporting service delivery and improvement, for example through volunteering
- maximising individual health and wellbeing, for example through self-management programmes and peer-to-peer support

A strategic lay forum of 11 lay representatives has now been established and is working to shape and support the development of involvement activities. Lay forum members joined other patients and local people as well as staff at a co-design event in March 2016 to help develop an action plan to achieve significant progress in all four areas for involvement.

North west London pathology

In 2015/16, we put in place the foundations for a new joint pathology service in partnership with Chelsea & Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust.

The partnership aims to modernise pathology services across north west London. Patients will benefit from a faster specialist testing service and standardised results available to clinicians across all Trusts to eliminate the need for repeat testing if care transfers from one hospital to another.

The service will operate as a hub and spoke model. It will provide a rapid response laboratory service for urgent work at each hospital site (spokes) and consolidate routine, non-urgent investigations at a centralised laboratory (hub). It will operate 24 hours, seven days a week.

Once the final stages of regulatory approval are confirmed, it is expected that the new service will begin in late 2016 and be fully implemented by mid 2017.

Looking ahead to 2016/17

The coming year is a critical one for our Trust and for the wider NHS. The clear priority from the NHS national leadership is to accelerate the adoption of new models of care and ways of working that will deliver a step change in quality and efficiency while also ensuring financial and operational 'grip'.

Reflecting the 'must-dos' that have been set for us by NHS Improvement in a bid to facilitate more joined up planning across local health systems, and taking forward our own strategic objectives and strategic plans, we have set the following objectives for 2016/17:

To deliver sustainable improvements in care quality – in particular to deliver the Trust's quality account targets for 2016/17, to roll-out a Trust-wide quality improvement methodology and to have a robust plan in place for expanding patient and public involvement.

To overachieve on the Trust budget for 2016/17 and to have a robust plan in place for achieving financial sustainability – due to our underlying deficit and additional cost pressures, and despite a cost improvement programme of over £50m, we have submitted a deficit budget for 2016/17 of £52m. We are putting in place additional measures with the ambition of delivering a smaller deficit.

To deliver the Trust's plan for meeting all of the national NHS operational performance standards – in particular the 95 per cent, 4-hour A&E wait, 92 per cent 18-week referral to treatment and all eight cancer care wait standards.

To play a key leadership role in developing and delivering the north west London sustainability and transformation plan – in particular to have a clear strategy in place for establishing an effective accountable care partnership for our local communities, and to progress implementation of our clinical strategy and estates redevelopment proposals.

To develop a culture of active engagement and empowerment across theTrust – in particular to embed our new organisational structure and ways of working to support and facilitate continuous improvement.

Performance against the five domains of quality

Our quality strategy is delivered through the achievement of our quality goals, which are:

Safe

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

Effective

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

Caring

To provide our patients with the best possible experience by increasing the percentage of inpatients who would recommend our Trust to friends and family if they needed similar care or treatment to 95%, and the percentage of A&E patients to 85%.

Responsive

To consistently meet all national access standards by the end of year three of the strategy.

Well-led

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

The original goals were developed in consultation with members of the public, our patients, members, Healthwatch, local authority overview and scrutiny committees, commissioners and Trust staff, through a series of development workshops held during 2014/15.

For 2016/17 we have further developed our effective and responsive goals, working with our clinical and management teams as well as stakeholders including patient representatives through the quality steering group.

Reviewing our performance against the challenging targets we set for 2015/16 we recognise that there is still much to be done to achieve and sustain improvement. We have therefore agreed that most of our targets will continue through the coming year, with some minor amendments.

Safe

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm and extreme harm/death. We believe harm is preventable, not inevitable.

We are seeking to deliver our goal by focusing improvements on the most common causes of avoidable harm. We have set out our key measures and performance below. For full details of our performance against our 'safe' targets please see our quality accounts.

Avoidable adverse events

Research conducted by NHS England suggests that around 10 per cent of patients will experience an adverse event while in hospital, half of which are considered avoidable. We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm.

Our percentage of severe/major harm and extreme harm/death incidents was below the national average. There has been a reduction – down from 40 in the previous year to 31 in 2015/16. This is in the context of over a million patient contacts in the year.

Zero never events

Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. We aim to have zero never events and in 2015/16 we had seven.

They are all related to practices in surgery. However, the root cause was different for each incident, and so specific actions have been taken for each. We also audited compliance with the five steps of the World Health Organization (WHO) surgical safety checklist and met 100 per cent of four out of five targets and 93 per cent of the fifth.

To avoid the repetition of these events in 2016/17 we developed a Safer Surgery programme including an extensive training programme.

Infection prevention and control

Healthcare associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in a healthcare setting.

Minimising the risk of infection through robust controls is a priority for the Trust, achieved through many measures including improved hand hygiene and reducing the use of antibiotics.

A hand hygiene audit of over 80 per cent of our wards showed 99 per cent compliance with good practice. Nevertheless, there is no room for complacency – especially with new antibiotic resistant pathogens arising in hospitals across the country – and a hand hygiene quality improvement programme is in place for 2016/17.

MRSA

Our target for 2015/16 was to have zero cases of MRSA in the hospital, we completed the year with seven cases – one fewer than 2014/15.

Clostridium difficile

For 2015/16 we set a target of 'no avoidable infections' and we had six cases attributed to lapses in care and 73 cases in general across the Trust – slightly down from 79 last year.

Carbapenemase-producing Enterobacteriaceae (CPE)

CPE is an emerging group of different pathogens worldwide which are resistant to almost all antibiotics, have the potential to spread rapidly and can cause serious infections. There are limited options available to treat infections caused by CPE, so antimicrobial stewardship is critical.

We experienced an outbreak of a type of CPE that affected 40 patients at St Mary's and Hammersmith hospitals between July 2014 and October 2015. Thirteen of the 40 patients involved in the outbreak died. An independent review showed that for seven of these patients, CPE cannot be ruled out as a contributory factor in the patients' deaths. However, all seven patients had complex health problems with serious co-morbidities.

We introduced control measures and the outbreak was declared over in December 2015. Three other smaller clusters of CPE arose, which have all been contained. This illustrates the emerging threat of CPE. Action taken includes improved screening and enhanced cleaning.

Hospital-acquired pressure ulcers

We aimed to reduce severe pressure ulcers (grade three and four) developed in hospital by 10 per cent, and far exceeded this with a 42 per cent reduction. The most severe ulcers (grade four) have been reduced to zero.

The programme of improvement included training, skin care champions on wards and working with Imperial College design centre to develop solutions for pressure ulcers as a result of friction, especially behind patient's ears from devices such as oxygen cannulae. We aim to reduce the incidence of avoidable severe pressure ulcers by a further 10 per cent in 2016/17 and strive towards a zero incidence.

Safe staffing

Our staff, patients and public need to know that our wards are safely staffed to provide the best possible care. We specifically measure the percentage of planned nurses, midwives and care assistants that were actually on duty for each shift. We exceeded our target of ensuring that all shifts have safe staffing levels – with 95 per cent for registered nurses (target 90 per cent) and 93 per cent for care staff (target 85 per cent).

Effective

Goal: To be in the top quartile for all national clinical audit outcomes

Clinical audit is a key improvement tool through which we can monitor and improve the quality of care that we provide. We set ourselves a target of being in the top quartile for all national clinical audit outcomes. However, most national audits are not reported in quartiles, and this has made it difficult to analyse our performance in this way. So we are changing our goal for 2016/17 to ensuring continuous improvement in national clinical audits with no negative outcomes.

The Care Quality Commission describes effective care as care, treatment and support which achieve good outcomes, promotes a good quality of life and is based on the best available evidence. We have made a number of improvements on these fronts throughout 2015/16 which will contribute to improved performance in national clinical audits. Here we have set out our key measures and performance. For full details of our performance against our 'effective' targets please see our quality accounts.

Mortality rates

Our mortality rates are consistently among the lowest in the country. We closely monitor our mortality rates using two indicators – HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator) which enable us to compare our rates with similar Trusts.

Our HSMR rate for December 2014 to November 2015 is the lowest of all acute non-specialist trusts in the country. All three of our main sites have lower than expected mortality rates during this period. Our SHMI rate for October 2014 to September 2015 is the third lowest of all acute non-specialist trusts in the country.

In 2016/17 we will review every death which occurs in the Trust through our new online mortality review system, furthering the opportunities to learn from any avoidable issues and put actions in place to reduce the likelihood of them happening again.

Discharging patients at the right time

In 2015/16 we implemented a discharge improvement programme, with one of the key aims being to improve the timeliness of discharge. An average of 580 bed days per month were lost to delayed transfers of care in 2015/16, with reasons including waiting for an assessment or placement at a care facility or for a care package to be finalised.

Untimely discharge has been identified as one of the most common reasons why A&E departments become full, causing longer waits for patients be seen and admitted or discharged. By discharging patients promptly where clinically appropriate, we are in a better position to place all patients appropriately in the right ward, in the right bed and at the right time.

We aimed to discharge 35 per cent of patients ready to go home before noon, but only achieved 28 per cent. We did, however, implement a host of improvements to our discharge arrangements which should show improvements in 2016/17. These included a seven day discharge service – joining up the hospital discharge team and social services to facilitate discharge including at weekends – and proactive discharge lounges with dedicated nurses and porters.

Offering patients timely participation in clinical trials

In 2015/16 we implemented a process of robust feasibility assessments for all clinical trials, ensuring that everything is in place in advance so patients can be recruited quickly. In 97.5 per cent of our research studies, we recruit the first patients within 70 days – the recognised standard. We have made considerable progress since quarter three 2014/15, when performance was 66.5 per cent.

Caring

Goal: To provide our patients with the best possible experience by increasing the percentage of inpatients who would recommend our Trust to friends and family if they needed similar care or treatment to 95 per cent, and the percentage of A&E patients to 85 per cent

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. We have set out our key measures and performance here. For full details of our performance against our 'caring' targets please see our quality accounts.

Friends and family test

Ninety-seven per cent of inpatients and 95 per cent of A&E patients said they would recommend our Trust to friends and family. Our friends and family test is one key indicator of patient satisfaction – asking patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

In 2015/16 we achieved our goal of increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family, exceeding our target for both and improving on our performance last year.

We also aimed to increase the numbers of people taking the test. For inpatient departments we achieved 27 per cent against a target of 40 per cent. For A&E we achieved 13 per cent against a target of 20 per cent. This has corresponded with an overall drop in response rates nationally.

We have tried to make it easier for people to take the test, introducing a variety of choices including electronic tablets, paper forms, a QR code so people can complete it through their smartphone and through a link on our new website. Members of the patient experience team or volunteers also attend wards and clinics daily to help encourage patients to complete the surveys.

Recognising diversity in feedback

In 2015/16 we changed our systems for collecting patient experience feedback to enable us to reach more diverse patient groups through the introduction of new surveys that can be completed by more of our patients. Our target was to identify any specific concerns that may impact on one group more than another.

We implemented patient experience surveys in the top ten languages used by our patients and in Makaton, which uses signs and symbols to help people communicate. We also produced them in yellow and black for patients with visual impairment and with age appropriate graphics for children and young people.

Responding to complaints

Complaints were high on the national agenda in 2014/15, with the Ombudsman, Healthwatch and the Patients Association all highlighting the value of each complaint as an opportunity to learn and support continuous improvement.

We made significant improvement in responding to complaints within the timescale agreed by the patient – achieving 100 per cent with the 1,145 complaints we investigated this year compared to 63.8 per cent in 2014/15. We achieved this by restructuring the complaints service and process following feedback from patients and staff.

But it is not just about timescales – we shifted the focus from providing a response letter to resolving the concern. We are now regularly receiving thank you messages and compliments from patients about the way in which their complaint was handled. We also put in post four experienced and skilled complaints handlers who provide a single point of contact for complainants throughout the process.

Responsiveness

Our goal: To consistently meet all relevant national access standards through responsive patient pathways in 2015/16 and 2016/17 and to exceed them by 2017/18.

Having responsive services that are organised to meet individuals' needs is a key factor in improving patient experience and in preventing delays to treatment.

Over the past two years, we have made significant progress in making sure cancer patients are seen quickly and that we regularly meet the national standard for diagnostics waits. However, we struggled to meet some other national targets consistently in 2015/16.

Here are the key performance indicators reflecting our responsiveness. To review our full performance against our responsive domain please see our 2015/16 quality accounts.

Referral to treatment (RTT)

Standard	Threshold	Q1	Q2	Q3	Q4
Patients treated within 18 weeks of referral	92.0%	91.8%	91.9%	90.4%	90.0%

We did not achieve the standard due to insufficient capacity in some specialties and issues with data validation. Towards the end of the year, we also saw the impact of industrial action by junior doctors.

An additional issue arose in the last quarter with an increase in the number of patients waiting more than 52 weeks – there were 47 at the end of March 2016. This was linked to issues with our RTT processes which meant we had not tracked these patients consistently. Clinicians have reviewed all of the 47 cases and confirmed that the delay has not resulted in clinical harm. All now have a treatment plan in place.

In partnership with our commissioners and regulator, we have put an agreed RTT improvement plan and 'trajectory' in place for 2016/17, including additional, targeted capacity. We are due to meet the 92 per cent standard from August 2016. We have also asked the NHS intensive support team to help us review our waiting lists and RTT processes and we are planning to bring in a mobile operating theatre on the Charing Cross Hospital site to provide additional capacity temporarily.

A&E

Like many NHS trusts, we have struggled to meet the 95 per cent standard for A&E patients waiting under four hours to be treated and discharged or admitted. Pressures on A&E are complex and include:

- we have seen an increase in patients attending A&E as well as in in patients arriving via emergency 'blue light' ambulance
- there has been an increase in unplanned bed occupancy, increased length of stay and too few hospital discharges during the first part of the day – all reducing the availability of beds for new urgent or emergency admissions
- pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery

Our A&E performance against the 95 per cent standard

Standard	Threshold	Q1	Q2	Q3	Q4
A&E patients admitted or treated and discharged within 4 hours	95%	91.82%	91.94%	90.43%	90.02%

Diagnostic tests

We were challenged in our diagnostic testing in early 2015/16, especially with waits for imaging, due to a combination of high staff turnover, the need for additional equipment and equipment repairs. We did not meet the standard, which was for no more than one per cent of patients to wait more than six weeks for their diagnostic test, between May and August 2015. A recovery plan which increased capacity was put in place and, apart from June when there was a flood in a diagnostic facility, the standard has been met consistently.

Cancer care

The Trust has worked hard to sustain the major improvements we have made in cancer care over the past two years, remaining one of the strongest performing trusts on this measure. Our performance against cancer care is shown in the table, right.

We achieved five out of the eight cancer standards across all quarters. We have implemented a number of actions to stabilise and improve performance. We are working in close partnership with Macmillan Cancer Support to make sure not only are our clinical standards met, but our patient experience is of a high level.

Performance in cancer care

	Threshold	Q1	Q2	Q3	Q4
2 week wait from referral to date first seen all urgent referrals	93.0%	93.3%	93.3%	93.6%	93.0%
2 week wait from referral to date first seen breast cancer	93.0%	93.9%	94.1%	93.9%	93.1%
31 days standard from diagnosis to first treatment	96.0%	97.2%	96.4%	97.2%	96.9%
31 days standard to subsequent Cancer Treatment – Drug	98.0%	99.4%	100.0%	100.0%	99.5%
31 days standard to subsequent Cancer Treatment – Radiotherapy	94.0%	97.5%	99.7%	99.7%	98.4%
31 days standard to subsequent Cancer Treatment – Surgery	94.0%	96.8%	97.5%	97.6%	98.1%
62 day wait for first treatment from urgent GP referral	85.0%	85.0%	85.3%	86.9%	81.6%
62 day wait for first treatment from NHS Screening Services referral	90.0%	92.4%	91.7%	93.5%	76.7%

Well-led

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

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We monitor staff engagement through our quarterly staff surveys and we also review our performance in the national staff survey.

Here we describe some of the key ways we measure how staff feel about the Trust. For full details of our performance against our 'well-led' targets please see our quality accounts.

Friends and family test – what staff think

In our survey, 60 per cent of staff said they would recommend the Trust to friends and family as a place to work – two per cent up from the previous year.

In terms of staff recommending the Trust to friends and family as a place for treatment, 77 per cent said they would do so – the same as the previous year.

Retaining good staff

We have chosen to focus on reducing voluntary turnover – the number of staff who leave the employment of the Trust of their own choice. Retaining good staff is a key aspect of building a strong, consistent workforce able to sustain the quality improvements we need to achieve.

We aimed at 9.5 per cent voluntary turnover and achieved 10.6 per cent. A key aspect of reducing the voluntary turnover rate is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and feel they are supported to develop.

We put a number of initiatives in place in 2015/16 which we hope to see having an impact in 2016/17. These include a talent management programme to identify and support the highest performers, more recruitment from within the existing workforce rather than appointing from outside the Trust, and the launch of our shared values and behaviours.

Reducing sickness absence

Low sickness absence is an indicator of effective leadership and good people management. As such, we chose this target as a measure of staff satisfaction and wellbeing. In 2015/16 we slightly exceeded our target to reduce the rate of sickness absence to 3.4 per cent or less – achieving 3.2 per cent.

We supported managers to streamline and manage sickness absence better, and ran a range of health and wealth being initiatives for staff, including smoking cessation clinics, annual wellbeing weeks, yoga classes, weight management programmes and mindfulness programmes.

