Imperial College Healthcare NHS
NHS Trust

ANNUAL REPORT 2014/15

Introduction and overview

Sir Richard Sykes
Chairman

Dr Tracey Batten
Chief executive

Given the increasing complexity in all aspects of our lives, we think our role is very simple. We want to play our full part in helping all those we serve to be as healthy as possible, ensuring that they can live their lives to the fullest.

We believe that we can do this by truly harnessing the amazing expertise, experience and enthusiasm of our 10,000 staff as well as our core partnership with Imperial College London, a world-leader in health and healthcare research.

We are at the beginning of the journey to achieve this vision but we reached a number of important milestones in 2014/15. In July 2014, we published our clinical strategy and outline estates redevelopment proposals, drawing on extensive input from our clinicians and wider staff groups. While there is still much to do to develop our plans further, especially through engagement with our patients and local communities, we are clear that the status quo is not an option if we are to meet future health needs.

Our inspection by the Care Quality Commission in September both reinforced our strategy to achieve our vision and served as a catalyst to redouble our efforts to get the essentials right, consistently, as soon as possible. It acted as a positive challenge, and the action plan developed in response to our 'requires improvement' rating has been a great launch pad for developing a wider-reaching quality strategy with input from our people and our patients.

We implemented the first phase of our new electronic patient administration system in April, and have continued to roll out additional modules. This is allowing us to move away from paper records and is opening up huge opportunities for real-time access to vital clinical information.

During the year, we were awarded the contract to be lead health provider for a community independence service for three London boroughs, working in partnership with nine other health providers across acute, community and primary care as well as with adult social services.

Though relatively small in scale currently, this model of care foreshadows the sort of genuinely integrated care that could have a profound impact on our community's health and wellbeing. Partnerships, more generally, have been a major theme of our recent work. With three other trusts in north west London, in December we were designated as one of the NHS's first 11 genomic medical centres to help deliver the 100,000 Genome Project.

We worked closely with commissioners on changes to our A&E services, including the planned closure of the emergency department at Hammersmith Hospital and the extension of the urgent care centre there to a 24/7 service in September. And, with significant challenges to A&E performance across the region through the winter, we have continued to work with commissioners and other providers to look, not just at what we need to do to improve, but what our role should be in the wider system.

This coming year is likely to be characterised by more challenge and change so it is especially important that we keep on track both with our immediate improvement plans and our longer-term strategy. Finances will be tighter than ever, many of our buildings are old and in a poor state, and we have to move forward to evolve our models of care to meet new needs. We know that openness, collaboration and creativity will be key and look forward to the opportunities this will bring.

Strategic report

About the Trust

Imperial College Healthcare NHS Trust provides acute and specialist healthcare for a population of just under two million people in north west London, and more beyond. Formed in 2007, we are one of the largest NHS trusts in the country.

With our academic partner, Imperial College London, we are one of the UK's seven academic health science centres, working to ensure the rapid translation of research for better patient care. We are also part of Imperial College Health Partners – the academic health science network for north west London – spreading innovation and best practice in healthcare more widely across our region.

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.

In July 2014, we published our **clinical strategy** which sets out how our clinicians would like to connect our many different services and specialties across our sites in order to achieve the best clinical outcomes. To support this, we proposed re-developing our three main sites to have their own distinct, yet interdependent, offer. Our clinical and estates strategies reflect the wider programme for service reconfiguration agreed for north west London, led by our local clinical commissioning groups. A business case for our estates redevelopment proposals is being considered at a national level within the NHS.

We work increasingly closely with Imperial College Healthcare Charity, which generously funded a range of initiatives for patients and staff in 2014/15. The Trust also receives valuable support from: COSMIC (Children of St Mary's Intensive Care); Leuka, a leukaemia research charity at Hammersmith Hospital; 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 hospitals and services

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

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. 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. Charing Cross has a 24/7 A&E department.

Hammersmith Hospital, Acton – a specialist hospital renowned for its strong research connections. It offers a range of services, including renal, haematology, cancer and cardiology care, and runs 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, foetal 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.

Community-based services

Increasingly, we are offering consultations and care in community facilities that would traditionally have been provided in our outpatients clinics, working closely with GPs and other primary and community care organisations. On 1 April 2015, we also became the lead health provider for the community independence service covering three of our boroughs – Hammersmith & Fulham, Kensington & Chelsea, and Westminster. This means partnering with other health care providers and adult social care to enable people with complex needs to get the care they need at home wherever possible, and to help them get home again as quickly as possible if they do need a spell in hospital.

Our commissioners

Around a third of our care is commissioned by our eight 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.

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.

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. Read more about this on page 16.

We are a major provider of education and training for doctors, nurses, midwives and allied health professionals. In 2014/15, nearly 200 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 train over 300 student nurses and midwives, many of whom gain their first job or qualification with us.

300+

Student nurses and midwives who train at the Trust.

The Trust in numbers

Our care

Over
one million
outpatient contacts

186,000
people treated
as inpatients

280,000+
people attended
one of our A&E departments
or urgent care centres

Over
8,700
babies born in
our hospitals

Our staff

Just over
10,000
staff, including:

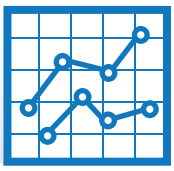
1,900
doctors

3,000
nurses and
midwives

500
allied health
professionals

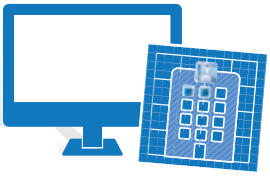
Our finances

We had a year-end
surplus, after adjusting
for impairments, of
£15.4m



We had a
turnover of over
£1,000m

We achieved
efficiency savings of
£39.7m
for reinvestment in
patient care



We invested
£32.9m
in building and
infrastructure projects

2014/15 in focus

Our main goals going into 2014/15, with a new leadership team, were to continue to build solid and **sustainable foundations** for the Trust, helping us to **provide better care**, more effectively and efficiently. We also embarked on our journey to develop a **shared vision** for the future, grounded in continuous **quality improvement**, making **best use of research** and learning and fully **engaging our staff**, patients, local communities and other stakeholders.