Statutory and mandatory training

Nearly 87 per cent of all staff have carried out their online statutory and mandatory training against our target of 95 per cent.

We have improved our compliance rates by over 17 per cent since last year and reported our highest compliance rate to date. We achieved the increase with a number of initiatives including the launch of our new online training system and ran awareness campaigns across the Trust.

Our statutory and mandatory training programme ensures the safety and well-being of all our staff and patients, this includes core skills modules which have a direct impact on patient safety, such as information governance, safeguarding adults and children. Our contracted and sub-contracted staff are also required to carry out this training.

Ward accreditation programme

Following our last CQC inspection, we decided to launch our own internal programme of ward inspection to carry out regular checks and instigate immediate improvement where necessary. This target was chosen to ensure this is implemented throughout the Trust as we believe it is a valuable tool in ensuring consistent levels of care across our wards.

We reviewed a total of 80 areas between July and November 2015, including all inpatient wards and our four main outpatient areas. Examples of good practice observed included caring and respectful communication with patients and excellent leadership in many areas. Examples of common areas for improvement include documentation and reviewing leadership development for more junior staff.

Ward accreditation programmes are designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed. It supports ownership of quality standards at frontline ward level.

Other highlights of 2015/16

Spring

The Trust congratulates The Duke and Duchess of Cambridge'

Her Royal Highness the Duchess of Cambridge gave birth to a daughter, Her Royal Highness Princess Charlotte of Cambridge at The Lindo Wing of St Mary's Hospital, an event that attracted the world's press.

Improved and expanded maternity services

More mums-to-be will be able to give birth at Queen Charlotte's & Chelsea and St Mary's hospitals following the improvement and expansion of facilities, increased staff numbers and opportunity for more pregnant women to see the same midwives for all their appointments.

Leadership programme scoops prestigious HR award

The Trust's suite of five leadership and development programmes scooped top prize in the HPMA Excellence in HRM Awards 2015. The programme was designed to directly impact on improving patient care and allow staff to apply their learning to real problems and situations.

New eye surgery technique brings real benefits to patients

Surgeons at the Trust introduced a new transplant technique known as Descemet's membrane endothelial keratoplasty, transforming eye surgery and recovery times for patients with Fuchs' endothelial dystrophy, a problem that results in gradually worsening vision.

Summer

Macmillan navigator launch for cancer patients

We launched our Macmillan navigator service – a single telephone contact for Trust cancer patients who will help guide each person with cancer through their health service journey from detection to diagnosis, through treatment and beyond.

Pioneering brain tumour surgery

A PhD student, Reuben Hill, successfully underwent pioneering brain surgery at Charing Cross Hospital, where surgeons used a specialist laser probe to detect the subtle differences between cancerous and healthy brain tissue along with an iKnife that instantly identifies the cancerous tissue, so healthy brain tissue is unaffected.

Surgeons advance glaucoma treatment with smallest ever implant

Our surgeons were amongst the first in the UK to introduce a new surgical eye pressure lowering device – the iStent – to help prevent sight loss for patients with mild to moderate glaucoma who need to have cataract surgery to improve their vision.

New specialist services for older patients

Frailty units at Charing Cross and St Mary's hospitals opened with dedicated space for older people needing a short stay in hospital, with a specialist team to help with such problems as falls, poor memory, weight loss and mobility problems.

Autumn

Rising IT star

Our IT project manager Felix Vaal scooped the Rising Star 2015 in the e-Health Insider Awards at an event that brought together over 700 of the country's top IT and clinical professionals from across the NHS in the UK.

More Smiles Appeal

The More Smiles Appeal was launched by Imperial College Healthcare Charity and charity COSMIC, aiming to raise at least £2 million towards a £10 million project to expand the children's intensive care unit at St Mary's Hospital.

New website

Our new Trust website was launched – the culmination of over a year's work to improve the content, navigation, accessibility and look and feel of the website for patients, local people and key stakeholders such as GPs.

A unique robot for enlarged prostate treatment

The UK's first robotic prostate artery embolisation took place at St Mary's Hospital using the Trust's endovascular robot – the only one of its kind in the UK – for men who are not suitable for surgery.

Winter

Biomedical scientists awarded Queen's Ebola Medal

Seven of our biomedical scientists were awarded the Queen's Ebola Medal for their life-saving work in the Ebola stricken country of Sierra Leone where they reduced the blood test turnaround times from five days to less than 24 hours, helping to slow the spread of the disease.

Better 'customer care' in outpatients

Our training programme 'Caring Matters' brought outpatient staff together to design solutions to improving customer care for patients – helping to reduce complaints.

Trust surgeon wins academic award

Mr Daniel Leff, a consultant oncoplastic breast surgeon at the Trust, was awarded the Gukas Award from the University of East Anglia (UEA) for his exceptional performance on the university's specialist clinical master's programme in oncoplastic breast surgery.

Integrated care moves a step closer

The Trust and Hammersmith & Fulham GP Federation signed a 'memorandum of understanding' to explore how we could work closer together to provide more integrated care for local people that dissolves hospital and primary care boundaries.

Accountability report

Corporate governance report
Annual governance statement

Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's vision, objectives and policies, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and acknowledge the responsibilities set out in the NHS Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level, and as such can only provide reasonable and not absolute assurance of effectiveness.

The system of control is based on an on-going process designed to identify and prioritise the risks to achievement of Imperial College Healthcare NHS Trust's vision, objectives and policies, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. This system has been in place at the Trust for the year ended 31 March 2016, and up to the date of approval of the annual report and accounts.

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

To align with the regulatory accountability framework the governance statement is structured against the domains of the well-led framework: strategy and planning; capability and culture; process and structures; and measurement. Well-led is also one of the CQC's domains; the Trust uses these domains widely as a reporting structure.

In listing items as 'significant issues', a number of factors have been considered, including whether:

- it may prejudice the achievement of priorities
- the significant issue outlined could undermine integrity or reputation
- the issues may divert resources from another significant aspect of business
- the issue could have a material impact on the accounts

Strategy and planning: how the board sets the direction for the organisation

Strategic direction

Our vision as a Trust is to be a world leader in transforming health through innovation in patient care, education and research. To deliver this vision, we need to achieve and sustain the following strategic objectives:

- to achieve excellent patient experience and outcomes, delivered efficiently and with compassion
- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an Academic Health Science Centre, to generate world-leading research that is translated rapidly into exceptional care
- to pioneer integrated models of care with our partners to improve the health of the communities we serve

The objectives reflect our long-term commitment to improve the quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce. They are supported by our values, behaviours and promise and will be delivered by our core strategies; clinical, quality and financial.

As an organisation, the Trust believes it is essential to progress longer-term developments as well as tackle immediate challenges if it is to provide the very best care, now and in the future.

One important development strand of this has been a refresh of the organisational values and behaviours, undertaken in 2015/16, to help establish

a shared view of 'who we are and what we stand for' as a Trust. These values, and the behaviours which support them, have been brought together with the core strategies and key improvement initiatives to define a transformation programme for the organisation. The main elements of this are outlined below.

Our ethos is to help everyone to be as healthy as they can be; we want to look out for the people we serve as well as look after them. Our promise is 'Better health, for life'. This will be achieved through our values and behaviours. Our values are:

- **Kind** – we are considerate and thoughtful, so you feel respected and included
- **Expert** – we draw on our diverse skills, knowledge and experience, so we provide the best possible care
- **Collaborative** – we actively seek others' views and ideas, so we achieve more together
- **Aspirational** – we are receptive and responsive to new thinking, so we never stop learning, discovering and improving

Each of these values has a number of behaviours associated with it, with the aim of ensuring our care is not only clinically outstanding, but also as kind and thoughtful as possible. Making the values become part of the way all staff behave on a day-to-day basis will not only help deliver this aim, but also improve the experience of every patient and every staff member

The Trust board will, early in 2016/17, review and approve the Trust's Operational Plan, which will describe how, as the Trust looks to the future, it seeks to have an active role in health system redevelopment, working with north west London partners to develop a five year Sustainability and Transformation Plan to transform health services for a sustainable north west London sector. Some Trust work streams are having a more immediate impact, with significant progress in 2015/16: Health informatics; integrated care; Patient services centre; North West London Pathology; and patient and public involvement.

Aligned with this will be other Trust priorities to return the Trust to financial balance, and to continue to increase the quality, safety, responsiveness and productivity of the care we provide to patients.

Implementation of the clinical strategy, developed through a large-scale engagement process, and approved by the Trust board in July 2014, continues, setting out how the Trust will improve services and deliver them in the most clinically and cost effective forms and addresses challenges and opportunities identified, whilst the quality strategy provides the processes and tools to continuously improve the quality, safety and responsiveness of services.

We are working to:

- offer routine services locally wherever possible
- centralise specialist services where it will improve clinical outcomes and safety
- join up services more effectively, linking with other health and social care providers
- personalise care and treatment around individual needs and preferences

Our clinical strategy will be delivered through the Clinical Strategy Implementation Programme (CSIP). This is an evolving portfolio of service developments and reconfigurations focusing on sustainable improvements in specific pathways or service areas, all contributing to achieving our clinical vision and the delivery of high quality services, seven days a week.

Phase one of the programme commenced in September 2015, with the following workstreams underway:

- review of vascular surgery services
- developing the ambulatory care strategy
- streamlining the pathway for patients with chest pain
- review of acute medical services on all three sites

Each workstream is consultant-led and involves a comprehensive review of the service, with input from stakeholders at all levels. Phase two is currently in the scoping stages and will launch in April 2016.

This will be supported by a reconfiguration of our services across three main sites as well as in local health centres. Our redevelopment programme heralds the most significant transformational changes to the estate in recent years, reflects the wider programme for service reconfiguration agreed for North West London, Shaping a Healthier Future, led by our clinical commissioning groups. A business case for our estates redevelopment is being considered at national level within the NHS. It will allow the Trust to provide care in fit for purpose care environments and to redesign pathways and care models.

Capacity to handle risk

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

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

The board assurance framework provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.

The assurance framework is being reviewed and updated, and a revised framework will be introduced in early 2016/17 reflecting national best practice. Responsibility for maintaining the framework rests with the trust company secretary. The framework is described further in the capability and culture section.

Annual quality account

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year.

In 2014-15, the Trust board undertook a review of our quality strategy to align our goals with the five CQC domains. The Quality Strategy 2015-2018 sets out our definition of quality, under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction, ensuring quality is our number-one priority. The strategy is designed to ensure we are providing safe, high-quality care and can achieve a 'good' rating in our next CQC inspection, while striving for outstanding. It was developed following an extensive consultation period with internal and external stakeholders to ensure it meets national, local and Trust priorities. Implementation of the quality strategy is supported by the quality improvement (QI) programme launched in September 2015.

The programme provides staff with the necessary skills and tools to enable and empower them to lead QI projects in their own work areas. This programme is made up of two elements: a quality improvement training programme providing blended training for our people, based on the IHI Model for Improvement (PDSA), and a team called the QI hub to support improvement delivery and measurement.

The Trust's annual quality account describes progress with the goals, targets and improvement programmes outlined in our Quality Strategy and sets the priorities for the following year.

An integrated operational and quality performance scorecard is reported to the Executive Operational Committee and the Board on a monthly basis. The report is divided into the five quality domains and includes the quality strategy goals and targets. The monthly quality report, which is reported to the Executive Quality Committee and the Board Quality Committee, specifically details the quality strategy goals and targets.

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

Significant issue: the Trust's financial position

The Trust set a deficit budget of £18.5m for 2015/16 largely reflecting the loss of £20m annual subsidy for the treatment of complex patients. Shortly after the midpoint of the financial year it became clear that the nature of the Trust's underlying financial position meant that a deficit outturn of in the region of £30-35m was more realistic.

In addition there were adjustments primarily to reflect a re-assessment of the condition of our estate, bringing our total year end position to a deficit of £47.9m. Furthermore, as 2015/16 included a significant degree of non-recurrent support, the recurrent underlying financial position was in deficit to in the region of £54m.

The Trust Executive, with the support of the Trust board, implemented centralised financial controls and appointed a strategic advisor with financial turnaround expertise. The strategic advisor's report was accepted by the Trust board at its January meeting and the implementation of phase 1 was completed in April 2016.

As outlined elsewhere in the statement, the report recommendations included a simplifying of the Trust's organisational structure, the implementation of more rigorous financial control at directorate level and a programme of deeper reviews of the sustainability of each service line.

The Trust has also been successful in its application to be part of the NHSI Financial Improvement Programme and the successful financial improvement partner started its first phase of work in the Trust on April 25th 2016.

The Trust's budget submission for 2016/17 was a deficit budget of £52m, consistent with the identified underlying financial position but including a significantly stretching efficiency programme. The first phase of the Financial Improvement Partner's work will be to produce an evaluation of the Trust's Financial, Operational and Leadership/ Governance strength – this will be shared with the Trust board and with NHSI around June/July 2016.

The Trust's 2016/17 plan includes a dependence upon a revolving working capital facility provided by the Department of Health to provide sufficient working capital for the running of the Trust. There are terms and conditions for the provision of this support which largely involve compliance with national financial guidelines, these have been accepted by the executive and Trust board.

The issue of going concern has been discussed at Audit, Risk and Governance Committee with the active contribution of external audit. The Trust board exercises much of its financial governance via the Finance and Investment Committee and the Audit, Risk and Governance Committee, both of these committees are engaged in the oversight of the issues and actions outlined above.

During 2015/16, commercially sensitive negotiations have continued around Trust-owned estate, estate owned by the Charity but used by the Trust and estate leased by the Trust. These negotiations have been overseen by formal sub-committees of the board and specially constituted single issue sub-committees reporting back to the Trust board. To the extent that there are any financial implications these are covered in the accounts which are prepared under the oversight of the Audit, Risk and Governance Committee.

Significant issue: condition of the Trust estate

As in 2014/15, this remains a significant issue for the Trust, and will not be fully resolved until the Trust is able to fund redevelopment of its sites, particularly the St Mary's Hospital site. The backlog maintenance to the Trust Estate has recently surveyed and is now estimated at £1.3bn, with most of it remaining as condition D.

The risk mitigation strategy, while redevelopment options are pursued, includes continued investment in the high risk items, pro-active risk surveys and targeted remedial works and with the award of the Hard FM contract an increased focus on planned preventative maintenance and statutory compliance.

Capability and culture: how the board ensures it has the appropriate experience and ability, and positively shapes the organisation's culture to deliver care in a safe and sustainable way

The Trust board

As outlined in the directors' report, the Trust board is accountable through the chairman, to the Trust Development Agency (TDA) (NHS improvement from 1 April 2016, following a merger with Monitor) and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The Trust board, and each of the committees, undertook a self-assessment of performance and effectiveness, using a detailed questionnaire developed by the Audit Commission for this purpose.

The questionnaire was sent to all committee members and standing attendees for completion. The findings were reported back to, and discussed at, the relevant committee and also to the Trust board to improve future performance.

Whilst the results varied between the committees, in general, areas of particular strength were seen to be the quality of the chair; links between the individual committees; and the skills and commitment of members.

Common areas where improvements were seen to be desirable were the length, relevance and timeliness of papers, and the understanding of the interaction of sources of assurance and how these map to risk.

Both of these areas have been addressed, with a revised committee template having been introduced, and a significant revision of the board assurance framework, as outlined here.

Risk assessment

The board assurance framework has been comprehensively reviewed during the latter part of 2015/16 to reflect best practice as outlined in 'Board Assurance: A toolkit for health sector organisations' (NHS Providers/Baker Tilly, 2015). An internal audit of the board assurance framework supports the change.

The proposed revised framework will be presented to the Trust board in May 2016, for implementation from June, and provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the robustness of internal controls to reduce or manage the risks to an acceptable level. An assurance mechanism is of a different nature, requires different information and will follow a difference structure to that of the usual reporting arrangements of an organisation.

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

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

The board assurance framework references areas of risk in the Trust against the strategic objectives, and also highlights the specific relevant risks on the corporate risk register. The key sources of control and assurances, both internal and external are reviewed for their adequacy and relevance.

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

As the Trust moves into 2016/17, the following are considered to be its current key risks as detailed on the corporate risk register.

Strategic Risks	Risk Mitigation and Control
Failure to maintain financial sustainability	• Appointment of an advisory team in May 2016 as part of the NHSI Financial Improvement Programme • The implementation during 2016/17 of financial turnaround disciplines on cash, discretionary expenditure and service line reviews as outlined by the strategic advisor's report presented in February • Contract Negotiating Team engaging with Divisions via Service Agreement Steering Group with progress reports on contracts to Finance and Investment Committee via the Executive Committee • Feedback on consultation of national tariff. Monthly financial reporting and performance reviews. Regular meetings with Commissioners and TDA to review contract performance • Star chamber approach in place to monitor urgent in-year measures taken • Cash controls. To include: stock control, cash monitoring, debt collection, creditor management
Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target	• Implementation of compliance and improvement framework with regulatory requirements to drive related quality improvement • Framework includes variety of quality activities, including delivery of the CQC action plan and peer review assessments based on CQC inspection methodology • CQC Intelligent Monitoring (IM) risks or outliers managed in line with the Trust's risk management policy • Framework is a component of the trust's quality strategy and aligns with other key trust initiatives • Implementation of the framework supported by a communication plan
Failure to meet required or recommended vacancy rates across all areas of the organisation	• Restructure and new admin support now in place to reduce the total time to hire. Head of Resourcing now in place • Recruitment open days being held with a rolling programme of recruitment – slight reduction in vacancy rates being experienced • All current vacancies for nursing in key areas advertised • Safe staffing on wards monitored through monthly fill rate reports • Shift fill rates maintained at 90-95%
Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	• Regular meetings with TDA for early identification of potential issues / changes in requirements • Active management of backlog maintenance • Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluations • Internal and external resource and expertise in place
Failure of critical equipment and facilities that prejudices Trust operations and increases clinical and safety risks	• Statutory and regulatory inspection are now in place to pick up risks to continued safe operation of the Trust • Formal reviews of operational performance conducted monthly • PLACE (Patient-Led Assessment of the Care Environment) undertaken to understand patient perceptions and identify priorities from a patient perspective • Estates & Facilities, Health & Safety, Fire and Compliance Committee established to monitor compliance
Risk of increased amount of time it takes to report on a diagnostic investigation due to the introduction of Radiology Information System and Picture Archive and Communication System	• Additional radiologist sessions to report on images and reduced turnaround time • Monitoring and reporting of backlog • New system being introduced early in 2016/17
Risk of Spread of Organisms such as CPE (Carbapenem-Producing Enterobacteriaceae)	• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship • CPE policy in place and patient and staff information available • Flagging system in CERNER for identifying readmissions of positive patients

Continues overleaf

Strategic Risks	Risk Mitigation and Control
Failure to deliver safe and effective care	• Executive responsibility for clinical governance revised • Compliance and improvement monitoring governance process through the Executive Quality Committee • Trust-wide reports including performance data in place • Staff training for incident and risk management including clinical audit, Datix, duty of candour, and organisational learning
Failure to deliver outpatient improvement plan	• Outpatient improvement steering group • Outpatient improvement monthly dashboard • Leadership walkrounds • Referral tracking indicators for OPD booking office
Failure to maintain key operational performance standards	• ED – Comprehensive control mechanisms including increasing capacity and escalation plans in place • RTT – Introduction of theatre utilisation meeting and patient review to ensure prevention of harm • Cancer Wait Times – Increased investment in cancer MDT coordinators and improved pathway tool • Diagnostic Wait Times – Increased radiological sessions and clear escalation plans
Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors	• Education transformation programme launched • Proactive management of recruitment and rotas • National trainer census complete – meets required standards • Formal process for the management of education action plans in place
Failure to assess the risks to the health, safety, and wellbeing of employees, workers, students, and visitors	• Strategic and Divisional/Corporate Health and Safety Committees in place • Trust-wide health and safety action plan, including a Trust risk profile • Health and safety risk assessments undertaken and recorded on assessnet • Health and safety training, including health and safety e-learning, manual handling training and fire safety training

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

The Trust board reviews and approves the monthly self-assessment statements required as part of the TDA's governance arrangements, following individual and Executive Committee sign-off. With the withdrawal of this process for 2016/17, the Trust will introduce a similar monthly compliance sign-off by directors, which will again, be presented to the Trust board.

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

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

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

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

Care Quality Commission registration

The Trust is currently registered with the Care Quality Commission (CQC) with no conditions.

The CQC did not carry out any inspections of the Trust during 2015/16; however, the Trust participated in CQC inspections of other providers and in special reviews carried out by the CQC as follows:

- the Marjory Warren ward was visited in April 2015 as part of the CQC's inspection of the Central London Community Healthcare NHS Trust (CLCH). Although the ward is on Trust premises, the staff and all aspects of care, including cleaning, are provided/delivered by CLCH
- some GP practices within the Hammersmith and Fulham CCG were inspected in September 2015. The GP practice within the Trust's Urgent Care Centre is included in this area, but it was not inspected
- the Trust was included in a national thematic review of integrated care for older people in November/ December 2015 which captured the area served by the Hammersmith and Fulham Health and Well-being Board. The Trust was not visited, however, Trust patients were included (records were reviewed) and Trust staff participated in focus groups
- the Trust was included in a national review of Information Governance practices in the NHS in November/ December 2015
- in January 2016 the CQC published a new approach to how child safeguarding will be jointly inspected by the CQC, Ofsted, Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP). The Trust's Tri-borough Children's Services had their inspection in February 2016, which was led and managed by the Local Safeguarding Children Board

The action plan developed by the Trust in response to the CQC inspection in September 2014 has been delivered throughout 2015/16, with progress monitored each month by the Executive Committee, Quality Committee, Trust Board, and the clinical quality group (CQG) led by the CCGs.

The majority of the action plan has been completed with a few outstanding actions remaining such as achieving the target for completion of statutory and mandatory training, although a Trust-wide programme to improve this is underway. Longer term actions which are not scheduled to be completed until 2017 include the Outpatients' Improvement Programme and refurbishment of two paediatric areas.

Six months after implementation of the action plan began, key performance indicators were introduced to check that the action taken had addressed the concern and had impacted positively on outcomes. Performance is reported alongside progress towards delivery of the action plan.

A compliance and improvement framework, based on the CQC's regulatory approach for NHS trusts was implemented during 2015/16. The framework included:

- core service reviews which are unannounced CQC style reviews, to check that services rated by the CQC as 'Inadequate' or 'Requires improvement' overall were making the necessary improvements. Nine core service reviews were undertaken throughout 2015/16
- deep dives to check that services rated by the CQC as 'Good' overall continued to meet this standard of care. Eight deep dives took place in 2015/16
- reviews to check on areas / services not visited by the CQC during the inspection in September 2014, for example a deep dive of the trust's seven renal satellite units and a core service review of the Western Eye Hospital
- introduction of a ward accreditation programme for all inpatient areas. A total of 80 clinical areas were reviewed in 2015/16

Looking ahead, the compliance and improvement framework for 2016/17 will take account of:

- lessons learned from implementation of the framework during 2015/16
- learning from other trusts that have improved and achieved better ratings following subsequent CQC inspections
- the outcomes of an Internal Audit evaluation of the framework's effectiveness
- the CQC's new strategy for regulating NHS trusts, for 2016-2021 (currently scheduled for publication in May 2016)

Raising concerns (whistle-blowing)

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

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

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

Step 2 and step 3 qualifying disclosures are reported to the Executive Committee and Quality Committee.

The Trust recorded 17 new protected disclosures on its whistleblowing database, a slight increase on the 15 disclosures in 2014/15. This was considered to be due primarily to heightened awareness of the need to report concerns following Trust communications encouraging people to raise concerns and the national Freedom to Speak Up campaign. Protected disclosures were made by people across the organisation and in a range of work settings, by people working in the corporate directorates and each of the divisions.

Disclosures related to a range of issues including patient safety, competence of staff, theft of medical supplies, discriminatory and unsafe recruitment practice, unsafe staffing levels and poor cleaning standards. On-going campaigns to encourage people to report incidents are likely to increase the number of centrally recorded protected disclosures in future years. People are encouraged to contact the freedom to speak up guardian and/or the designated non-executive director if they do not have confidence in the normal processes for raising concerns or if they have already raised a concern but not received a satisfactory response.

The Trust will continue to promote awareness through a communications campaign which will include posters, briefings and manager information via the Trust's main communication channels. It will also be incorporated into the workforce policy training sessions provided to managers.

The staff survey results for 2015 indicate an increased number of staff witnessing errors or incidents and a top 20 per cent score for staff reporting concerns. Confidence in the perception of the fairness and effectiveness of procedures put in place designed to deal with these issues has reduced. The Trust's result for this factor was in the bottom 20 per cent when compared to other acute trusts in England. The Trust will embark on work to address this including the relaunch of its raising concerns (whistleblowing) policy. The Trust has amended understanding workforce policies training to ensure managers are aware of their responsibilities in handling concerns that are raised in relation to unsafe practices and or errors.

Leadership development

The Trust has offered five leadership programmes to leaders and managers across the Trust from senior leader to frontline supervisor.

Horizons, our strategic leadership programme has run two cohorts in year, preparing our most senior leaders for their current and next role. Our Aspire programme supports those new to a senior leadership role and has run three cohorts this year, with some significant workplace projects completed as a result.

For those in management role, we offer our Headstart programme, with four completed cohorts, and our fourth programme Foundations provides support to those in their first supervision of team leadership role. In addition we have offered our unique Paired Learning programme which aims to bring together junior doctors and junior managers or other clinicians into a joint leadership development programme.

To support all our leaders, we run a twice yearly Leadership Forum to bring together all our senior leaders for a day of development and networking. We continue to offer bespoke training in Performance Development Review skills, (PDR) to support our refreshed PDR process, and we also provide training in Coaching and mentoring, and offer all our delegates on programmes access to an internal coach to support their development.

Informal meetings of board members continued on a bi-monthly during 2015/16. Where appropriate these took a developmental approach, either in learning or in enabling broader debate on key areas of interest. During 2015/16 these included:

- a workshop on the development of Trust values: board members contributed their views to those of over 6,000 staff in creating the Trust values: Kind, Collaborative, Aspirational, Expert
- a discussion focused on clarifying the information that the Trust board needed to shape its understanding of operational, clinical and financial performance on a monthly basis, culminating in a revised Performance Scorecard
- a workshop on 'Living the values' – how could board members be part of exemplifying and influencing others to embed the new Trust values
- a detailed discussion on the way in which the Trust should address transformation improvement, and the organisational review required to support this
- a detailed review of the Trust's plans for financial recovery, and progress towards building sustainable financial plans for 2015/16

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

Emergency preparedness

The Trust participates in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process

carried out by NHS England. In July 2014, NHS England issued new Core Standards for EPRR, which set out the minimum standards NHS organisations must meet and are assessed against.

The Trust's annual assessment was completed in October 2015 and the following results were achieved:

- 12 core EPRR standards; 8 = Green, 4 = Amber and 0 = Red
- 51 evidential measures – 43 = Green, 8 = Amber and 0 = Red
- 31 HAZMAT/CBRN equipment check – 31= GREEN
- 4 further (deep dive) evidential measures relating to pandemic flu preparedness resulted in all 4 areas being rated GREEN with a further comment by NHS England, "this is a succinct and well laid out plan providing a huge amount of information regarding the Trust preparation and response for a pandemic. Support the green rating of the other aspects of the deep dive assurance."

An action plan for the amber ratings has been prepared and is being co-ordinated and monitored by the EPRR team. The actions are reported through Executive Committee and in a six-monthly report to Trust board.

Information governance

The Health Records, Applications and Caldicott Committee is responsible for the review of the Trust information governance policy, strategy, staff communications plan and subordinate information governance policies.

The chief information officer is the senior information risk officer (SIRO) with overall responsibility for information governance (IG). The Caldicott guardian is the appointed senior clinician, who carries the ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information.

Information governance toolkit return

The Trust has submitted an overall return of 67 per cent (satisfactory). The satisfactory rating was achieved by ensuring the Trust was able to return a minimum level 2 assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2015 and in March 2016. The final audit report gave the Trust 'substantial assurance' of the self-assessment. The Trust has maintained a satisfactory information governance toolkit return for the last four years.

Information governance training

All staff including students, temporary staff and honorary contract holders, must undertake annual mandatory information governance training. This is provided using the Trust's independently audited online information governance training programme. The requirement set by the Department of Health is 95 per cent of staff must undertake approved information governance training on an annual basis (if the Trust fails to reach this target then it must submit an unsatisfactory information governance toolkit return). In the 2015/16 financial year the Trust achieved 97 per cent compliance.

Information security incidents

The Trust had no data security breaches that required reporting to the Information Commissioner's Office during 2015/16. Information security incidents are reported via the Trust's incident reporting system DATIX. Information governance incidents are also separately recorded in the Department of Health provided IG SIRI database. Incidents are reported to the Caldicott guardian at the weekly Caldicott review meeting. They are also reported via the Caldicott guardian annual report and the Caldicott guardian half year report to the health records, applications and Caldicott Committee. Incidents relating to ICT security are discussed at the ICT Security Audit and Risk Committee (ICT-SARC) where they can be used to inform the ICT risk register and/or the informatics audit programme managed by TIAA, the Trust's independent auditors. A summary of the 39 IG SIRIs / CYBER IG SIRIs that occurred during the 2015/16 are set out below:

Total number of reported IG SIRIS / IG CYBER SIRIs 01/04/15 – 31/03/16	Number
Level 2 Serious Incidents (Reported to DH and Information Commissioner's Office)	0
Level 1 IG SIRIS (Internally Reported)	35
Level 0 IG SIRIS (Near misses)	4
Total	39

Clinical audit

The Trust's Clinical Audit Programme was developed in 2014 when responsibility for effectiveness transferred to the medical director in order to implement a comprehensive process of practice review. This programme ensures that we are providing healthcare in line with standards, and lets us and our patients know where services are doing well, and where improvements could be made. It includes national clinical audits, locally developed priority clinical audits and audits of NICE guidance compliance, processes for which are described below.

- National Clinical Audits – outcomes from these publications are outlined in the quality report which is presented to Executive Quality Committee and Board Quality Committee. Actions and recommendations are assigned a lead and a timeframe and logged on a clinical audit database. The lead is responsible for completing the action and submitting the evidence to the corporate safety and effectiveness team who then confirm that the action is closed.
- Local Clinical Audit – we have introduced a corporate audit team who conduct audits in chosen priority areas to support improvement work being undertaken throughout the Trust; this includes the qualitative WHO checklist audit, an audit of the correct use of consent documentation and an audit of patient transfers between sites. These audits are logged and the actions managed in the same way as national audits. A summary of these audits, and the level of assurance obtained as to whether there is a robust series of internal controls in place, is reported quarterly to the Executive Quality Committee, along with progress against any actions and recommendations.
- NICE guidance audits – these are mandatory reviews of NICE guidance undertaken by each division. From April 2016 evidence for compliance with these guidelines will be uploaded onto the audit database and reviewed quarterly as part of the clinical audit programme report.

Serious incidents

The Trust has a robust process in place to ensure appropriate review and action is taken for all patient safety incidents. We investigate all incidents which are reported on the Trust's incident reporting system, Datix. Incidents graded low harm, no harm or near miss are reviewed locally.

All patient safety incidents graded moderate and above are reviewed at a weekly panel held in the medical director's office. Each incident is reviewed when it is first reported on Datix, and then again each week until the investigation has been completed and it is closed from a trust perspective. Incidents that are deemed to be 'Serious Incidents' or never events also undergo an investigation which involves root cause analysis.

We monitor actions that result from incident investigations. Following investigation, all actions are assigned a lead and logged centrally on the Datix system. Once the leads feel that the action has been completed, they submit evidence to the corporate safety and effectiveness teams who confirm closure of the action.

Learning from these incidents is shared to promote improved care and prevent reoccurrence. This is done through communications programmes for specific themes e.g. safer surgery, divisional quality boards and newsletters, via the Trust intranet and through meetings with individual teams.

Never events

The Trust reported seven never events in 2015/16. A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The never events related to the following:

- 3 wrong implants
- 1 wrong site surgery
- 2 retained foreign object post-procedure
- 1 wrong device inserted.

They are all related to practices in surgery, however the root cause was different for each incident, so individual actions have been taken for each, including performance management procedures. There were however similar themes from each incident, particularly related to compliance with the WHO safer surgery checklist and to effective team work and leadership in theatres.

An improvement programme has been implemented to promote safer surgery throughout the organisation and prevent similar events occurring, including the launch of an invasive procedures policy, designed to be compliant with the newly published National Safety Standards for Invasive Procedures (NatSIPPs), the introduction of a mandatory online WHO checklist training programme and the implementation of a simulation training programme to promote improved team-working in theatres.