The key themes for the year in terms of achievements and challenges are described in the following pages. More detail on our operational performance is provided on **page 25**. Our annual governance statement – including a summary of our key risks – is on **page 36**. Our sustainability report starts on **page 30** and our chief financial officer's report and statement of accounts begins on **page 72**.

Quality first

Quality improvement was boosted by a challenging Care Quality Commission (CQC) inspection in September 2014, leading to the development of a new approach that is galvanising staff across the Trust.

CQC inspection

Overall, the CQC rated the Trust as 'requires improvement' following our inspection in September 2014.
We were rated 'good' for providing effective care and being caring, and 'requires improvement' for providing safe care, being responsive to patients' needs and being well-led.

While there was disappointment with the overall rating, we viewed the CQC's inspection report as being extremely constructive. It clearly set out our challenges while also recognising the positive impact of our work over the previous year and highlighting the great care that we already provide.

Since publication of the CQC report in December, we have agreed and begun to implement an action plan to address all the 'must do' and 'should do' recommendations as quickly as possible. This includes a major push to reduce our staff vacancy levels, an outpatient development project, and a redoubling of efforts to reduce our surgery waiting list. We addressed urgent issues around cleanliness and infection control in St Mary's Hospital A&E department immediately after the inspection and, following a reinspection in November, our rating there moved from 'inadequate' to 'requires improvement'.

> **We viewed the CQC's inspection report as being extremely constructive.**

Quality strategy

Building on the CQC action plan, our medical director has been working with patients, staff and other stakeholders to develop a new quality strategy. The strategy, to be launched later in 2015, will set clear goals and measures for what we will seek to achieve over the next three years.

Critically, we are also developing and investing in an organisation-wide quality improvement methodology to support implementation of the strategy. This is a systematic way of working, backed up with tailored training and support, to encourage and facilitate improvement at all levels. We want to encourage more staff-led projects such as how we addressed sleep disturbances on wards. In 2014/15, nurses gathered data to identify the causes of broken sleep and came up with simple but effective improvements, such as blackout curtains and better ward temperature regulation, which have had a big impact on patients.

Innovating to improve safety

While we have one of the lowest patient mortality rates in England, we have been working to strengthen our safety systems further. It is essential that we get things right first time. If not, we need to find out why so that, if it was something that should have been avoidable, we can share learning to prevent similar incidents in the future. This culture of learning and reporting is already evident – we successfully increased our reporting of safety incidents (42.98 incidents per 1,000 bed days in 2014/15, exceeding the 35.1 average for similar organisations) while maintaining an overall low level of harm.

Duty of candour legislation also came into force and further strengthened our open and transparent approach to reporting. There are now specific requirements that when things go wrong, patients and their carers must be informed of the incident with full, truthful information, provided with reasonable support and an apology.

> **[Our] systematic way of working, backed up with tailored training and support, will encourgae and facilitate improvement at all levels.**

Hello, my name is…

As part of our work to improve patient experience, in 2014 we joined the *#Hellomynameis* campaign.

The campaign was launched by Dr Kate Granger in response to her own experience of care when receiving cancer treatment. The campaign aims to encourage and remind healthcare staff about the importance of introductions in the delivery of care. But it is not just about knowing someone's name – it is about making a human connection, beginning a therapeutic relationship and building trust.

As part of our response to the campaign, we ran events with staff and patients to design a new, more welcoming name badge.

> **By developing cancer care with a partner as well-known as Imperial, we hope to have real impact and share the learning elsewhere.**
>
> Sarah Gigg, senior development manager, Macmillan Cancer Support

Responding to patients

We saw some great results from a range of projects that are putting patients' views and ideas at the heart of service development.

Turning around cancer care experience

In 2014, we were one of the most improved trusts in the annual national cancer patient experience survey. One key factor was our partnership with Macmillan Cancer Support to help redesign key cancer care pathways.

We built on this work further in February 2015, with a new, three-year collaborative improvement programme to transform cancer care across north west London. Supported with a £2m investment from Macmillan, the programme is enabling healthcare professionals to work alongside patients to ensure we have the right staff in the right place to support individuals, and their GPs, throughout their cancer journey, making sure care is properly joined up.

Dementia carer's passport

People with dementia often rely on their carers to help guide them through everyday experiences and it's their feedback that led to development of the Trust's nationally recognised 'carer's passport'. The passport makes it easy for carers to visit outside of normal hospital visiting times, so that they can support their friend or family member. Posters on wards welcome carers and help spread the message.

The dementia team has also been working on other initiatives to ensure that the Trust is dementia friendly, including dementia training for all staff and a weekly drop-in session offering support to relatives, friends and staff.

Assessing the healthcare environment

It can be hard to see things through the eyes of others, so we really value the input from our local Healthwatch. The team at Healthwatch Central West London organised several patient-led assessment of the care environment (PLACE) inspections during the year. Overall, the results were good.

The team found the staff respected patients' privacy and dignity, and they judged the environment acceptable. They did not identify any major concerns, but they made several recommendations for improvement, for example, to make hot food available 24 hours a day.

There was a drop in some scores on the previous year due to concerns about single-sex accommodation, bathrooms and the availability of quiet rooms for private conversations. We responded to the feedback with an immediate action plan, with a particular focus on privacy and dignity.

Learning from 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 have been reviewing the way we work looking at how to create a more responsive and caring complaints service for our patients and identify learning for our people.

In 2014/15, we had 1,242 formal complaints and 11 per cent more patients using our Patient Advice and Liaison Service (PALS) compared with the previous year. A major trigger for complaints last year was teething problems with our new electronic patient administration system which impacted particularly on the timeliness and accuracy of outpatient appointment information. Since July, as the new system has bedded in, we have seen a reduction in this type of complaint.

The Trust's current complaints procedure fully reflects the Parliamentary and Health Service Ombudsman's six Principles for Remedy. When the Trust has made a mistake or provided poor service, its response to the complaint is guided by these principles. Plans are underway to develop a more flexible and responsive complaint service that is tailored to the individual complaint. This will enable continuous improvement and a strong emphasis on customer service.

Developing services fit for the future

The publication of our clinical strategy in July 2014 was a major milestone, kick-starting a long-term programme of clinical transformation to ensure we are able to meet future health needs and enabling our current services and models of care to respond to more immediate pressures.

Our new clinical strategy

Our clinical strategy set out how our clinicians would like to connect our many different services and specialties across our three main sites in order to achieve the best clinical outcomes.

It addresses our key challenges by:

- 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.

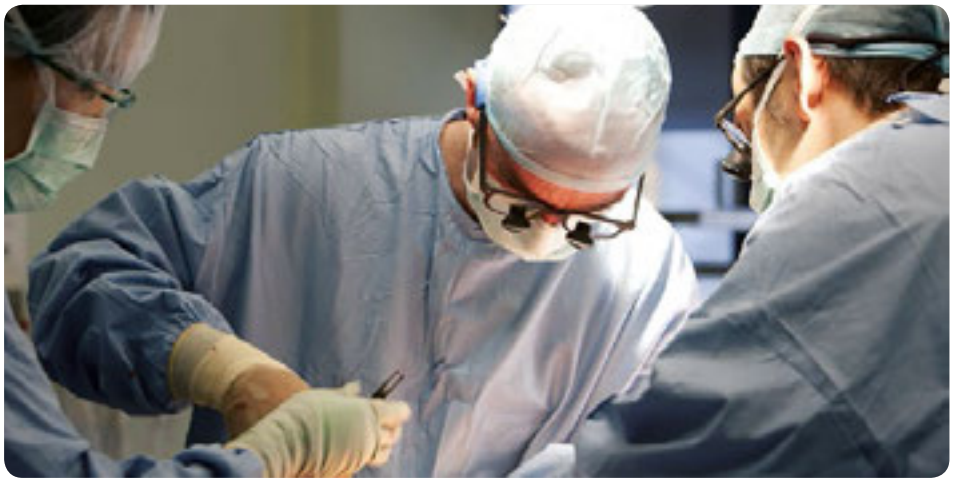
There is now much more work underway to develop our plans further, especially through engagement with our patients and local communities.

Tackling A&E challenges

Our A&E services were a big focus during 2014/15. In September, after much preparation, we made a number of changes that had been agreed the previous year as part of the *Shaping a healthier future* service reconfiguration programme for north west London, led by local clinical commissioning groups. The changes included closing Hammersmith Hospital's A&E department and extending the urgent care centre there to a 24/7 service, and concentrating more senior A&E doctors at St Mary's and Charing Cross hospitals.

The changes went smoothly and the increase in A&E attendances at St Mary's and Charing Cross was broadly in line with projections. However, we also saw a new pattern of attendances emerge, with much bigger fluctuations in numbers during the day and over the week, and an increase in how poorly the patients attending were. Along with many trusts across England, we struggled to meet the A&E waiting time targets through the second half of 2014/15.

"Our A&E services were a big focus during 2014/15."



A&E performance also reflects how well the whole patient pathway is working, not just how well we are doing at the 'front door'. In 2014/15 our performance against the target of 95 per cent of patients being assessed, treated, admitted or discharged in under four hours was 93.67 per cent. Challenges to reach this target included ensuring a good flow of patients through our hospitals and a speedy return home or to their local hospital or community facility, when they were well enough.

Through a project working to improve all aspects of emergency pathways across our Trust, we managed to get back to the 95 per cent target for A&E waits of four hours or less in the first week of March. We've dipped a little since but with a much better understanding of the measures that make the most difference, we are confident of reaching and maintaining the standard long term.

Surgical innovation centre

In January 2015, HRH The Prince of Wales officially opened our surgical innovation centre, bringing together patient care, education and research in one integrated facility.

At the heart of the surgical innovation centre are two theatres for patients to benefit from the latest techniques in minimally invasive surgery such as robotics and image guidance surgery, and the first Da Vinci robotic programme in the UK, which aids surgeons in performing enhanced remote surgery. As well as using innovative techniques to enable patients to be ready to go home sooner, the centre also improves patient experience by providing consultation, diagnosis and treatment planning in the same place on the same day.

Moving into the community

We have a long track record of reaching into the community to improve access to specialist care for GPs and patients, such as through the ground-breaking 'connecting care for children' service.

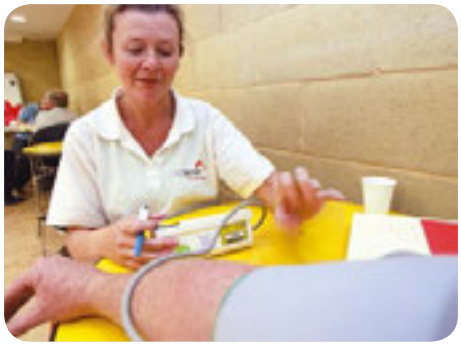
Youth violence intervention project

In October 2014 we launched a new service to help tackle youth gang violence.

Youth workers from Redthread – an organisation that helps young people change their risky lifestyles – work with victims and perpetrators of violence when they're treated at the trauma unit at St Mary's Hospital.

"In 2013 we were seeing about 11 serious stabbings and one gunshot wound each month," explained Dr Asif Rahman, consultant in emergency medicine at the Trust.

The project, supported by Imperial College Healthcare Charity, enables Redthread to continue to work with these young people and their communities once they leave hospital.



2014/15 saw a significant increase in our community presence.

On 1 April 2015, we became the lead health provider for the community independence service for Hammersmith & Fulham, Kensington & Chelsea, and Westminster. In partnership with other acute, community and primary care providers and with adult social services, we enable people with complex needs to get the care they need at home wherever possible and to help them get home with the support they need as quickly as possible if they require a spell in hospital.

We were also awarded the contract to provide the Hammersmith & Fulham community gynaecology service in January 2015. The service will provide the first level of care for all women across the borough referred for non-urgent gynaecological problems. The service, delivered at the Parkview Centre for Health and Wellbeing in White City and Charing Cross Hospital, makes it easier for women to access care and encourages early intervention. A similar community service will deliver respiratory and cardiology care to residents of Westminster, Kensington & Chelsea over the coming year.

Genomic medicine centre designation

Health and healthcare is certain to be radically transformed through discoveries in genetics and molecular medicine. In December 2014, NHS England announced that Imperial College Healthcare NHS Trust in partnership with three other trusts – Royal Brompton & Harefield, Royal Marsden and Chelsea and Westminster Hospital – had been designated as one of the first 11 genomic medicine centres. The trusts will work together to deliver the Prime Minister's 100,000 Genomes Project: an initiative to sequence the entire genome of 100,000 NHS patients before the end of 2017. This genetic information, together with tissue samples and other clinical data, will be used to help diagnose patients and families with inherited rare diseases, and will enable us to target drugs more specifically to particular groups of patients with common cancers.