Process and structures: how reporting lines, structures and accountabilities support the effective oversight of the organisation

Trust board

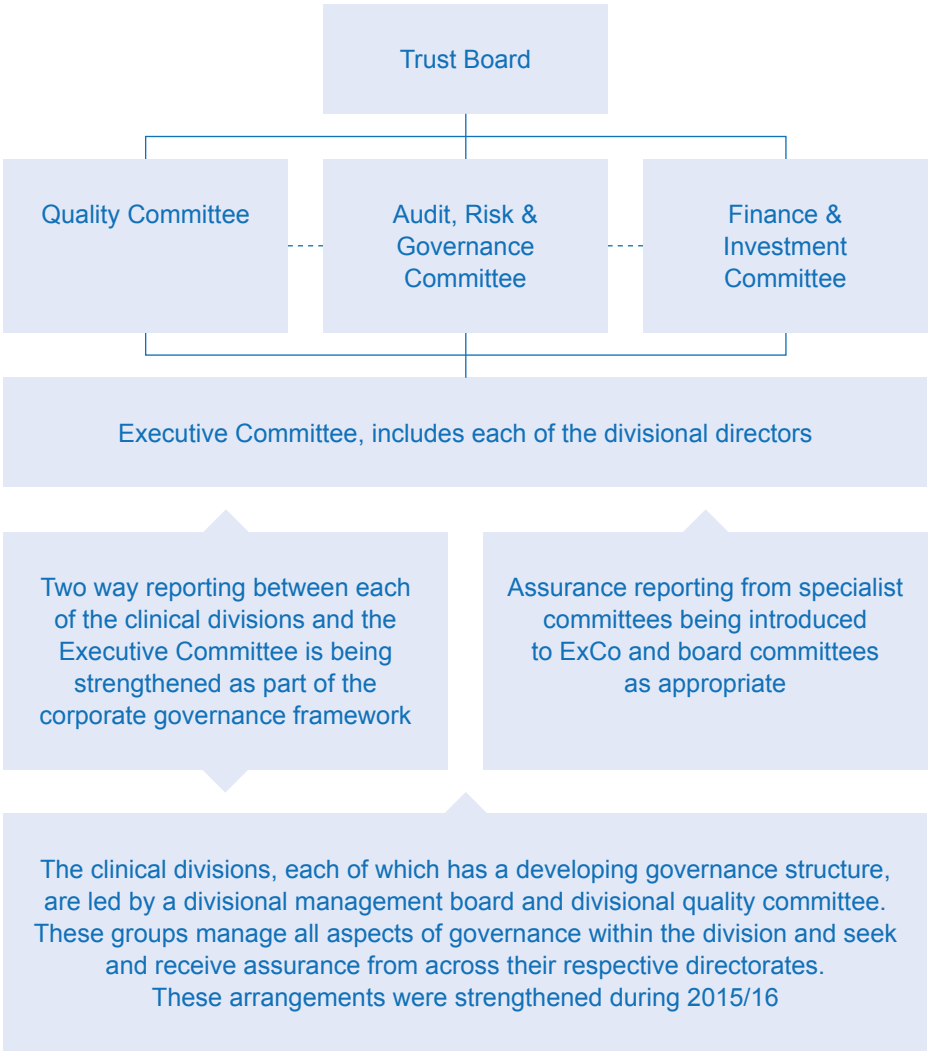
Details of the Trust board and its committees are contained within the directors' report. As outlined, each of the committees and the board undertake an annual self-assessment of effectiveness; areas requiring improvement are considered as part of board development.

Risk and control framework

The Trust has a systematised framework for ensuring effective reporting mechanisms, not only from the divisional management and divisional quality groups, but also from the specialist committees (for example the Health and Safety Committee and Infection Control Committee); the framework for this is outlined in the table, right.

As outlined here in strategy and planning, the risk management policy describes the approach that the Trust will take to identifying, managing and mitigating risk. All risks and potential hazards are identified and are recorded at directorate level, which identify key controls and mitigating action plans formulated to deal with these.

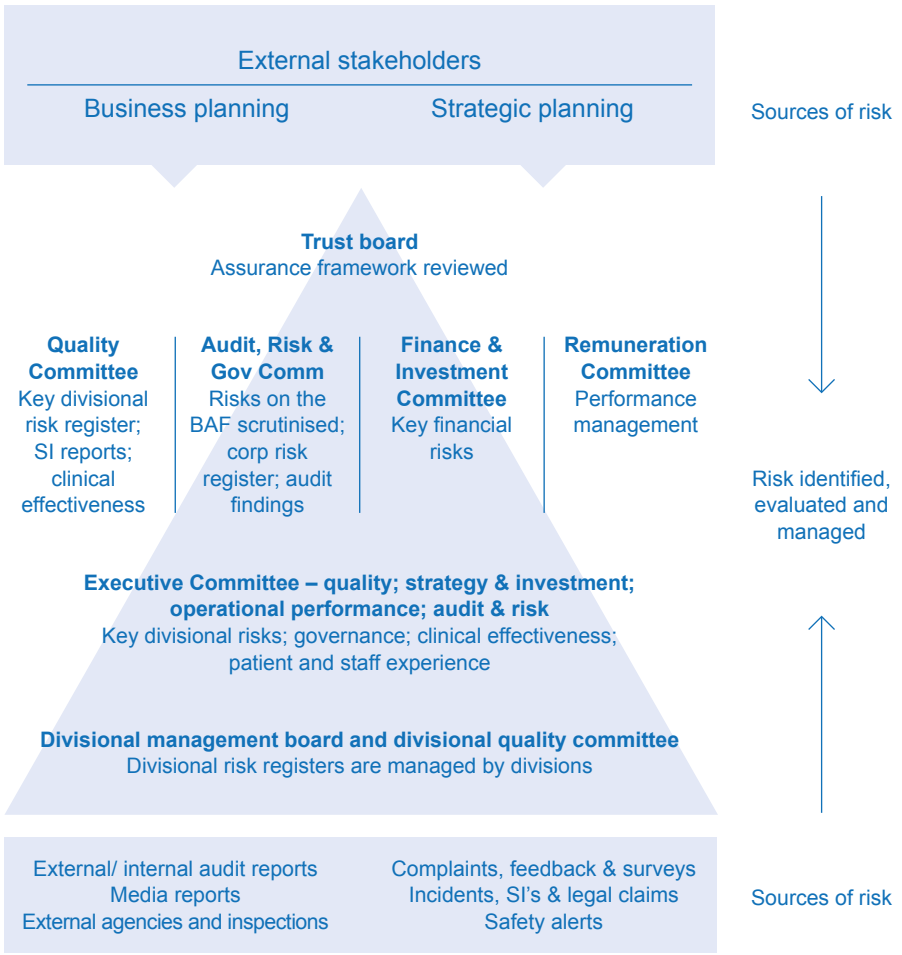
Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be satisfactorily resolved or managed at a local level, they are considered for inclusion in the divisional or functional registers, with risks on these registers in turn reviewed for inclusion in the corporate risk register. Each division has a governance lead; their key role is to support the division in identifying and mitigating risks.



The table articulates the way in which the clinical divisions link into the board assurance framework.

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

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



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

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

The board receives the Trust performance scorecard which consists of a range of key performance indicators highlighting performance against quality, safety and operational targets. The quality report, which provides up-to-date information on a wider range of quality and safety indicators, is also reviewed monthly at the Executive Committee and at meetings of the Quality Committee where detailed reviews are undertaken of areas where potential issues are identified.

A suite of metrics, aligned to the five CQC domains of quality, have been agreed as the indicators of progress towards achieving the quality strategy. These metrics have been developed on a divisional and site basis as well as at Trust level, covering patient safety, patient experience and clinical effectiveness, highlighting current quality and safety issues and action being taken.

The Strategic Health and Safety Committee is now embedded, and this brings together representatives from all

divisions and functions across the Trust. Clear assurance reporting is now in place to ensure appropriate compliance with legislation and robust management of any identified health and safety risks.

The standing orders and financial instructions were reviewed at the Trust board and Audit, Risk and Governance Committee respectively, and required no further changes. The delegations of financial authority were also reviewed and revised, and approved by the Audit, Risk and Governance Committee. All documents will be further reviewed to ensure appropriate arrangements are in place to reflect the revised organisational structure outlined below.

Revised organisational arrangements

Towards the end of 2015 the Trust engaged external expertise to review the Trust performance year to date (particularly following from the emerging financial position at month seven), and to provide advice on a suggested way forward which would support rapid improvement in financial and operational performance. Part of the proposals from this review led to the introduction of an short-term enhanced cash control system and an effective cost control system, with a team of three per directorate that review all areas of controllable costs to identify opportunities for reduction.

The review also recommended a review of the organisation structure. The executive team reviewed both the clinical and corporate management structures, looking to build on the divisional structure put in place in 2013, to devolve authority and responsibility further to the frontline and to ensure clear and simple lines of accountability. The structure is designed to further empower and support staff to lead and deliver change, drive improvement, and to ensure clear and simple lines of accountability – starting with frontline staff. This review will be key to delivery of our transformation programme, in particular the quality strategy.

The review aimed to:

- simplify and minimise the reporting layers between 'the ward and the board' to help speed up decision making and the escalation of issues
- devolve and clarify accountabilities and responsibility for delivering operational, quality and financial targets
- establish the key organisational units for driving and leading improvement and ensure their leaders and staff are sufficiently empowered, informed and resourced to deliver effectively
- strengthen site-based control while maintaining the integrity of specific services and patient pathways that often span two or more sites

Phase one of the review (completed 1 April 2016) saw the Trust move from five clinical divisions to three, with the three divisional directors reporting directly to the chief executive. Simplifying the reporting layers between the ward and the board will help speed up decision making and the escalation of issues. Under the structure, the divisional directors will escalate any areas of concern directly to the chief executive, facilitating pre-emption of issues.

Success will be measured by an increased sense of empowerment and clarity for all staff, an increase in the pace of delivery of our clinical strategy, improvements in quality of care, and, vitally for our sustainability, a return to financial surplus. It should also make the organisation more open and transparent to patients and external stakeholders as well as a better place for staff to work.

Alignment of governance reviews with the well-led framework

'Well-led' is one of the CQC domains, as well as forming a key part of the TDA and Monitor oversight regimes. The Trust has undertaken a comprehensive self-assessment, at corporate level, against each of the CQC key lines of enquiry (KLOE) and prompts, reviewing mainly divisional, executive and board groups and committees.

In this first review, each prompt has been assigned an executive director or directors, and allocated a RAG rating demonstrating where (at this corporate level) the Trust currently is against the prompt. This review will be mirrored across the Trust as part of a broader move to self-assessment against the CQC domains. A key consideration identified as needing development is the definition and embedding of a revised view of leadership at all levels from ward to board.

Areas where key gaps against prompts were identified were:

- working and reporting arrangements where working with partners
- comprehensive staff understanding of their role in delivering both the vision/values and strategy
- visibility of 'leaders' across the Trust
- comprehensive embedding of a culture focused on needs and experience of those who use our services
- involving those who use services in decision making

Specific actions have been identified, and each of these areas are being addressed during 2016/17.

Changes to the governance of Imperial College Healthcare Charity

The Department of Health has confirmed that Imperial College Healthcare Charity will complete its process of changing from an 'NHS Charity' to a fully independent one on 1 April 2016. The new Charity will have the same name, but a new Charity number and company number, and legally will have the status of a charitable company limited by guarantee.

The new Charity and the Trust have agreed and signed a Memorandum of Understanding which confirms the Trust as the principal beneficiary of the Charity and covers areas of joint working. The Charity's five current independent Trustees will transfer to the Board of the new Charity whilst one further independent Trustee is being recruited through advertising and a search agency. The Trust will initially be represented on the Charity Board by Julian Redhead (Medical Director) and Michelle Dixon (Director of Communications) with a Trust Non-executive Director to join the Charity Board in due course.

Operationally there will be no noticeable change: all current programmes run by the Charity in terms of grants, fund-raising and arts will continue and the Charity's assets – endowment and other funds and property – transfer from the 'old' Charity to the new one on or just after 1 April.

Other items

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

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

As part of ensuring an effective corporate governance assurance framework, the Trust has undertaken a review of arrangements against the five domains of the code: leadership; effectiveness; accountability; remuneration; and relationships with shareholders (commissioners/ partners).

Significant issue: improving the flow of the emergency patient pathway and achieving the emergency department target

Up until September 2014 the Trust consistently met the standard of ensuring that 95 per cent of patients are seen, treated and discharged from an urgent or emergency care setting within four hours. The average performance by month since September 2014 has fallen to 92.7 per cent, with June 2015 being the only month during 2015/16 where performance was in excess of 95 per cent. Performance has further deteriorated since November 2015 to an average of 89.1 per cent.

In January 2015, a review was commissioned to provide support to the Trust in improving four hour performance. The initial focus was to understand the reasons why performance at St. Mary's Hospital had deteriorated so significantly. The review identified the key drivers to be associated with increasing demand and acuity.

As a result of the review, steps were taken to improve processes, resilience and responsiveness in emergency department operations, simple and complex discharges, bed flow and management, internal delays and hospital urgency and responsiveness triggers. An action plan was put into place to instigate this and a number of measures including increasing the amount of consultant cover in the Emergency Department at St Mary's, the physical expansion of the Ambulatory Emergency Care units at St. Mary's, Charing Cross and Hammersmith Hospitals to increase the number of patients they can accommodate, and relocating the Urgent Care Centre at St. Mary's to create additional capacity in the main Emergency Department, were put into place.

The action plan had some success and performance began to improve. The summer of 2015/16 saw an average performance of 94.14 per cent and the four hour standard was achieved for the month of June 2015. However, even at this stage it was recognised that some of the improvement was due to seasonal factors and that further measures would be needed to ensure sustainable delivery of the four hour standard.

The actions taken at this stage with the aim of maintaining performance included improving the process for patient discharge, extending the opening times of the Ambulatory Emergency Care units, increasing the number of doctors on duty in the Emergency Department at Charing Cross Hospital and opening additional inpatient beds. In addition, some improvements were made across the healthcare system such as reducing the number of delayed transfers of care (DTOCs) which contributed to a reduced inpatient length of stay.

By December 2015, it was clear that the level of performance achieved over

the summer had not been sustained in spite of the additional actions taken. This is due in part to increasing numbers of attendances to the Emergency Departments and increasing emergency admissions, which are reflective of national pressures on the entire emergency service system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery, as well as the on-going problem of a mismatch in timing between admissions and discharges.

To address the challenges associated with delivering four hour performance and to minimise the risk of crowding in the Emergency Departments, it is clear that a strengthened approach is required.

A performance management structure has been established that will enable the Emergency Departments, Clinical Directorates and Divisional and Executive Teams to work together, in partnership with commissioners and other external stakeholders, to implement the trust and system wide actions necessary to sustainably meet the four hour performance standard. Through this process a set of actions and a performance trajectory have been agreed, and the Trust is planning to deliver an improvement in performance month on month during 2016/17.

Significant issue: reducing waits for elective procedures and achieving the referral to treatment (RTT) target

The Trust has worked hard to reduce the waits that patients experience when awaiting elective procedures, but in line with many other Trusts, this remains a challenge. Performance for March 2016 was 89.2 per cent of patients on an incomplete pathway waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92 per cent.

The reasons for this disappointing performance relate to capacity in some specialties, to changes in our validation processes and better accuracy of our reports, and to the impact of industrial action by junior doctors in January, February and March 2016. The specialties with the most significant challenges include:

- orthopaedics (validation processes have highlighted incorrect application of detailed RTT rules for some patients, so the waiting list is longer than we had previously reported);
- neurology and neurosurgery (a combination of staffing, estates and validation issues); and
- general surgery (validation processes have highlighted incorrect closure of pathways after diagnostic investigations)

Performance in early 2016/17 is not expected to improve because of the extended junior doctor's industrial action in April, and because orthopaedics and general surgery are still completing detailed validation resulting in further patients being added to the waiting list.

Trust plans for 2016/17 include a detailed improvement plan and trajectory agreed with commissioners and NHS Improvement which will deliver the 92 per cent standard from August 2016.

The following steps have been taken or are being put in place:

- The Trust is finalising plans to use a mobile operating theatre on the Charing Cross Hospital site to provide additional capacity for patients waiting 20 weeks or more, from early June. Mobile operating theatres are routinely used in the NHS to boost capacity. This extra capacity would coincide with the planned refurbishment of the short-stay, planned surgery unit at Charing Cross, Riverside theatres. There is already a plan being put in place to re-provide the normal Riverside capacity at Hammersmith Hospital for the period of the refurbishment, so this mobile theatre will provide additional capacity to reduce the waiting lists.
- The Trust has also asked the NHS Intensive Support Team to review its waiting lists and RTT processes and this review will report at the end of May 2016. This will help the Trust to fully understand its RTT challenge and design improved processes for managing waiting lists in order to ensure that the 92 per cent target is met sustainably in future, with much more emphasis on getting the administrative processes right first time, and much less reliance on intensive validation processes after the event.
- These steps include specific plans for additional staff and clinics in many different specialties.

Significant issue: embedding the organisational changes

The organisation change implemented in April 2016 represents a significant and challenging change for the Trust. By reducing the levels of management accountability from 'ward to board' to four levels, accountability and responsibility for delivering quality, operational and financial targets will sit clearly at both a Divisional and Directorate level. The Trust has expanded the number of directorates in order to improve each Division's ability to manage their expanded portfolios.

Within clinical directorates, the accountable officer will be the general manager rather than the clinical director. This is in recognition of the full-time nature of devolved

accountability. In practice, clinical directorates will mirror the integrated leadership teams of the divisions.

The proposed devolution of more authority to the frontline means that there will be six corporate divisions: the office of the medical director; the office of the director of nursing; finance; communications; information and communications technology; and people and organisation development. The executive management team now includes the chief executive and the directors of these six corporate divisions plus the three clinical divisional directors. There are four executive Trust board directors: chief executive; medical director; director of nursing and chief financial officer.

To support the expanded direct responsibilities of the chief executive – particularly in helping to ensure effective co-ordination across the whole organisation, strong performance management of all divisions and the build and maintenance of relationships with key external partners – the Trust has created the role of assistant chief executive as part of the office of the chief executive.

While it is vital that the Trust maintains an organisation-wide management structure to help ensure it provides a fully integrated offer to patients across all of its sites, it also needs to ensure effective management and oversight on a site by site basis. Through a matrix management approach the Trust is able to ensure close co-ordination between Divisions, Directorates, and site-based operations and estates leads.

While devolving authority further to divisions and to clinical directorates, the Trust also needs to ensure firm financial and operational control at all levels, especially as it works to return to financial surplus. The Trust is introducing new ways of working, combined with improved access to financial and performance data, especially for clinical directorates. In addition, the Trust provides robust selection and leadership development support to the existing and new leads of the Divisions, Directorates and site based teams. Progress will be reviewed by the Trust board each quarter.