Building strong foundations

As well as pursuing our strategy to achieve our longer-term vision, we have been redoubling our efforts to get the essentials right, consistently, as quickly as possible. This means ensuring strong foundations are in place.

Moving towards digital patient records

In a Trust caring for around one million patients each year, it is a particularly challenging task to ensure that each patient's information is accurate, stored securely and available when and where it is needed. Our vision is for an entirely paperless system.

In April 2014, we laid the foundation for this goal, by implementing phase one of an electronic patient administration system, Cerner. As anticipated, we had to put significant resource into getting the system bedded in, particularly in terms of ensuring good data quality. In the last quarter of the year, we established that data was as good or better than pre-implementation, and we included additional modules to support information management in our A&Es and operating theatres. We also piloted electronic clinical documents and medications management in outpatient and inpatient settings and will be rolling this out across the Trust in the coming year.

Closer working with our GPs

We want to work even more closely with our GPs, as referrers to our services and, increasingly, as partners in the provision of services. We are investing in improving communications and engagement channels, including our GP advice services across a range of specialties, our professional development events and IT systems.

Governance improvements

Good governance lies at the centre of successful organisations. In 2014/15, we reviewed and strengthened our internal processes to better manage risks and provide assurance that our Trust is well-led. Our updated board assurance framework helps focus the Trust on delivering its vision and objectives, with updated key performance indicators.

For more information
Read our annual governance statement on **page 36**

> **It covered excellent topics relevant to my practice.**

Quote from a GP attending a study day in February 2015

Improving recruitment and reducing vacancies

We've worked hard to address our vacancy rate and reliance on interim and agency staff, particularly for nursing roles. Although this has been a priority for some time, our CQC inspection further highlighted the challenge. Our CQC action plan includes our goal to achieve and maintain a 5 per cent vacancy rate for band 2 – 6 ward-based nursing and midwifery roles. To ensure that we stay on track to achieve this as soon as possible, we've sped up our recruitment processes, we're using social media to promote vacancies more widely and we've introduced 'offer on the day' large scale recruitment events which enable successful candidates to go home with a confirmed offer of employment. We've also launched a new careers microsite to promote the roles on offer at the Trust.

Foundation trust membership

Our application to become a foundation trust has been put on hold following our CQC inspection as we need to achieve at least an overall rating of 'good' to go forward. However, our plans for developing an active and engaged membership to help shape our thinking and actions are not standing still. In March 2015, we launched a new member newsletter and we're currently developing an events programme for the coming year. We're also keen to continue growing our membership.

5%

Our vacancy rate goal for band 2 – 6 ward-based nursing and midwifery roles. Our work to reach this target includes using social media more widely to promote vacancies and introducing large-scale recruitment events.

Research and innovation

Our focus on translational research and innovation as an academic health science centre continued to produce real benefits for our patients. Increasingly, we are looking to innovate in all areas of our work, building on our reputation for clinical research.

New therapy for rare degenerative disease

Friedreich's ataxia is a rare inherited disease that attacks the central nervous system. Within 15 years of diagnosis, people living with the condition usually need to use a wheelchair.

In 2014, our Biomedical Research Centre funded a team that provided the first clinical evidence of a potential new therapy for the condition. The first-in-human study found that a molecule called nicotinamide can help to restore the levels of a protein known to be deficient in people with Friedreich's ataxia. Several patients reported improvements in motor function. The work is now being developed into a larger-scale study.

MRI scans unlock signs of accelerated ageing

By studying the brain scans of patients with serious head injuries, our traumatic brain injury team has identified patients at risk of future neurological problems. The research carried out over the last five years used MRI scans to study rates of brain shrinkage known as atrophy.

Patients' brains showed increased atrophy, which translated to an additional five years of normal ageing. The amount of atrophy increased with the time since injury, indicating that accelerated ageing may have been triggered by the injury. Patients were recruited from the major trauma centre at St Mary's, where a centre for neurotrauma research is currently being established.

Sprints: ground-breaking approach to service innovation

The Trust has developed a new approach to service improvement known as quality improvement sprints. These two-day problem-solving events bring together healthcare staff with other professionals, including engineers, artists and others, to focus on real-life problems in healthcare. Small groups visit the services to gain a deep understanding of the situation. Then on day two, everyone comes together, to work up potential solutions.

One sprint team redesigned a form that was being incorrectly completed, causing administrative backlogs. The new version, currently being piloted, is easier for clinicians to complete, and doubles up as a tool to help patients plan what they want to say in appointments.

This technique allows patients at risk of neurodegenerative problems after traumatic brain injury to be identified more accurately, and forms part of plans for large scale tracking of patients after their injury and to ensure appropriate treatment.

Stem cells show promise for stroke

A stroke therapy has shown promising results in the first trial of its kind in humans. Five patients received the treatment, which uses stem cells extracted from their own bone marrow. The study was conducted by our doctors, working with scientists at Imperial College London. The therapy is thought to trigger the brain to produce new brain cells.
Six months later there were no ill-effects on participants, and all the patients showed improvements in clinical measures of disability.

The findings were published in August 2014 in the journal Stem Cells Translational Medicine. The next step will be doing more tests and working out the best dose and timescale for treatment before starting larger trials.

Nursing and midwifery research

A new nursing and midwifery research strategy is aiming to provide nurses and midwives with the skills and knowledge to continually improve their care. This has generated research projects focusing on areas such as improving sleep for patients, improving dignity in hospitals, nurse-led management of back pain, and preventing and managing pressure ulcers.

5

Number of patients who took part in a stroke-therapy trial that used stem cells from their own bone marrow. After six months, all five patients had showed improvements in clicnical measures of disability.

Investing in our people

There is much evidence that high quality healthcare is directly linked to engaged and motivated staff. In 2014/15, we expanded and improved our range of programmes to ensure we nurture and develop our people, help them stay well and healthy, and enable them to share their learning.

Engaging our staff

Every quarter we run staff surveys to measure engagement, right down to ward and department level. In 2014/15 we increased our overall response rates from 26 to 55 per cent and our engagement score from 37 to 41 per cent. Our managers are able to review their own results locally and develop action plans to address the issues raised. In the latest survey, at least half of respondents reported that action had been taken as a result of the findings.

Meanwhile, in the national NHS staff survey, we maintained our position with a rating of 'above average' across all acute trusts on the overall engagement score.

Internal communication is vital to achieve high levels of engagement. During the year we developed our channels to improve communication with our staff. In addition to regular chief executive open forums, there are weekly and monthly updates following each executive team and board meeting to ensure staff are kept up to date with the latest developments.

Developing talent

Leadership development is an important part of our offer to staff. In 2014/15, our first cohorts completed the certificate in medical leadership. This course – one of a series of in-house leadership programmes

We increased our engagement survey response rate from

26% → 55%

...and our engagement score from

37% → 41%

– offers bespoke development for our top leaders. We have seen a big return on investment as a result of the projects undertaken as part of the programmes.

We also launched a coaching and mentoring register, which draws on our managers' skills and expertise to support others. More than 30 relationships have already formed and all delegates on our programmes will be offered this valuable form of development.

These initiatives are supported by our new talent management process. This enables us to identify and develop individuals who have the potential to move into more senior positions and develop clear succession planning.

Recognising great work

To recognise the hard work, dedication and achievements of our people, in April 2014 we launched a new recognition scheme, generously supported by Imperial College Healthcare Charity. The scheme is called *Make a Difference* to reflect the impact of people who go the 'extra mile' in making a difference to the lives of patients and colleagues.

There are a number of award categories used to recognise and celebrate the achievements of staff, including instant recognition, bi-monthly team awards and a high-profile annual awards ceremony. There are also dedicated award categories for bank staff and volunteers.

Looking after our staff

We introduced a new strategy for staff health and wellbeing in 2014/15, accompanied by an extensive range of benefits, covering physical health, health promotion, occupational health and mental and emotional wellbeing. There are now staff groups for cycling, weight loss, fitness challenges and smoking cessation, as well as yoga, counselling, mediation and support for traumatic events, complemented by a new staff health and wellbeing microsite. The initiative is complemented by a flexible benefits scheme that helps staff buy a car or pay for childcare. We are working on more ways to help our staff, as part of our work to ensure an engaged, healthy workforce and to attract and retain high-quality staff.

Training and education for nurses and midwives

From March 2015, all our new healthcare support workers will complete a care certificate. The initiative, designed to ensure a consistent quality of care for our patients, is part of our new nursing and midwifery education strategy. The strategy focuses on excellence in undergraduate education and postgraduate training, ensuring that nurses and midwives have opportunities that help them develop and improve the quality of care.

> **Leadership development enables us to identify individuals who have the potential to move into more senior positions.**

Staff in the spotlight: national recognition for their work

We are proud of our staff, but some received special recognition in national awards this year, including:

Professor Jacqueline Dunkley-Bent, director of midwifery and divisional director of nursing, was named a BME pioneer by the *Health Service Journal* for her work in mentoring and inspiring junior staff and responding to female genital mutilation.

Consultant paediatrician Dr Bob Klaber won the NHS Inspirational Leader of the Year award at the annual London Leadership Recognition Awards for his work on improving training and supporting junior doctors.

Director of Nursing Janice Sigsworth was recognised by the *Nursing Times* for excellence in leadership. She is passionate about integrating education and research into clinical practice to improve patient experience and outcomes.

A team of midwives working with vulnerable women at St Mary's Hospital has won a Royal College of Midwives award for their work on improving the experience of pregnant women and promoting choice and continuity of care.

Mansoor Khan, a trauma surgeon at St Mary's Hospital, won a Military and Civilian Health Partnership Award for training military medical teams in Afghanistan.

Vascular lead nurse Jan Hitchcock won the *British Journal of Nursing* "Rising Star in IV therapy award" for her work to introduce a non-touch technique when administering IV therapies.

Looking ahead to 2015/16

We have five key goals for the coming year:

1 We will prioritise quality improvement, embarking on our new three-year quality strategy, completing our CQC action plan, and launching a Trust-wide quality improvement methodology.

2 We will progress our clinical strategy, continuing to evolve more integrated care models, ensuring the best configuration of services in the near as well as longer term and progress our estates redevelopment to ensure modern facilities that are fit for purpose. We'll also focus on improving our patient administration processes to provide more responsive customer care.

3 We will meet all our performance targets, working to ensure we reach and maintain standards in A&E waiting and referral to treatment times in particular.

4 We will increase effective engagement with staff, patients and local communities, especially in terms of helping us shape how our services evolve for the future and the redevelopment of our estates. We will also develop a revised set of values and behaviours with our staff and stakeholders to help ensure we are working towards a shared vision.

5 We will ensure medium-term financial stability, delivering on our financial plan through sustainable efficiency initiatives that drive quality improvements as well as savings.

Our operational performance

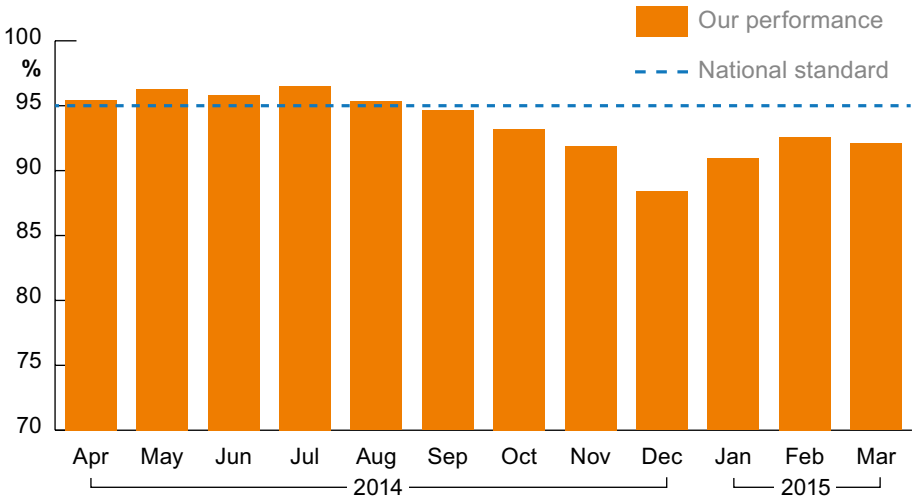
It's important that we keep a focus on maintaining and improving our operational performance as part of continually improving our quality of care overall. While 2014/15 saw the Trust make real progress on cancer care standards, it was a challenging year for some other aspects of performance.