Measurement: how the board receives appropriate, robust and timely information which supports the leadership of the Trust

The Trust board ensures that the resources are used economically, efficiently and effectively by means of regular detailed finance and performance reports. These are considered in detail by the Finance and Investment Committee. The Audit, Risk and Governance Committee receives regular reports from the Trust's internal auditors, TIAA and external auditors BDO LLP. The Finance and Investment Committee have requested, and will receive in 2016/17, clearer service line level profitability information. This level of information will support the organisation structure and its objective for greater devolved power and decision-making.

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

In relation to the data accuracy in the quality accounts, there are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include: data are derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

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

The Trust and its board have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

Delivering for Patients: the 2015/16 TDA Accountability Framework

The TDA reviews the Trust's financial, quality and operational performance against the national targets, and RAG rates these against domains described in the Accountability Framework; these ratings form part of its escalation decision tree. Information to quarter three (the latest available) shows the Trust's ratings as follows:

		M1	M2	M3	M4	M5	M6	M7	M8	M6
Imperial	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15
Responsive	2	3	2	3	3	3	3	3	2	2
Effective	5	5	5	5	5	5	5	5	5	5
Safe	4	4	5	3	5	4	4	4	5	5
Caring	4	5	4	5	5	5	4	4	4	5
Well-led	4	5	5	5	5	5	5	5	5	5
Quality	3	3	3	3	3	3	3	3	2	2
Finance	R3			R3			R2			
Sustainability	3			3			3			
Moderated	**3**			**3**			**2**			

Conclusion

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

- The head of internal audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. I take very seriously the lessons we must learn from significantly missing our financial budget in 2015/16 and I believe that the investments we are making in the financial team and help from a financial improvement programme will deliver the necessary improvement. In other internal audits carried out (and listed in appendix 1), a range of assurances from significant assurance to no assurance has been given. The one audit with no assurance was completed at management request where specific management control issues had been identified; a comprehensive action plan is being implemented. Across all audits, management have accepted, and taken action to address, recommendations made in these reports.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements
- The board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively
- Other sources of information including: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; reports from external assessments; Deanery and Royal College assessments; accreditation of clinical services; and the patient environment action team assessments.

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

I consider that any significant issues are included in the report, namely: the Trust's financial position; condition of the Trust estate; improving the flow of the emergency patient pathway and achieving the emergency department target; reducing waits for elective procedures and achieving the referral to treatment (RTT) target and the embedding of the organisational review. Action to address each of these areas is detailed in the relevant section of the governance report.

Dr Tracey Batten
Chief executive
1 June 2016

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

The chief executive of the NHS Trust Development Authority has designated that the chief executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the chief executive of the NHS Trust Development Authority. These include ensuring that:

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

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

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

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

Dr Tracey Batten
Chief executive
1 June 2016

Directors' report

The Trust board and its committees

The Trust board

The Trust board is accountable, through the chairman, to the NHS Trust Development Authority (TDA). The Trust board at 31 March 2016, consisted of the chairman, seven non-executive director posts, chief executive, medical director, director of nursing, chief operating officer and chief financial officer, as outlined below.

They are collectively responsible for the strategic direction and performance of the Trust, and have a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The membership of the Trust board is balanced and appropriate. Full biographies for each of the Trust's board directors are available on the website at: www.imperial.nhs.uk

The members of the Trust board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector.

The Trust board is confident that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability. The selection process, led by the TDA, and the board seminars and development programme in place ensure that the non-executive directors have appropriate skills and experience.

The Trust board has the capability and experience necessary to deliver the Trust's business plan, and the governance structure the Trust has in place (outlined in processes and structures below) is appropriate to assure the board of this delivery. The board development programme has been largely incorporated into the normal working of the board. Its aims are: to ensure that the board is fit to govern the Trust; is able to set and review performance standards in all areas of responsibility; operates as a unitary function and is aware of, and successfully manages, competing priorities and future challenges against the trust's strategic objectives; and can assure itself on aspects of clinical quality.

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust board directors have been assessed as being a fit and proper person to be directors of the Trust.

The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development; for executive directors, by the chief executive, for non-executive directors and the chief executive by the chairman, and for the chairman, by the TDA.

The directors have been responsible for preparing this annual report and the associated accounts and quality account and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, and strategy.

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

- Richard Alexander was appointed as chief finance officer on 3 August 2015 following a period of cover by Alan Goldsman as interim chief finance officer.
- Dr Julian Redhead was appointed as medical director on 1 February 2016 on Professor Chris Harrison's departure to The Christie NHS Foundation Trust as Medical Director
- Dr Rodney Eastwood was reappointed for a period of two years from 1 July 2015
- The Trust board had one non-executive director vacancy at 31 March 2016.

Sir Gerald Acher has also been reappointed for a period of four years from 1 April 2016.

The Trust board at 31 March 2016 was as follows:

Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy chairman
Professor Sir Anthony Newman Taylor	Non-executive director
Jeremy Isaacs	Non-executive director
Dr Rodney Eastwood	Non-executive director
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Vacancy	Non-executive director
Dr Tracey Batten	Chief executive
Steve McManus*	Deputy chief executive and chief operating officer
Dr Julian Redhead	Medical director
Professor Janice Sigsworth	Director of nursing
Richard Alexander	Chief financial officer

*Mr McManus left the Trust board on 31 March 2016

Disclosure to auditor

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

Attendance at Trust board meetings: 1 April 2015 – 31 March 2016

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

Member*	Attendance (actual/possible)
Non-executive directors*	
Sir Richard Sykes, chairman	6/7
Sir Gerald Acher	6/7
Jeremy Isaacs	7/7
Prof Sir Anthony Newman Taylor	6/7
Dr Rodney Eastwood	7/7
Dr Andreas Raffel	7/7
Sarika Patel	6/7
Executive directors	
Dr Tracey Batten, chief executive	7/7
Steve McManus, deputy chief executive and chief operating officer	6/7
Alan Goldsman, interim chief financial officer (to 31 July 2015)	4/4
Richard Alexander, chief financial officer (from 3 August 2015)	3/3
Professor Janice Sigsworth, director of nursing	7/7
Professor Chris Harrison, medical director (to 30 January 2016)	7/7
Dr Julian Redhead, medical director (from 1 February 2016)	0/0

*Changes to the board membership are outlined above in capability and culture

**There was one vacant non-executive post as at 31 March 2016

Board committee meetings: 1 April 2015 – 31 March 2016

The board has a total of five committees which meet regularly; each is chaired by a non-executive director. A number of board responsibilities are delegated either to these committees or individual directors. The Trust board approves the terms of reference which detail the remit and delegated authority of each committee.

Committees routinely provide a report to the Trust board showing how they are fulfilling their duties as required by the board. In addition to regularly reporting to the Trust public board, the Audit, Risk and Governance Committee minutes are reported to the Trust public board, and the minutes of other committees reported to the Trust private board.

Audit, Risk and Governance Committee

The role of the Audit, Risk and Governance Committee is to provide the Trust board with independent and objective assurance that adequate audit, internal control, risk management, and corporate governance arrangements are in place and working effectively. It is also responsible for providing assurance on the Trust's annual report and accounts and the work of internal and external audit and local counter fraud providers and any actions arising from that work. The terms of reference of the Audit, Risk and Governance Committee are available upon request.

The committee met six times in the reporting period.

Member	Attendance (actual/possible)
Sir Gerald Acher (chair)	6/6
Professor Sir Anthony Newman Taylor	5/6
Sarika Patel	5/6
Dr Andreas Raffel	5/6
Dr Tracey Batten	6/6
Alan Goldsman	3/3
Richard Alexander	3/3
Prof Janice Sigsworth	6/6
Prof Chris Harrison	2/5
Dr Julian Redhead	1/1
Steve McManus	4/6

During 2015/16, the committee has remained observant of the key financial, operational and strategic risks facing the Trust through review of the board assurance framework (to gain on-going assurance of risk and internal control processes), and through internal sources of validation and by way of triangulation with the Quality Committee. The committee has reviewed and approved the annual internal and external audit plans, and has reviewed and evaluated internal audit reports on key systems of internal audit control, including finance, governance, risk management, policy scrutiny, human resources and payroll. A full list of internal audits provided by TIAA (the Trust's internal auditor) in 2015/16 is attached as appendix one. The committee has received regular reports on the counter-fraud activity at the Trust, ensuring appropriate action in matters of potential fraudulent activity and financial irregularity. The corporate risk register is reviewed regularly. The committee has undertaken a number of in-depth reviews where specific risks were identified, including radiology information system and picture archiving computer systems (RIS/PACS) concerns (where a new system is due to be implemented early in 2016/17), operating theatres efficiency

(where progress towards improved productivity had been observed, though with much further work to do), medical education transformation programme (where the Trust could demonstrate good success in attracting trainees) and the recruitment function (where the overall time to recruit had been much improved).

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

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

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

The committee's terms of reference were amended to reflect that the Audit, Risk and Governance Committee would act as an auditor panel; as from 2017/18, the Trust will appoint their own external auditors and manage the resulting contract and relationship.

During the reporting period the Trust's external audit services have been provided by BDO LLP. The committee has received and reviewed progress reports from BDO LLP in delivering its responsibilities as the Trust's external auditor, together with other matters of interest.

The members of the Audit Risk and Governance Committee meet as required with both the external and internal auditors without the presence of management to discuss issues emerging through audits. The committee has also discussed improvements expected of the internal auditors which the chairman had previously discussed with them.

Quality Committee

The quality Committee is responsible for seeking and securing assurance that the Trust's services are delivering to patients, carers and commissioners the high levels of quality performance expected of them by the Trust board. It also seeks and provides assurance in relation to patient and staff experience, and health and safety; performance is monitored in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the Care Quality Commission and ensures that there is a clear compliance framework against these.

The committee met seven times during the reporting period.

Member	Attendance (actual/possible)
Professor Sir Anthony Newman Taylor (chair)	6/7
Sir Gerald Acher	4/7
Dr Rodney Eastwood	4/7
Dr Tracey Batten	5/7
Prof Janice Sigsworth	7/7
Prof Chris Harrison (until 30 January 2016)	3/5
Dr Julian Redhead (from 1 February 2016)	2/2
Steve McManus	5/7

Discussion included regular review of divisional risks, the Trust's comprehensive quality report, including the infection prevention and control report; annual reports such as whistle-blowing, responsible officer's (relating to medical appraisals), safeguarding, and equality. A number of in-depth reviews were also undertaken in areas of potential quality concern such as outpatient services, safer surgery and nurse vacancies.

Finance and Investment Committee

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

The committee met six times in regular format during the reporting period, and also held four extraordinary meetings.

Member	Attendance (actual/possible)	Extraordinary meeting attendance
Sarika Patel (chair to 31 December 2015)	4/4	4/4
Dr Rodney Eastwood	6/6	2/4
Jeremy Isaacs	3/6	2/4
Dr Andreas Raffel (chair from 1 January 2016)	5/6	1/4
Dr Tracey Batten	5/6	3/4
Alan Goldsman	2/2	1/2
Richard Alexander	4/4	2/2
Steve McManus	4/6	3/4

Discussion included: the Trust's financial position including delivery of cost improvement plans and financial recovery plans; review of key business cases; private patient developments; and major tenders. The committee also oversaw, on the Trust board's behalf, the strategic review of financial and operational performance (outlined in the annual governance statement), which was conducted Pelham Allen, an experienced turnaround consultant.

Redevelopment Committee

The committee, established in November 2015, is to undertake thorough and objective review of the development transformation programme, including performance reviews and financial issues, and to review investment requirements and risks associated with the overall redevelopment transformation programme.

The committee met four times in the reporting period.

Member	Attendance (actual/possible)
Sir Richard Sykes (chair)	4/4
Jeremy Isaacs	2/4
Dr Andreas Raffel	4/4
Dr Tracey Batten	4/4
Richard Alexander	4/4

Discussions focused on the Shaping a Healthier Future investment business case, the appointment of advisors to support the Trust in its redevelopment programme, the submission (and subsequent withdrawal) of a planning application adjacent to the St Mary's site, and potential options for redevelopment.

Remuneration and Appointments Committee

On behalf of the Trust board, the committee is responsible for all decisions concerning the appointment, remuneration and terms of service of executive directors and other very senior appointments.

The committee met three times during the reporting period, where discussions included the approval of the appointments of the chief financial officer, the director of people and OD, and the medical director.

Member	Attendance (actual/possible)
Jeremy Isaacs (chair)	3/3
Sir Richard Sykes	3/3
Dr Andreas Raffel	2/2
Sarika Patel	1/1

Other disclosures

Interests

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust board directors which may conflict with their management responsibilities. This register is updated at each board meeting; the register as at 31 March 2016 is attached at appendix 4, and is available to the public on the website at www.imperial.nhs.uk.

The Trust board considers that all its non-executive directors are independent in character and judgement, although it notes that Professor Sir Anthony Newman Taylor, as an appointee of Imperial College London, brings its views to the Trust board.

Pensions and remuneration

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

Cost allocation and charges for information

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

Equality disclosures

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

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

Better payment for suppliers

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

Emergency preparedness

The Trust is required, and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005. Details are included in the annual governance statement.

Principles for Remedy

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

Dr Tracey Batten
Chief executive
1 June 2016

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

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

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

By order of the Trust board

Dr Tracey Batten
Chief executive
1 June 2016

Richard Alexander
Chief financial officer
1 June 2016

Remuneration and staff reports

Remuneration report

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

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

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

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

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

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based.

Salary levels (which typically take effect from 1 April) for executive directors in 2015/16 are set out in the staff report.

The Trust has taken advantage of flexibilities offered in the agenda for change to offer pay spot salaries to ten senior managers who are not executive directors.

These salaries are set by the relevant executive director with approval from the director of people and organisation development.

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

Non-executive directors are normally appointed on fixed term contracts of between two and four years. Non-executive directors are not generally members of the pension scheme, and receive payments based on benchmarking data for similar posts elsewhere in the NHS.

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

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the Trust and the median remuneration of all staff.

The banded remuneration of the highest paid director in the financial year 2015/16 was £322,928 (£342,500 in 2014/15). This was 9.54 times (9.46 times in 2014/15) the median remuneration of the workforce, which was £33,852 (£36,188 in 2014/15).

In both 2014/15 and 2015/16 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £10,060 to £296,400 (2014/15 £7,616 to £296,400).

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.

Staff report

Workforce composition by staff group

At the end of 2015/16 the Trust employed 10,517 staff. Approximately 80 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in table titled 'headcount by Trust staff group' below.

Headcount by Trust staff group	Headcount
Admin & Clerical	1,764
Allied Health Professional (Qualified)	542
Allied Health Professional (Unqualified)	66
Doctor (Career Grade)	37
Doctor (Consultant)	882
Doctor (Training Grade)	1,382
Estates	42
Nursing & Midwifery (Qualified)	3,368
Nursing & Midwifery (Unqualified)	896
Pharmacist	123
Scientific & Technical (Qualified)	715
Scientific & Technical (Unqualified)	280
Senior Manager	420
Trust Total	10,517

Workforce composition by sex

71 per cent of our workforce is female and 29 per cent is male. The high proportion of female workers is typical of NHS organisations. The proportion of male employees increases in more senior roles. The gender tables below show that in 2015/16 women accounted for 54 per cent of senior managers, 27 per cent of board directors and 30 per cent of executive directors.

Gender – all	Headcount
Female	7,440
Male	3,077
Trust Total	**10,517**

Gender – Senior Managers	Headcount
Female	219
Male	184
Trust Total	**403**

Gender – Board of Directors	Headcount
Female	3
Male	8
Trust Total	11

Gender – Executive Team	Headcount
Female	3
Male	7
Trust Total	10

Workforce composition by age and ethnicity

Age Group	Headcount
16-19 years	5
20-29 years	2,223
30-39 years	3,150
40-49 years	2,674
50-59 years	1,872
60 years and over	593
Trust Total	**10,517**

Ethnic Origin	Headcount
White – British	2,999
White – Irish	350
White – Any other White background	1,331
Mixed – White & Black Caribbean	63
Mixed – White & Black African	60
Mixed – White & Asian	75
Mixed – Any other mixed background	156
Asian or Asian British – Indian	781
Asian or Asian British – Pakistani	152
Asian or Asian British – Bangladeshi	104
Asian or Asian British – Any other Asian background	1,080
Black or Black British – Caribbean	405
Black or Black British – African	932
Black or Black British – Any other Black background	462
Chinese	176
Any Other Ethnic Group	538
Undefined	434
Not Stated	419
Trust Total	**10,517**

Average staff numbers

Average staff numbers	Total	Permanently Employed	Other	Prior YearTotal	Prior Year Permanently Employed	Prior Year Other
Medical and dental	1,954	1,846	108	1,837	1,793	44
Administration and estates	2,534	2,232	302	2,437	2,012	425
Healthcare assistants and other support staff	1,397	1,340	57	1,275	1,248	27
Nursing, midwifery and health visiting staff	3,683	3,525	158	3,563	3,440	123
Scientific, therapeutic and technical staff	877	755	122	855	713	142
Healthcare Science Staff	548	548	0	548	548	0
TOTAL	10,993	10,246	746	10,515	9,754	761
Staff engaged on capital projects (included above)	11	11	0	25	10	15

(Information subject to audit)

Sickness absence

Low sickness absence is an indicator of effective leadership, good people management and staff wellbeing and as such this an important key performance indicator for the Trust. In 2015/16, the Trust achieved a sickness absence rate of 3.2 per cent (6.28 days) in March 2016 against a target of 3.40 per cent. This compares to a rate of 3.7 per cent (6.87 days) in 2015.

Employment of staff with disabilities

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

Off payroll arrangements

It is Trust policy that all substantive staff should be paid through the payroll wherever possible. In 2015/16 one board member (Mr A Goldsman) with significant financial responsibility was engaged on an off-payroll basis in the 2015/16 financial year.

In addition, the Trust has needed to engage a number of contractors on an off-payroll basis to support fixed term assignments in areas such as the North West London Pathology project. NHS bodies are required to disclose specific information about off payroll engagements.

Exit packages

In 2015/16 the Trust approved severance payments to eleven staff.

Remuneration tables

Salary & Pension disclosure tables: information subject to audit

			(a)	(b)	(c)	(d)	(e) =	(f) = (a to e)
Salaries and Allowances	Salary	Other Remuneration	Salary (inc Other)	Expenses Payments (taxable)	Performance Pay and Bonuses	Long term Performance Pay and Bonuses	Pension Related Benefits	Total Remuneration (Inc. Pension Related Benefits)
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(Total to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Names & Title	£000	£000	£000	£00	£000	£000	£000	£000
Sir Richard Sykes, Chairman	20 - 25	0	20 - 25	0	0	0	0	20 - 25
Jeremy Isaacs, Non-executive Director	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Sir Gerald Acher, Non-executive Director	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Dr Rodney Eastwood, Non-executive Director	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Prof. Sir Anthony Newman Taylor	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Sarika Patel, Non-executive Director	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Andreas Raffel , Non-executive Director	5 - 10	0	5 - 10	0	0	0	0	5 - 10
Tracey Batten, Chief Executive	295 - 300	0	295 - 300	140	10 - 15	0	n/a	320 - 325
Alan Goldsman, Chief Financial Officer[1]	0	115 - 120	115 - 120	0	0	0	n/a	115 - 120
Richard Alexander, Chief Financial Officer[2]	135 - 140	0	135 - 140	0	0	0	New Board Member	135 - 140
Steve McManus, Chief Operating Officer	185 - 190	0	185 - 190	0	0	0	37.5 - 40	225 - 230
Prof Janice Sigsworth, Director of Nursing	155 - 160	0	155 - 160	0	0	0	20 - 22.5	180 - 185
Prof. Chris Harrison, Medical Director[3]	70 - 75	125 - 130	200-205	0	0	0	Left	200 - 205
Dr Julian Redhead, Medical Director[4]	10 - 15	205 - 210	215 - 220	0	0	0	New Board Member	215 - 220

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Pension benefits	**Real increase in pension at pension age**	**Real increase in lump sum at pension age**	**Total accrued pension at pension age at 31st March 2016**	**Lump sum at pension age related to accrued pension at 31st March 2016**	**Cash equivalent Transfer Value at 1st April 2015**	**Real increase in cash equivalent transfer value[5]**	**Cash Equivalent Transfer Value at 31st March 2016**	**Employer's contribution to stakeholder pension**
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name	**£000**	**£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	n/a
Jeremy Isaacs, Non-executive Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Gerald Acher, Non-executive Director	n/a	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	n/a
Prof. Sir Anthony Newman Taylor	n/a	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	n/a
Andreas Raffel, Non-executive Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Tracey Batten, Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alan Goldsman, Chief Financial Officer[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Richard Alexander, Chief Financial Officer[2]	New Board Member	New Board Member	20 - 25	65 - 70	New Board Member	New Board Member	410	n/a
Steve McManus, Chief Operating Officer	2.5 - 5	0 - 2.5	60 - 65	170 - 175	972	38	1,010	n/a
Prof Janice Sigsworth, Director of Nursing	0 - 2.5	5 - 7.5	70 - 75	210 - 215	1,324	45	1,369	n/a
Prof. Chris Harrison, Medical Director[3]	Left	Left	Left	Left	1,144	Left	Left	n/a
Dr Julian Redhead, Medical Director[4]	New Board Member	New Board Member	45 - 50	135 - 140	New Board Member	New Board Member	782	n/a

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

2 Richard Alexander joined the Board on 3rd August 2015

3 Prof. Chris Harrison left the Board on 31st January 2016. The amount under "Other Remuneration" above is payable for the Clinical Role

4 Dr Julian Redhead joined the Board on 1st February 2016. The amount under "Other Remuneration" above is payable for the Clinical Role

5 Real Increase in CETV: This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and uses common market valuation factors for the start and end of the period

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

Remuneration tables for 2014/15

Salaries and Allowances	Salary	Other Remuneration	Bonus payments	Expenses Payments (taxable)	Exit Packages	Pension Related Benefits	Total Remuneration
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(Total to nearest £00)		(bands of £2,500)	(bands of £5,000)
Names	**£000**	**£000**	**£000**	**£00**	**£**	**£000**	**£000**
Sir Richard Sykes, Chairman	20 - 25	0	0	0	0	n/a	20 - 25
Sir Thomas S Legg, Non-executive Director[1]	0 - 5	0	0	0	0	n/a	0 - 5
Jeremy Isaacs, Non-executive Director	5 - 10	0	0	0	0	n/a	5 - 10
Sir Gerald Acher, Non-executive Director	5 - 10	0	0	0	0	n/a	5 - 10
Dr Rodney Eastwood, Non-executive Director	5 - 10	0	0	0	0	n/a	5 - 10
Prof. Sir Anthony Newman Taylor	5 - 10	0	0	0	0	n/a	5 - 10
Sarika Patel, Non-executive Director	5 - 10	0	0	0	0	n/a	5 - 10
Andreas Raffel, Non-executive Director	5 - 10	0	0	0	0	n/a	5 - 10
Tracey Batten, Chief Executive[2]	290 - 295	0	0	499	0	n/a	340 - 345
Bill Shields, Chief Financial Officer / Chief Executive[3]	170 - 175	0	0	0	0	Left	170 - 175
Alan Goldsman, Chief Financial Officer[4]	0	90 - 95	0	0	0	n/a	90 - 95
Steve McManus, Chief Operating Officer	185 - 190	0	0	0	0	20 - 22.5	210 - 215
Prof. Nick Cheshire, Medical Director /Chief Executive[5]	0 - 5	0 - 5	0	0	0	Left	0 - 5
Prof Janice Sigsworth, Director of Nursing	155 - 160	0	0	0	0	20 - 22.5	180 - 185
Prof. Chris Harrison, Medical Director	85 - 90	150 - 155	0	0	0	17.5 - 20	260 - 265
Marcus Thorman, Chief Financial Officer[6]	0 - 5	0	0	0	0	Left	0 - 5

(Information subject to audit)

Pension Benefits	Real increase in pension at age 60	Real increase in lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31st March 2015	Total accrued lump sum at age 60 related to accrued pension at 31st March 2015	Cash equivalent Transfer Value at 31st March 2015	Cash equivalent Transfer Value at 31st March 2014	Real increase in cash equivalent transfer value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Names	**£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 S Legg, Non-executive Director[1]	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
Prof. Sir Anthony Newman Taylor	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
Andreas Raffel , Associate Non-executive Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Tracey Batten, Chief Executive[2]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Bill Shields, Chief Financial Officer / Chief Executive[3]	Left	Left	Left	Left	Left	1,028	Left
Alan Goldsman, Chief Financial Officer[4]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Steve McManus, Chief Operating Officer	0 - 2.5	5 - 7.5	55 - 60	170 - 175	972	911	61
Prof. Nick Cheshire, Medical Director /Chief Executive[5]	Left	Left	Left	Left	Left	1,011	Left
Prof. Janice Sigsworth, Director of Nursing	0 - 2.5	5 - 7.5	65 - 70	205 - 210	1,324	1,251	73
Prof. Chris Harrison, Medical Director	0 - 2.5	5 - 7.5	55 - 60	165 - 170	1,144	1,076	68
Marcus Thorman, Chief Financial Officer[6]	Left	Left	Left	Left	Left	445	Left

1 Sir Thomas Legg left the Board on 31st December 2014

2 Dr Tracey Batten joined the Board on 7th April 2014. £49,900 - taxable relocation costs on appointment

3 Bill Shields left the joint Chief Executive role on 6th April 2014 and reverted to the Chief Financial Officer role. He left the Board on 4th January 2015

4 Alan Goldsman joined the Board on 5th January 2015. The amount under “Other Remuneration” above is payable to Alan Goldsman Limited and is net of VAT

5 Prof. Nick Cheshire left the Board on 6th April 2014

6 Marcus Thorman left the Board on 6th April 2014

Exit Packages agreed in 2015-16

	2015-16							
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	2	10,081	0	0	2	10,081	0	0
£10,000-£25,000	3	50,498	0	0	3	50,498	0	0
£25,001-£50,000	1	29,761	1	27,479	2	57,240	0	0
£50,001-£100,000	1	67,632	2	139,432	3	207,064	1	78,240
£100,001 - £150,000	1	124,708	0	0	1	124,708	0	0
Total	**8**	**282,680**	**3**	**166,911**	**11**	**449,591**	**1**	**78,240**

	2014-15							
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	2	17,893	0	0	2	17,893	0	0
£10,000-£25,000	5	89,543	0	0	5	89,543	0	0
£25,001-£50,000	3	123,969	0	0	3	123,969	0	0
£50,001-£100,000	3	221,144	2	144,973	5	366,117	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
Total	**13**	**452,549**	**2**	**144,973**	**15**	**597,522**	**0**	**0**

(information subject to audit)

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Where the Trust has agreed early retirements, the additional costs are met by the the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

Exit packages - Other Departures analysis

	2015-16		2014-15	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	2	89	0	0
Exit payments following Employment Tribunals or court orders	1	78	2	145
Total	3	167	2	145

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

Expenditure on consultancy services

	2015-16	2014-15
	£000s	£000s
Consultancy services	**3,283**	13,370

Chief financial officer's review

Table 1: For all off-payroll engagements
as of 31 March 2016, for more than £220 per day and that last longer than six months:

Number of existing engagements as of 31 March 2016	14
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	3

Confirmation that 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.

Table 2: For all off-payroll engagements
between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	17
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	16
Number for whom assurance has been requested	13
Of which:	
assurance has been received	7
assurance has not been received	6
engagements terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements
of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	14

Although the Trust has met the statutory financial performance targets (see table right), 2015/16 was an extremely challenging year financially. We missed our planned deficit of £18.5m by nearly £12m with an operational outturn of a £30.1m deficit, and a final deficit outturn after provisions of £47.9m. This combined with a deficit financial plan for 2016/17 will lead to the Trust receiving a qualified use of resources assessment from our auditors.

While the Trust board acknowledges that the majority of major teaching hospitals recorded a financial deficit in 2015/16 and were similarly qualified in their use of resources assessment we are in no way complacent about the challenge of our financial position.

We appointed a strategic advisor with turnaround expertise in November once the position became clear and working with his recommendations implemented the first phase of those changes in April 2016. We were successful in our application to join the NHSI Financial Improvement Programme and are now working with their recommended partner on a plan for a return to financial sustainability.

Statutory financial duties

Duty	Requirement	Achievement
1. Breakeven duty	To ensure total expenditure does not exceed income, on a year on year cumulative basis.	Achieved – cumulative surplus of £22.3m remaining
2. External Financing Limit (EFL)	To remain within DH borrowing limit	Achieved – cash outflow of £14.6m
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 DH	Achieved – Net spend of £34.4m

Additionally the Trust has delivered efficiency savings of £28.9m (out of a planned £36.1m) in 2015 / 16.

Capital expenditure (excluding externally funded schemes) for the period was £34.9m; with schemes aimed at achieving a balance between maintaining and replenishing the asset infrastructure, reducing risk, investing in information technology and improving the patient experience.

Income and Expenditure

The Trust's financial goal for 2015/16 was to allow for one year of deficit (£18.5m, largely driven by the removal of the subsidy for complex specialist care) before returning to surplus in 2016/17. Half way through the year it became clear that additional risks, in particular the gap between the Trust's income plan and the Commissioner's level of affordable activity combined with a slow start to growing our private patient income, would drive an increase in this deficit to around £30m.

The Trust's total operating revenue (see notes 3 and 4 to the accounts) was £1,020m; an increase of £20m compared to the previous year. This increase in income included a £40m increase in the value of services commissioned for local patients, no increase in that commissioned nationally for specialised services and a reduction in Education, Training and Research income as well as the removal of the £24m subsidy received last year for the provision of complex specialist care.

Some additional funding was also received from NHS commissioners to support reduction in patients waiting for treatment and to meet extra demand for patient care services over winter.

The total operating expenditure (see note 6 to the accounts) was £1,038m including an asset revaluation of £15.5m and donated asset adjustment of £2.2m. After adjusting for the revaluation and donated asset adjustment, overall expenditure has increased by £83m when compared to the previous year. This increase has been driven by the cost of delivering additional activity, together with costs associated with inflation and other NHS policy driven cost pressures; the implementation of a new patient administration system (Cerner); and an increase in the costs and provisions associated with estates and backlog maintenance.

In line with established accounting practice the Trust commissioned an independent professional firm to undertake a valuation of its Estate. The accounts record an overall net increase of £15.5m in the value of the Trust asset base. This revaluation is excluded from the Department of Health's assessment of the Trust's breakeven duty.

The Trust's efficiency programme aimed to deliver savings in excess of approximately 3.7 per cent of planned turnover, of which around 80 per cent (£28.9m) was achieved. The Trust invested in a programme of clinical service transformation, to improve the quality and value of services.

All of the cost improvement projects were carefully planned and implemented through the Executive Committee, where any potential risks to patient safety and patient experience are rigorously assessed to ensure that none would have a detrimental impact on service quality and patient experience. The key themes included increases in income from community services and other areas of clinical work, programmes leading to clinical pathway redesign, reviewing key contracts, negotiating better prices with suppliers, and reducing overheads.

Capital Expenditure

The Trust continues to invest in its capital infrastructure to help achieve its strategic service objectives. During 2015/16 the Trust invested a total of £38.1m to modernise its estate, deal with backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2015/16 included:

- Backlog maintenance £12.4m
- Medical equipment £3.2m
- IT investment £6.8m

Total capital expenditure is detailed (in note 10.1 to the accounts).

Liquidity, cash and working capital

The Trust maintained a strong cash position throughout the year; remaining within its external financing limit (EFL), with a year-end cash position of

£24.2m. This is £11.9mm less than the level anticipated when the cash plan was developed at the start of the financial year, reflecting the increase in the deficit.

Financial outlook

The Trust has entered 2016/17 with a significant underlying deficit, and has therefore set a challenging target for improving productivity and cost reduction with a cost improvement programme (CIP) totalling £54.1m; about 7.4 per cent of 'influenceable' spend (CIP target alternatively reported as 5.4 per cent of turnover). Every division is contributing to delivering this and benchmarking shows that this challenge is consistent with what other hospitals are doing too. All of these initiatives are assessed by the Trust's medical director and director of nursing to ensure there is no impact on the quality of care.

Despite all this, the Trust is unable to set a plan to break even on income and expenditure. A planned deficit of £52.0m has been set by the Board. This target falls significantly short of the control total set necessary to qualify for £24m additional sustainability and transformation funding and therefore this funding is not included in the above budget.

The Trust continues to need to invest to meet a very significant programme of backlog maintenance across its estate and to update medical equipment, imaging facilities and operating theatres. The capital programme has been set at £38m excluding external donations and financing. Under Shaping a Healthier Future the Trust has continued to work with local commissioners and the sector provider Trusts in developing a business case which will deliver the very best care for patients across north west London. The Trust is actively exploring the extent to which commercial funding can be secured to provide new facilities for patients.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF IMPERIAL COLLEGE HEALTHCARE NHS TRUST

We have audited the financial statements of Imperial College Healthcare NHS Trust (the Trust) for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 (the 2015-16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers;
- the table of pension benefits of senior managers;
- the tables of exit packages;
- the analysis of average staff numbers; and
- the information on pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Imperial College Healthcare NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

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

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Imperial College Healthcare NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Exception report – conclusion on the use of resources

Auditor's responsibilities

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

Basis for qualified conclusion

Following the withdrawal in 2015/16 of additional top-up funding received by specialist hospitals to reflect the treatment of complex patients, the Trust set a deficit budget for the year of £18.5 million. The Trust's outturn position for 2015/16, as reported in the Statement of Comprehensive Income, was a £30.2 million deficit, adjusted to £47.9 million in Note 25 in respect of the financial performance for the year used by the Department of Health for financial monitoring. This is a significant deterioration compared to the Trust's budgeted deficit. In addition, the Trust's medium term financial plan shows a further substantial deterioration, with a forecast deficit of £52 million for 2016/17.

The deterioration in the Trust's finances occurred due to being unable to deliver additional timely savings to mitigate the impact of the reduction in budgeted income and additional cost pressures.