Along with many trusts across England, we struggled to meet the A&E waiting time targets through the second half of 2014/15. On average, across the year, 93.67 per cent of our patients were assessed, treated, admitted or discharged in under four hours, against a national standard of 95 per cent. Following the changes to A&E services across the Trust in September 2014, we saw a new pattern of attendances emerge, with much bigger fluctuations in numbers during the day and over the week, and an increase in how poorly the patients attending were.

A&E performance also reflects how well the whole patient pathway is working, not just how well we are doing at the 'front door'. And we have had challenges in ensuring a good flow of patients through our hospitals and a speedy return home or to their local hospital or community facility when they are well enough. Through a project working to improve all aspects of emergency pathways across our Trust, we managed to get back to the 95 per cent target for A&E waits of four hours or less in the first week of March. We've dipped a little since but with a much better understanding of the measures that make the most difference, we are confident of reaching and maintaining the standard in the long term.

A&E performance:

Percentage of patients assessed, treated, admitted or discharged within four hours



A&E performance also reflects how well the whole patient pathway is working, not just how well we are doing at the 'front door'.

Referral to treatment

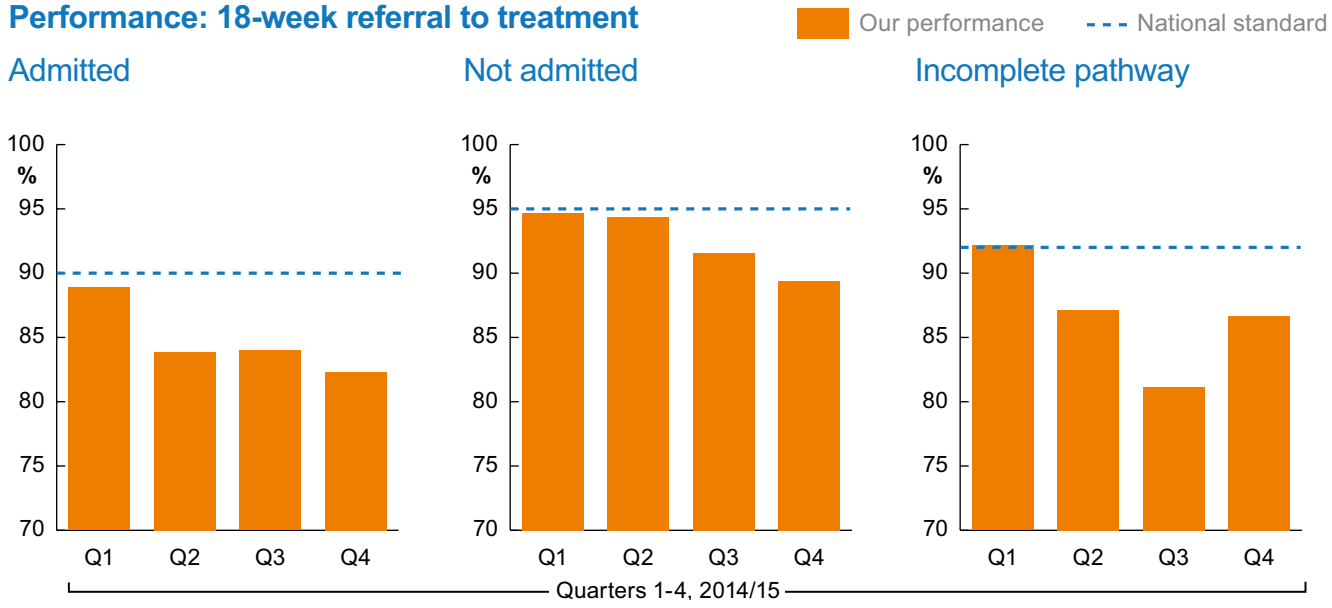
There are three referral to treatment (RTT) standards that the Trust is expected to deliver on:

- 90 per cent of patients treated as an inpatient should be treated within 18 weeks (admitted)
- 95 per cent of patients treated as an outpatient should be treated within 18 weeks (not admitted)
- 92 per cent of patients still waiting for treatment (on a waiting list) should have waited less than 18 weeks (incomplete).

In 2014/15, our new patient administration system required a bedding-in period before data was sufficiently accurate to report against our RTT standards. In some specialties, we also needed to have a particular focus on reducing the number of patients who had already been waiting over 18 weeks.

With support from NHS England and the NHS Trust Development Authority, we were able to make good progress in both areas. We are now working to a plan to return to achieving all three RTT standards within the first six months of 2015/16.

Performance: 18-week referral to treatment



Cancer care

In 2014/15, performance on the eight cancer waiting times remained broadly strong, maintaining and building on the improvement work undertaken in 2013/14.