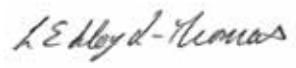
These issues are evidence of weaknesses in proper arrangements for the financing of sustainable delivery of services.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Imperial College Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

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



Leigh Lloyd-Thomas
For and on behalf of BDO LLP, Appointed Auditor
London, UK

2 June 2016

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

Financial statements

Statements of accounts

Statement of comprehensive income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	8.1	**(582,670)**	(553,389)
Other operating costs	6	**(455,378)**	(541,775)
Revenue from patient care activities	3	**832,193**	795,699
Other operating revenue	4	**187,712**	204,915
Operating deficit		**(18,143)**	(94,550)
Investment revenue		**200**	231
Other gains		**0**	213
Finance costs		**(763)**	(812)
Deficit for the financial year		**(18,706)**	(94,918)
Public dividend capital dividends payable		**(11,482)**	(14,351)
Retained deficit for the year		**(30,188)**	(109,269)

Other comprehensive income

	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**0**	(39,342)
Net gain on revaluation of property, plant & equipment	**274**	232
Subtotal Other Comprehensive Income	**274**	(39,110)
Total comprehensive income for the year*	**(29,914)**	(148,379)

Financial performance for the year

Retained deficit for the year	**(30,188)**	(109,269)
Impairments	**(15,533)**	123,818
Adjustments in respect of donated gov't grant asset reserve elimination	**(2,158)**	856
Adjusted retained (Deficit)/surplus	**(47,879)**	**15,405**

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

The notes on pages 81 to 100 form part of this account.

Statement of financial position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets			
Property, plant and equipment	10	**447,887**	429,639
Intangible assets		**4,792**	4,086
Total non-current assets		**452,679**	433,725
Current assets			
Inventories	13	**14,874**	13,458
Trade and other receivables	14.1	**106,076**	122,117
Cash and cash equivalents	15	**24,204**	43,333
Total current assets		**145,154**	178,908
Total assets		**597,833**	612,633
Current liabilities			
Trade and other payables	16	**(157,708)**	(134,458)
Provisions	19	**(37,244)**	(27,629)
Borrowings	17	**(1,533)**	(2,032)
Total current liabilities		**(196,485)**	(164,119)
Net current assets/(liabilities)		**(51,331)**	14,789
Total assets ledd current liabilities		**401,348**	448,514
Non-current liabilities			
Provisions	19	**0**	(13,175)
Borrowings	17	**(17,144)**	(18,677)
Total non-current liabilities		**(17,144)**	(31,852)
Total assets employed		**384,204**	**41**6,662
FINANCED BY:			
Public Dividend Capital		**694,744**	697,288
Retained earnings		**(312,917)**	(282,729)
Revaluation reserve		**2,377**	2,103
Total Taxpayers' Equity:		**384,204**	416,622

The notes on pages 81 to 100 form part of this account.

The financial statements on pages 77 to 100 were approved by the Board on 1 June 2016 and signed on its behalf by

Dr Tracey Batten,
Chief executive
1 June 2016

Statement of changes in taxpayers' equity for the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2015	**697,288**	**(282,729)**	**2,103**	**416,662**
Changes in taxpayers' equity for the year				
Retained deficit for the year	0	(30,188)	0	(30,188)
Net gain on revaluation of property, plant, equipment	0	0	274	274
Permanent PDC received – cash	856	0	0	856
Permanent PDC repaid in year	(3,400)	0	0	(3,400)
Net recognised revenue/(expense) for the year	**(2,544)**	**(30,188)**	**274**	**(32,458)**
Balance at 31 March 2016	**694,744**	**(312,917)**	**2,377**	**384,204**
Balance at 1 April 2014	**696,288**	**(175,475)**	**43,228**	**564,041**
Changes in taxpayers' equity for the year				
Retained deficit for the year	0	(109,269)	0	(109,269)
Net gain on revaluation of property, plant, equipment	0	0	232	232
Impairments and reversals	0	0	(39,342)	(39,342)
Transfers between reserves	0	2,015	(2,015)	0
New permanent PDC received – cash	1,000	0	0	1,000
Net recognised revenue/(expense) for the year	**1,000**	**(107,254)**	**(41,125)**	**(147,379)**
Balance at 31 March 2015	**697,288**	**(282,729)**	**2,103**	**416,662**

Statement of cash flows for the year ended 31 March 2016

	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities		
Operating deficit	**(18,143)**	(94,550)
Depreciation and amortisation	**34,536**	33,834
Impairments and reversals	**(15,533)**	123,818
Interest paid	**(763)**	(812)
PDC Dividend paid	**(11,796)**	(14,366)
(Increase)/Decrease in Inventories	**(1,416)**	756
(Increase)/Decrease in Trade and Other Receivables	**16,355**	(25,846)
Increase in Trade and Other Payables	**27,588**	584
Provisions utilised	**(8,064)**	(3,381)
Increase in movement in non cash provisions	**4,504**	1,945
Net Cash Inflow from Operating Activities	**27,268**	21,982
Cash Flows from Investing Activities		
Interest Received	**200**	231
Payments for Property, Plant and Equipment	**(40,703)**	(28,263)
Payments for Intangible Assets	**(1,318)**	(2,672)
Proceeds of disposal of assets held for sale (PPE)	**0**	3,307
Net Cash Outflow from Investing Activities	**(41,821)**	(27,397)
Net Cash Outflow before Financing	**(14,553)**	(5,415)
Cash Flows from Financing Activities		
Gross Temporary (2014/15 only) and Permanent PDC Received	**856**	1,000
Gross Temporary (2014/15 only) and Permanent PDC Repaid	**(3,400)**	0
Loans repaid to DH – Capital Investment Loans Repayment of Principal	**(1,226)**	(1,226)
Other Loans Repaid	**(806)**	(1,475)
Net Cash Outflow from Financing Activities	**(4,576)**	(1,701)
NET DECREASE IN CASH AND CASH EQUIVALENTS	**(19,129)**	(7,116)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**43,333**	50,449
Cash and Cash Equivalents (and Bank Overdraft) at Year End	**24,204**	43,333

Notes to the accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health.

The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements

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

The Trust has determined that the financial statements should be prepared on a going concern basis, as assurance has been received from the Department of Health that a revolving working capital facility will be made available to support the 2015-16 deficit and the planned deficit for 2016-17

The Trust has obtained an Alternative Site Valuation report and used this information to account for transactions and balances, rather than estimating site values.

Key sources of estimation uncertainty

Note 14.1 shows the trade and other receivables of the Trust. The provision for impairment of receivables is based on assumptions concerning the future and other sources of information about the age and recoverability of the debt.

Note 19 shows the provisions of the Trust. Management undertook a thorough review of provisions based on assumptions concerning the future and other sources of information.

1.3 Revenue

Revenue in respect of services provided to both NHS and private patients is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

The main source of revenue for the Trust is from commissioners for healthcare services, private patients, education and research grants, and other (non-patient care) income.

Revenue relating to NHS patient care spells (but not private patients) that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer.

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

1.4 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS 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.

The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.5 Other expenses

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

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000 or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

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

All assets are measured subsequently at valuation. Land and buildings used for the NHS Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value in existing use at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Valuations are determined as follows:

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

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

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1.7 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current

assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and its amount.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.9 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.10 Leases

The Trust as lessee

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

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

The NHS Trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Inventories

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

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

1.13 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates of minus 1.55 per cent for 0-5 years, minus 1.00 per cent for 6-10 years and minus 0.80 per cent for over 10 years in real terms (1.37 per cent for employee early departure obligations).

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

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 19.

1.15 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Contingencies

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

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

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

1.17 Financial assets

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

All of the NHS Trust's financial assets are classified as loans and receivables.

They are measured at amortised cost less any impairment.

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

The amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.18 Financial liabilities

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

All of the NHS Trust's financial liabilities are classified as other financial liabilities.

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

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Public Dividend Capital (PDC) and PDC dividend

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

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

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.21 Losses and special payments

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

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

premiums then being included as normal revenue expenditure).

1.22 Research and development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* – Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Income generation activities

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

This included services for private patients to the value of £44m. The income from private patients exceeded the associated costs.

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

3. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**762**	654
NHS England	**305,281**	306,746
Clinical Commissioning Groups	**456,445**	424,032
Foundation Trusts	**3,748**	3,098
Department of Health	**156**	96
Additional income for delivery of healthcare services	**3,400**	0
Non-NHS:		
Local Authorities	**8,589**	9,815
Private patients	**44,444**	43,068
Overseas patients (non-reciprocal)	**4,095**	3,244
Injury costs recovery	**1,934**	2,067
Other	**3,339**	2,879
Total Revenue from patient care activities	**832,193**	795,699

4. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**7,384**	5,818
Education, training and research	**113,983**	127,043
Charitable and other contributions to revenue expenditure -non- NHS	**1,808**	140
Receipt of donations for capital acquisitions – Charity	**3,129**	133
Receipt of Government grants for capital acquisitions	**119**	209
Non-patient care services to other bodies	**39,889**	30,581
Income generation (Other fees and charges)	**3,443**	3,765
Rental revenue from operating leases	**7,854**	7,001
Other revenue	**10,103**	30,225
Total Other Operating Revenue	**187,712**	204,915
Total Operating revenue	**1,019,905**	1,000,614

Other revenue includes £1,208k of Income from Car Parking

5. Overseas visitors disclosure

	2015-16 £000s	2014-15 £000s
Income recognised in-year (invoiced amounts and accruals)	**4,095**	3,244
Cash payments received in-year (re receivables at prior year end)	**384**	463
Cash payments received in-year (in respect of invoices issued in-year)	**1,239**	1,197
Amounts added to provision for impairment of receivables (re receivables at prior year end)	**1,743**	593
Amounts added to provision for impairment of receivables (in respect of invoices issued in-year)	**167**	826
Amounts written off in-year (irrespective of year of recognition)	**903**	1,051

6. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**9,708**	10,411
Services from CCGs/NHS England	**651**	446
Services from other NHS bodies	**1,994**	286
Services from NHS Foundation Trusts	**9,856**	9,624
Total Services from NHS bodies	**22,209**	20,767
Purchase of healthcare from non-NHS bodies	**7,609**	6,667
Trust Chair and Non-executive Directors	**61**	66
Supplies and services – clinical	**224,125**	193,323
Supplies and services – general	**35,325**	36,992
Consultancy services	**3,283**	13,370
Establishment	**8,071**	7,384
Transport	**13,564**	12,214
Business rates paid to local authorities	**4,743**	3,063
Premises	**42,648**	37,655
Hospitality	**169**	81
Insurance	**528**	541
Legal Fees	**879**	627
Impairments and Reversals of Receivables	**11,879**	10,296
Inventories write down	**495**	356
Depreciation	**33,387**	33,348
Amortisation	**1,149**	486
Impairments and reversals of property, plant and equipment	**(15,533)**	123,818
Internal Audit Fees	**211**	211
Audit fees	**164**	278
Other auditor's remuneration (2015-16 Quality Accounts Review)	**18**	25
Clinical negligence	**25,068**	16,173
Research and development (excluding staff costs)	**23,797**	23,619
Education and Training	**2,475**	1,386
Change in Discount Rate	**0**	(50)
Other	**9,054**	(921)
Total Operating expenses (excluding employee benefits)	**455,378**	541,775
Employee Benefits		
Employee benefits excluding Board members	**581,286**	552,037
Board members	**1,384**	1,352
Total Employee Benefits	**582,670**	553,389
Total Operating Expenses	**1,038,048**	**1,095,164**

7. Operating leases

7.1. Trust as lessee

	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense				
Minimum lease payments			**8,583**	8,360
Total			**8,583**	8,360
Payable:				
No later than one year	7,177	1,083	**8,260**	7,779
Between one and five years	3,250	1,004	**4,254**	9,327
After five years	3,067	0	**3,067**	3,860
Total	**13,494**	**2,087**	**15,581**	20,966

7.2. Trust as lessor

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	7,854	7,001
Total	**7,854**	7,001
Receivable:		
No later than one year	7,654	7,027
Between one and five years	2,164	7,667
After five years	1,655	3,120
Total	**11,473**	17,814

8. Employee benefits and staff numbers

8.1. Employee benefits

	2015-16 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits – Gross Expenditure			
Salaries and wages	**497,605**	445,008	52,597
Social security costs	**37,366**	37,366	0
Employer Contributions to NHS BSA – Pensions Division	**49,288**	49,288	0
Other pension costs	**14**	14	0
Termination benefits	**234**	234	0
Total employee benefits	**584,507**	**531,910**	**52,597**
Less Employee costs capitalised	**1,837**	643	1,194
Gross Employee Benefits excluding capitalised costs	**582,670**	531,267	51,403

Employee Benefits – Gross Expenditure 2014-15	**Total** £000s	Permanently employed £000s	Other £000s
Salaries and wages	472,827	431,412	41,415
Social security costs	35,896	35,896	0
Employer Contributions to NHS BSA – Pensions Division	46,395	46,395	0
Other pension costs	12	12	0
Termination benefits	445	445	0
TOTAL - including capitalised costs	555,575	514,160	41,415
Less Employee costs capitalised	2,186	635	1,551
Gross Employee Benefits excluding capitalised costs	553,389	513,525	39,864

8.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

9 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000s**	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**173,924**	**492,448**	141,792	385,458
Total Non-NHS Trade Invoices Paid Within Target	**149,815**	**423,925**	126,897	345,409
Percentage of NHS Trade Invoices Paid Within Target	**86.14%**	**86.09%**	89.50%	89.61%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,902**	**55,597**	4,112	35,089
Total NHS Trade Invoices Paid Within Target	**4,208**	**43,083**	3,631	30,943
Percentage of NHS Trade Invoices Paid Within Target	**71.30%**	**77.49%**	88.30%	88.18%

10.1. Property, plant and equipment

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

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	8	1,290	0	805	0	0	2,103
Movements (upward revaluation)	2	272	0	0	0	0	274
At 31 March 2016	**10**	**1,562**	**0**	**805**	**0**	**0**	**2,377**

	Land	Buildings	Assets under construction & payments on account	Dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000's	£000	£000	£000	£000	£000
At 1 April 2014	37,508	2,761	0	2,138	821	0	0	43,228
Movements	(37,500)	(1,471)	0	(2,138)	(16)	0	0	(41,125)
At 31 March 2015	8	1,290	0	0	805	0	0	2,103

Additions to Assets Under Construction

Assets under construction & payments on account	**2015-16 £000's**	2014-15 £000s
Buildings excl Dwellings	10,875	5,476
Plant & Machinery	3,597	2,300
Total additions in year	**14,472**	7,776

10.2. Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dewllings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2014	210,895	314,959	2,930	16,098	123,053	30,205	833	698,973
Additions of Assets Under Construction	0	0	0	7,776	0	0	0	7,776
Additions Purchased	0	9,995	0	0	13,105	2,573	66	25,739
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	342	0	0	342
Reclassifications	0	5,544	0	(13,681)	1,974	5,676	0	(487)
Disposals other than for sale	0	0	(2,765)	0	(2,767)	0	0	(5,532)
Revaluation	(119,758)	(20,650)	(25)	0	0	0	0	(140,433)
Impairments/negative indexation charged to reserves	(37,500)	(1,702)	(140)	0	0	0	0	(39,342)
At 31 March 2015	**53,637**	**308,146**	**0**	**10,193**	**135,707**	**38,454**	**899**	**547,036**
Depreciation								
At 1 April 2014	0	4,106	13	0	79,400	19,544	271	103,334
Disposals other than for sale	0	0	(24)	0	(2,414)	0	0	(2,438)
Revaluation	0	(20,882)	(25)	0	0	0	0	(20,907)
Impairments/negative indexation charged to operating expenses	0	9,830	0	0	0	0	0	9,830
Reversal of Impairments charged to operating expenses	0	(5,770)	0	0	0	0	0	(5,770)
Charged During the Year	0	16,953	36	0	12,522	3,748	89	33,348
At 31 March 2015	0	4,237	0	0	89,508	23,292	360	117,397
Net Book Value at 31 March 2015	**53,637**	**303,909**	**0**	**10,193**	**46,199**	**15,162**	**539**	**429,639**
Asset financing:								
Owned – Purchased	53,637	287,144	0	10,193	43,833	15,162	539	410,508
Owned – Donated	0	15,495	0	0	2,115	0	0	17,610
Owned – Government Granted	0	1,270	0	0	251	0	0	1,521
Total at 31 March 2015	**53,637**	**303,909**	**0**	**10,193**	**46,199**	**15,162**	**539**	**429,639**

10.3. Property, plant and equipment

The Trust uses the following lives for each class of asset:-

Property, plant and equipment	Minimum Life	Maximum Life
Building excl Dwellings	25	60
Plant & Machinery	5	15
Information Technology	5	8
Furniture and Fittings	10	10

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

The Trust had its estate valued by an independent RICS Chartered Surveyor, GVA Grimley Ltd, on a modern equivalent asset basis as at 31 December 2015.

The Trust has discussed movements in relevant indices to 31 March 2016 with GVA Grimley Ltd and does not consider a further update is required at year end.

11. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI		
Changes in market price	(15,533)	123,818
Total charged to Annually Managed Expenditure	**(15,533)**	123,818
Total Impairments of Property, Plant and Equipment changed to SoCI	**(15,533)**	123,818
Donated and Gov Granted Assets, included above		
PPE – Donated and Government Granted Asset Impairments: amount charged to SOCI – DEL	**0**	453

The reversal of impairment this year (above) is as a result of the valuation of the Trust's property portfolio as at 31st December 2015 by an independent RICS Chartered Surveyor, GVA Grimley Ltd, on a modern equivalent asset value basis.

12. Commitments

12.1. Capital commitments

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

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	**5,679**	4,491
Total	**5,679**	4,491

13. Inventories

	Drugs £000s	Consumables £000s	Energy £000s	**2015-16 Total £000s**	2014-15 Total £000
Balance at start of year	5,163	7,895	400	**13,458**	14,214
Additions	124,440	41,612	175	**166,227**	148,896
Inventories recognised as an expense in the period	(125,109)	(38,865)	(342)	**(164,316)**	(149,296)
Write-down of inventories (including losses)	(275)	(220)	0	**(495)**	(356)
Balance at end of year	**4,219**	**10,422**	**233**	**14,874**	13,458

14.1. Trade and other receivables

	Current	
	31 March 2016	31 March 2015
	£000s	£000s
NHS receivables – revenue	**43,555**	68,303
NHS prepayments and accrued income	**25,916**	17,183
Non-NHS receivables – revenue	**37,701**	33,793
Non-NHS prepayments and accrued income	**19,415**	16,153
PDC Dividend prepaid to DH	**453**	139
Provision for the impairment of receivables	**(25,820)**	(19,024)
VAT	**3,230**	4,330
Interest receivables	**4**	3
Other receivables	**1,622**	1,237
Total	**106,076**	122,117

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

14.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**20,312**	9,125
By three to six months	**18,694**	6,562
By more than six months	**11,313**	6,333
Total	**50,319**	22,020

14.3. Provision for impairment of receivables

	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	**(19,024)**	(11,404)
Amount written off during the year	**5,083**	2,676
Increase in receivables impaired	**(11,879)**	(10,296)
Closing balance	**(25,820)**	(19,024)

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

15. Cash and cash equivalents

	Current	
	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	**43,333**	50,449
Net change in year	**(19,129)**	(7,116)
Closing balance	**24,204**	43,333
Made up of		
Cash with Government Banking Service	**24,111**	43,232
Commercial banks	**62**	72
Cash in hand	**31**	29
Cash and cash equivalents as in statement of financial position and cash flows	**24,204**	43,333
Patients' money held by the Trust not included above	**60**	73

16. Trade and other payables

	31 March 2016	31 March 2015
	£000s	£000s
NHS payables – revenue	**9,030**	10,656
NHS payables – capital	**177**	0
NHS accruals and deferred income	**10,396**	7,753
Non-NHS payables – revenue	**30,045**	32,009
Non-NHS payables – capital	**8,065**	12,580
Non-NHS accruals and deferred income	**79,156**	58,800
Social security costs	**5,643**	5,365
Accrued Interest on DH Loans	**32**	0
Tax	**6,013**	5,909
Other	**9,151**	1,386
Total	**157,708**	134,458
Total payables (current and non-current)	**157,708**	134,458
Included above:		
Outstanding Pension Contributions at the year end	**6,961**	45

17. Borrowings

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**1,226**	1,226	**17,144**	18,370
Loans from other entities	**307**	806	**0**	307
Total	**1,533**	**2,032**	**17,144**	**18,677**
Total borrowings (current and non-current)	**18,677**	**20,709**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	1,226	307	**1,533**
1 - 2 Years	1,226	0	**1,226**
2 - 5 Years	3,678	0	**3,678**
Over 5 Years	12,240	0	**12,240**
Total	**18,370**	**307**	**18,677**

	31 March 2015		
	DH	**Other**	**Total**
	£000	£000	**£000**
0-1 Years	1,226	806	**2,032**
1 - 2 Years	1,226	307	**1,533**
2 - 5 Years	3,678	0	**3,678**
Over 5 Years	13,466	0	**13,466**
Total	**19,596**	**1,113**	**20,709**

18. Deferred income

	Current	
	31 March 2016	31 March 2015
	£000s	£000s
Opening balance at 1 April	**22,095**	22,369
Deferred revenue addition	**7,673**	6,848
Transfer of deferred revenue	**(2,975)**	(7,122)
Current deferred Income at 31 March	**26,793**	22,095

19. Provisions

	2015-16	Comprising:	2014-15		
	Total	Legal Claims	Redundancy	Other	Total
	£000s	£000s	£000s	£000s	£000
Balance at beginning of year	**40,804**	148	158	40,498	42,240
Arising during the year	**20,322**		0	20,322	16,918
Utilised during the year	**(8,064)**	(28)	(147)	(7,889)	(3,381)
Reversed unused	**(15,818)**		(11)	(15,807)	(14,923)
Change in discount rate					(50)
Balance at end of year	**37,244**	120	0	37,124	40,804
Expected Timing of Cash Flows:					
No Later than One Year	**37,244**	120			

We have included a provision based on expert advice for issues relating to the condition of the Trust's estate
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2016	258,979
As at 31 March 2015	142,592

20. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(56)**	(97)
Other	**0**	(1,200)
Net value of contingent liabilities	**(56)**	(1,297)

21. Financial instruments

21.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust actively manages accounts receivable in relation to private patients and has clear policies in place to minimise this risk

Liquidity risk
The Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources The Trust is not, therefore, exposed to significant liquidity risks.

21.2. Financial Assets

Receivables - NHS	69,471
Receivables - non-NHS	46,943
Cash at bank and in hand	24,204
Total at 31 March 2016	**140,618**
Receivables – NHS	85,486
Receivables – non-NHS	40,769
Cash at bank and in hand	43,333
Total at 31 March 2015	**169,588**

All financial assets are receivable within one year and the carrying value approximates their fair value.

21.3. Financial Liabilities

	Other
NHS payables	11,696
Non-NHS payables	98,656
Other borrowings	18,677
Total at 31 March 2016	**129,029**
NHS payables	10,656
Non-NHS payables	101,708
Other borrowings	20,709
Total at 31 March 2015	**133,073**

21.3. Financial Liabilities (cont.)

Borrowings / Loans – repayment of principal and interest falling due in:

	31 March 2016			
	DH £000s Principal	DH £000s Interest	Other (Interest Free) £000s	Total £000s
0-1 Years	1,226	711	307	2,244
1 - 2 Years	1,226	663	0	1,889
2 - 5 Years	3,678	1,700	0	5,378
Over 5 Years	12,240	2,516	0	14,756
Total	**18,370**	**5,590**	**307**	**24,267**

All financial liabilities, other than other borrowings, are payable within one year. The carrying value of all financial liabilities approximates to their fair value. The maturity date for the DH Loan is March 2031

22. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Imperial College Healthcare NHS Trust.

The Department of Health is regarded as a related party. During the year 2015/16 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below detailing income and expenditure for the year along with the debtor and creditor as at 31 March 2016.

	Creditor £000	Debtor £000	Income £000	Expenditure £000
Department of Health	0	407	50,054	0
NHS England	1,936	21,299	315,797	232
NHS Foundation Trusts including:				
Chelsea and Westminster	1,736	3,864	17,681	3,710
CCGs including:				
Brent	855	4,447	57,114	0
Camden	107	52	7,432	0
Central London (Westminster)	416	6,322	55,468	0
Ealing	1,065	4,267	71,724	0
Hammersmith and Fulham	941	8,727	85,379	400
Harrow	120	930	10,940	0
Hillingdon	116	833	11,623	0
Hounslow	169	571	30,962	0
Richmond	42	941	10,314	0
West London (Kensington & Chelsea & Qpp)	551	6,181	69,862	0
Other NHS Bodies including:				
Health Education England	0	1,248	64,594	3
NHS Litigation Authority	0	0	82	25,582
HM Revenue and Customs	11,656	3,230	0	37,366
NHS Pension Scheme	7,106	0	0	49,288
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	0	5	429	6,815

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Hammersmith and Fulham.

The Trust has also received revenue and capital payments from a number of charitable funds.

The Trust works in partnership with Imperial College London as an Academic Health Science Centre. Trust balances with Imperial College London for the period were as follows:
Debtors at 31 March 2016 were £2,590k (2014-15 £2,357k)
Creditors at 31 March 2016 were £10,562k (2014-15 £8,518k)
Income for the 12 months to 31 March 2016 was £7,549k (2014-15 £7,256k)
Expenditure for the 12 months to 31 March 2016 was £38,404k (2014-15 £35,453k)

22. Related party transactions (cont)

2014-15	Creditor £000	Debtor £000	Income £000	Expenditure £000
Department of Health	2,131	20,300	68,916	0
NHS England	2,183	18,158	316,330	43
NHS Foundation Trusts including:				
Chelsea and Westminster	1,547	2,900	14,967	3,953
CCGs including:				
Brent	806	2,357	50,811	0
Camden	102	639	7,550	0
Central London (Westminster)	374	2,462	46,307	0
Ealing	853	3,079	62,443	0
Hammersmith and Fulham	815	9,748	86,163	400
Harrow	84	395	8,650	0
Hillingdon	60	566	9,494	0
Hounslow	168	1,544	29,222	0
Richmond	127	163	10,262	0
West London (Kensington & Chelsea & Qpp)	475	3,154	68,002	0
NHS Trusts	0	0	0	0
Other NHS Bodies including:				
Health Education England	0	2,156	64,550	1
NHS Litigation Authority	0	3	29	16,693
HM Revenue and Customs	11,274	4,330	0	35,896
NHS Pension Scheme	45	0	0	46,473
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	981	33	410	8,312

23. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	1,900,055	421
Special payments	133,517	104
Total losses and special payments	2,033,572	525

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	1,653,503	556
Special payments	197,185	83
Total losses and special payments	1,850,688	639

There were no cases individually over £300,000

24. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years. Financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

24.1. Breakeven performance

	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	838,148	839,328	900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905
Retained surplus/(deficit) for the year	12,750	12,025	9,102	(1,909)	(20,479)	(39,955)	(102,576)	(109,269)	(30,188)
Adjustment for:									
Adjustments for impairments	0	0	0	7,055	12,060	48,379	117,142	123,818	(15,533)
Adjustments for impact of policy change re donated/government grants assets					0	601	562	856	(2,158)
Break-even in-year position	12,750	12,025	9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)
Break-even cumulative position	12,750	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283

* Adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	1.52	1.43	1.01	0.56	-0.89	0.93	1.54	1.54	-4.69
Break-even cumulative position as a percentage of turnover	1.52	2.95	3.76	4.24	3.25	4.08	5.59	7.01	2.18

24.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

24.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16	2014-15
	£000s	£000s
External financing limit (EFL)	**14,644**	6,235
Cash flow financing	**14,553**	5,415
Underspend against EFL	**91**	820

24.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16	2014-15
	£000s	£000s
Gross capital expenditure	**38,123**	36,529
Less: book value of assets disposed of	**(440)**	(3,307)
Less: capital grants	**(119)**	(209)
Less: donations towards the acquisition of non-current assets	**(3,129)**	(133)
Charge against the capital resource limit	**34,435**	32,880
Capital resource limit	**35,480**	33,000
Underspend against the capital resource limit	**1,045**	120

Appendix 1: Internal audit reports issued 2015/16

Review	Status	Finding
Raising Concerns	Final report	Substantial Assurance
Family & Friends	Final report	Substantial Assurance
Ionising Radiation	Final report	Substantial Assurance
Corporate /Clinical Governance – review of Serious Incidents to evaluate if any were due to financial cause.	Final report	Substantial Assurance
Financial Ledger & Feeder Systems	Final report	Substantial Assurance
Cerner Go Live	Final report	Substantial Assurance
Bank & Treasury	Final report	Substantial Assurance
Education	Final report	Substantial Assurance
Research & education – data quality	Draft report	Substantial Assurance
Research	Final report	Substantial Assurance
Review of the Research Arrangements	Final report	Substantial Assurance
IG toolkit & compliance	Final report	Substantial Assurance
Cerner – electronic prescribing	Final report	Substantial Assurance
Review of Datix system	Final report	Substantial Assurance
Workforce	Final report	Reasonable Assurance
Safety Thermometer	Final report	Reasonable Assurance
Estates – Back log Maintenance	Final report	Reasonable Assurance
Junior Doctor's hospital at Night	Final report	Reasonable Assurance
Income Commissioning & SLA	Final report	Reasonable Assurance
Financial Reporting/Planning & Budgetary Control	Final report	Reasonable Assurance
Review of Wireless infrastructure	Final report	Reasonable Assurance
ICT – project wireless	Final report	Reasonable Assurance
BAF/Risk Management	Final report	Reasonable Assurance
Emergency department - data validation	Final report	Reasonable Assurance
Review of Capital and Investment Projects	Final report	Reasonable Assurance
Financial ledger & feeder systems	Final report	Reasonable Assurance
VTE	Final report	Limited Assurance
Nurse & Midwifery Staff Vacancies	Final report	Limited Assurance
Safeguarding adults	Final report	Limited Assurance
Confidential waste	Final report	Limited Assurance
Occupational Health	Final report	No Assurance

The internal audit team also supported the completion of the in-house reviews taken to support CQC compliance:

CQC – Deep Dive review
Maternity & Gynaecology

CQC – Deep Dive review
Critical Care Charing Cross Hospital

CQC – Deep Dive review
Hammersmith Hospital - outpatients

CQC – Deep Dive review
Charing Cross Hospital – outpatients

CQC – Deep Dive review
Emergency department

CQC – Deep Dive review
St Mary's Hospital Critical Care

CQC – Deep Dive review
St Mary's Hospital CYP

CQC – Deep Dive review
St Mary's Hospital EOLC

CQC – Core Services review
2 Charing Cross Hospital Med

CQC – Core Services review
2 Charing Cross Hospital Surgery

CQC – Core Services review
2 Charing Cross Hospital Critical Care

CQC – Core Services review
2 Hammersmith Hospital Medicine

CQC – Core Services review
2 Hammersmith Hospital Surgery

CQC – Core Services review
2 Hammersmith Hospital Critical Care

CQC – Core Services review
2 St Mary's Hospital Medicine

CQC – Core Services review
2 St Mary's Hospital Surgery

Appendix 2: Directors' register of interests

Sir Richard Sykes Chairman

- Director, EDBI Pte Ltd since 2011
- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Non-Executive Chairman of NetScientific plc since 2008
- Chairman of Royal Institution of Great Britain since 2010
- Chancellor Brunel University since 2013
- Chairman PDS Biotechnology Corporation since 2014

Sir Gerald Acher Non-Executive Director

- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Trustee of KPMG Foundation
- President of Young Epilepsy
- Chairman Brooklands Museum Trust
- Chairman Cobham Community Bus CIC

Dr Rodney Eastwood Non-Executive Director

- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy [Secondary school]
- Trustee of the London School of ESCP Europe (a pan-European Business School)
- Member of the Editorial Advisory Board of HE publication
- Member of the Board of Trustees of the RAF Museum
- Chairman, Audit Committee, Royal Society of Biology
- Consultant to Brunel University

Jeremy M Isaacs Non-Executive 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
- Marex Spectron Group Limited – Director (NED)
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust
- Designated member of JRJ Ventures LLP
- Member of LSBI LLP
- Director of Elljay Limited
- Member of Bridges Ventures Advisory Board
- Nomad Foods Limited – Director (NED)

Professor Sir Anthony Newman-Taylor Non-Executive Director

- Chairman, Colt Foundation
- Trustee, Rayne Foundation
- Chairman, independent Medical Expert Group, Armed Forces Compensation Scheme, MoD
- Member, Bevan Commission, Advisory Group to Minister of Health, Wales
- President'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
- Chairman, Work Health Expert Committee, Health and Safety Executive

Sarika Patel Non-Executive Director

- Board – Centrepoint
- Board – Royal Institution of Great Britain
- Partner – Zeus Capital
- Board – London General Surgery

Dr Andreas Raffel Non-Executive Director

- Senior Adviser at Rothschild
- Deputy Chair of Council of Cranfield University
- Member of the International Advisory Board of Cranfield School of Management
- Non-Executive Director, Olswang LLP
- Trustee and board member Crime Reduction Initiative (CRI)

Dr Tracey Batten Chief Executive

- Trustee of The Point of Care Foundation
- Spouse appointed Non-Executive Director of BUPA Board (12th January 2016)

Richard Alexander Chief Financial Officer

- Non-Executive Director of HDI – Health Data Insights
- Ex Oracle employee and current shareholder

Professor Janice Sigsworth Director of Nursing

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

Dr Julian Redhead Medical Director

- Trustee – Royal Society Prevention Accidents
- Director – Stadium Doctors Ltd
- Shareholder – Fortius Clinic
- Medical Director – Fortius Clinic
- Inspector – Care Quality Commission
- Major Incident Doctor – London Ambulance Service
- Doctor – Chelsea Football Club

Alternative formats

The performance report is also available in other languages, large print and audio format on request. Please contact the communications directorate on 020 3313 3005 for further details.

Este documento encontra-se também disponivel noutros idiomas, em tipo de imprensa grande e em formatoáudio, a pedido.

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

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

Dokument ten jest na zyczenie udostepniany takze w innych wersjach jezykowych, w duzym druku lub w formacie audio.

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

Full accounts

If you require a set of our full accounts, please contact
Trust company secretary, Jan Aps
jan.aps@imperial.nhs.uk

Imperial College Healthcare NHS
NHS Trust

Charing Cross Hospital

Fulham Palace Road
London W6 8RF

020 3311 1234

Hammersmith Hospital

Du Cane Road
London W12 0HS

020 3313 1000

Queen Charlotte's & Chelsea Hospital

Du Cane Road
London W12 0HS

020 3313 1111

St Mary's Hospital

Praed Street
London W2 1NY

020 3312 6666

Western Eye Hospital

Marylebone Road
London NW1 5QH

020 3312 6666

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