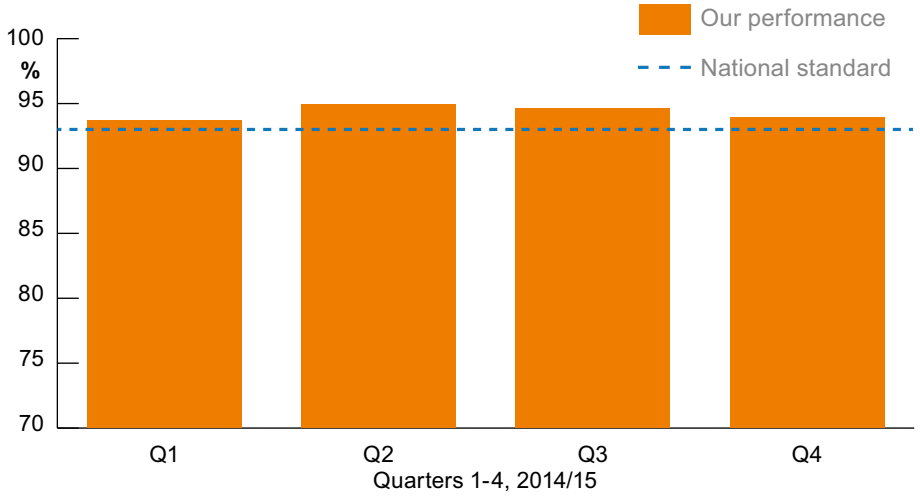
- The two week wait standard for urgent referrals was achieved in all four quarters.
- The breast symptom two-week wait standard was achieved in three quarters, with only quarter 1 being lost due to service-specific capacity problems that were resolved in-quarter.
- All four 31 day standards (first definitive treatment, subsequent drug treatments, subsequent radiotherapy treatments, subsequent surgery) were achieved in all four quarters.
- The 62 day first treatment standard was achieved in the first three quarters, but the Trust underperformed in quarter 4. The standard was achieved in March, but the recovery was not sufficient to recover the quarter. Performance against the standard has been maintained into April and May and quarter 1 2015/16 is expected to be achieved.
- The Trust achieved the 62 day screening standard in three quarters, with underperformance reported in quarter 3 as a result of a large number of delays relating to a number of particularly complex cases.

The Trust has enhanced its cancer administrative team and undertaken pathway mapping work with other providers in north west London to reduce the number of delays related to inter-trust referrals.

Internally, the cancer performance and improvement team has continued to work with clinical teams on resolving operational barriers, which will continue into 2015/16.

Cancer performance:

Two-week wait standard for urgent referrals



Cancelled operations

In 2014/15, the Trust rate for cancelling operations for non-clinical reasons was 0.88 percent against a tolerance of 0.80 per cent. The main challenge was due to additional emergency admissions. In March, the Trust cancelled 0.55 per cent of operations for non-clinical reasons and we're committed to ensuring that we continue to perform within the threshold in the coming year.

Health and safety

We have a duty to protect the health, safety and wellbeing of all our employees, patients, and visitors. In 2014/15, we implemented a new health and safety strategy and revised our governance structure to ensure that risks are better managed.

Along with strengthening our internal processes, we continued to collaborate with relevant partners. A formal joint health and safety forum was set up with trade unions and we improved working processes with Imperial College London on management of hazardous substances and emergency planning.

We improved our reporting of incidents with an estimated 10 per cent increase in accident and incident reporting from December 2014 to March 2015. We also improved the quality of these accident investigations.

For the effective management and monitoring of safety issues, it's vital that we have accurate and timely data. During the year we addressed this by improving the quality of health, safety and wellbeing management information, enabling us to spot accidents trends and review performance data.

Quality

We have a long-term commitment to continuously improve the quality of care we give our patients. Our quality priorities for 2014/15 were divided into three categories:

- patient safety
- clinical effectiveness
- patient experience.

Detailed information on our performance in these areas is outlined in our quality account. Below is a summary of our work in the areas of infection prevention and control, falls and reporting of incidents of serve or extreme harm. Detailed information on our planned improvements in these areas is also provided in our quality account.

Infection prevention and control

Minimising risk of infection through robust infection control is a key priority for the Trust.

- *Clostridium difficile* – against a threshold of fewer than 65 cases, we had 77 cases during the year. When reviewing the incidents, three have been identified as a potential lapse of care attributed to the Trust while the other cases are related to external factors. For 2015/16 we have set the target of 'no avoidable infections' and identified a number of improvements to address this as outlined in our quality account.
- MRSA – against a target of zero the Trust had eight cases of MRSA blood stream infections. This is an improvement on the previous year when we had 13 cases and we will continue work to achieve the target of zero.

Falls

Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. A significant number of falls result in severe or moderate injury. In 2014/15, we reported an average of 0.22 falls per 100 patients, compared

0.22

The Trust's average number of falls per 100 patients – a positive figure compared with the national average of one per 100 patients.

Health and safety: 2014/15 highlights

2,928 health and safety risk assessments

79 extra fire wardens trained

83% compliance for statutory mandatory training against a target of 95%. This is being tackled through an improved tracking system and additional training opportunities

18 incidents involving staff injury or ill health formally reported to the Health and Safety Executive

The majority of injuries related to slips, trips and falls.

to the national average of one per 100. Improvements that contributed to this achievement comprised undertaking a risk assessment for each patient within six hours of admission and proactive continence management to avoid preventable falls when patients use the bathroom. We also put in place a system of reviewing the medication given to high-risk patients to ensure a fall will not be caused by their medication.

Incidents of severe or extreme harm

The Trust performed better than the national average with fewer reported patient safety incidents resulting in severe harm or death. Data from the National Reporting and Learning System for quarters 1 and 2 shows that the Trust had 0.34 per cent of reported incidents graded as severe harm incidents, against a national average of 0.49 per cent. However, when looking specifically at incidents of extreme harm, our incident rate is higher than the national average at 0.3 per cent. We believe this is partly due to increased openness and transparency regarding reporting and awareness of safety issues. Actions that supported this area of work included streamlining the review of the incidents and categorising them as moderate, major or extreme and sharing learning with staff through our intranet site.

Friends and family test

The friends and family test (FFT) is one of the important ways in which we measure the experience of our patients. It is based on the question of whether patients would recommend our ward, department or service to their friends and family if they needed similar care and treatment. It provides the NHS with a 'net promoter score' – a universal measurement tool that rates our performance.

94%

Percentage of our patients who would recommend the Trust's services, based on feedback from 160,000 patients who completed the friends and family test in 2014/15.

During 2014/15, over 160,000 patients responded to the FFT at the Trust. Overall, patients responded very positively, with 94 per cent willing to recommend us. Less than 2 per cent of patients said that they would not recommend the Trust.

All patients are asked to comment on why they would or wouldn't recommend the Trust, and we know from these responses that kind, helpful and friendly staff are the main reason why patients would recommend us. The primary reasons why patients would not recommend the Trust are related to processes, such as booking appointments and long waiting times in clinics. These are areas that the Trust continues to work on.

We had performance targets set by our commissioners in 2014/15 relating to response rates for FFT. The Trust achieved all these targets with the exception of quarter 4 A&E response rate, which fell just short.

While overall the willingness to recommend the Trust is very high, we would like to see improvements in the antenatal care responses. Analysis of the comments has shown that the issues relate to long waiting times and the antenatal clinic environment. The maternity team has been working hard to help women by providing clinics in community settings where they can be seen more quickly. It is also reviewing hospital clinic templates and renovating facilities.

For more information
Read about our quality measures in our **quality account** on our website

Sustainability report

Carbon and energy management

Through 2014/15 we have continued to progress our commitment to the NHS carbon management programme, reducing harmful impacts to the environment, improving efficiency and resilience in the way that we operate our hospitals, and promoting health and wellbeing of staff and local populations.

We remain committed to significantly cutting our carbon emissions by 2020. 2014/15 emissions are down by 18 per cent compared with the 2009/10 baseline emissions.

After reviewing our existing electrical and mechanical infrastructure and future needs, we developed a metering strategy to improve our energy monitoring, reporting and targeting. This involved adopting new monitoring and targeting software that provides near real-time data to staff, patients and visitors and engage them in supporting our energy reduction plans. With time, the system will integrate with the building management system and display costs, consumption and emissions data across main entrances and employee terminals.

We negotiated favourable export tariffs for a much longer duration of the day. This resulted in improved operating terms and better use of the combined heating and power plant, leading to associated income and heat savings. We also bought advance allowances of the carbon reduction commitment energy efficiency scheme, saving £32,000 on our carbon tax payments.

We have installed LED lighting and, through a continuous review of the building management system, set points and operating times more effectively.

During the year we saw benefits arising from projects supported by our interest-free loans from Salix Finance and our continued association with advanced demand side management. These projects resulted in using less overall electricity, reducing our gas consumption by 8 per cent and giving savings on water consumption of 13 per cent from 2012/13. Two of our sites, Hammersmith Hospital and Charing Cross Hospital, are no longer required to be in the carbon reduction commitment energy efficiency scheme. This will give a net reduction in our carbon tax liability of almost £2m over the next five years.

Waste reduction

Our continued focus on recycling and energy recovery systems was recognised with an entry in the 2015 national recycling awards. Working with our waste management contractors, we increased our CO_2 savings from 200,000kg in 2012/13 to 1.5m kg in 2014/15.

We implemented a programme to identify and measure food-waste volumes from onsite catering operations to support our waste reduction strategy. By segregating food waste, we made significant inroads towards cleaning up the domestic household waste stream, allowing more waste to be recycled. We trained all our kitchen, restaurant and ward-based catering staff to separate food waste, ensuring that only suitable digestible food is collected for disposal in the digester.

Travel and transport

Our contracted patient and staff transport service has taken actions to reduce its associated carbon footprint by replacing vehicles with euro 6 engines. We encourage staff to use the hospital inter-site bus to minimise car usage. The Trust's actions in promoting health and wellbeing for staff are highlighted on page 22. We continue to use staff incentives to promote individual responsibilities for reducing the carbon footprint including our cycle strategy; cycle-use schemes, with 88 new recruits this year; and lease of pedometers. We monitor work-related travel through a single booking supplier.

Procurement

We use the approved Department of Health terms and conditions for procurement, which contain sustainability clauses, and we regularly review our compliance against these. We make all our furniture purchases from the Crown Commercial Services framework, which is Forestry Commission certified. We purchase all paper and stationary through NHS Supply Chain – mostly from the 'premier elements earth' range, which has a high post-consumer waste content. We recycle medical equipment that is decommissioned through auctions and reinvest these funds in new kit.

Our plans for 2015/16

The planned initiatives for 2015/16 will further support us in becoming a more efficient user of energy, lowering our associated carbon emissions and support improvements in operational resilience. We also aim to realise cost-effectiveness benefits by reducing direct energy costs and non-energy charges in the form of lower carbon levies, operational and maintenance and service costs.

Key plans

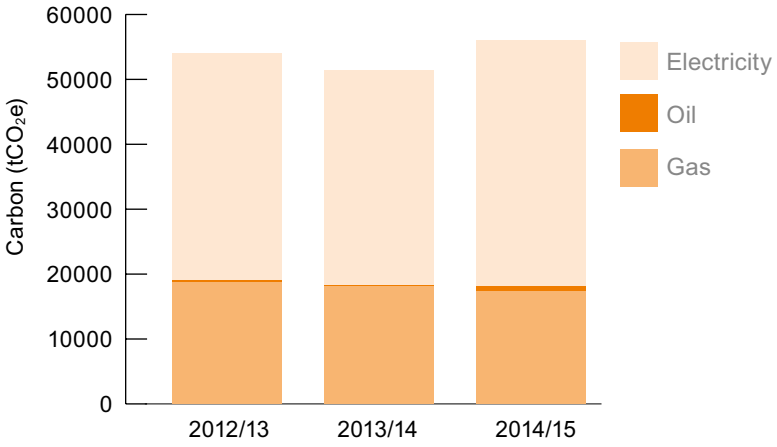
- Develop an overarching strategic plan for a sustainable, resilient healthy place to work in line with Department of Health guidance and supporting procedural documents
- Outline our approach to green travel within a transport strategy
- Implement a communications plan, with promotional events and collaborations with sustainability groups and local stakeholders
- Run an executive workshop on realising the value and benefits in the estates strategy
- Install Team Sigma – an energy monitoring and management package integrated into the building management system – and launch energy dashboards in public areas, to raise awareness of energy use and future efficiencies
- Establish a strategic partnership with the Carbon and Energy Fund – a £300m plus fund to support NHS projects. Drawing on the fund's expertise, we will upgrade our energy infrastructure at no net cost. The specific projects include:
  - extending the existing medium temperature hot water heating circuit to the remaining Hammersmith Hospital buildings still using steam
  - reducing steam distribution losses by installing GEM steam traps and flue gas economisers at St Mary's Hospital
  - extending operational hours and using all CHP-generated electricity on site instead of exporting it to the national grid
  - providing new standby generators
  - taking part in the national grid's short-term operating reserve programme
  - including medium temperature hot water boilers in the CHP quality assurance boundary, thus becoming exempt from the climate change levy.

Our energy usage

The Trust spent £8,916,631 on energy in 2014/15, which is a 0.9 per cent increase on energy spend from last year.

Resource		2012/13	2013/14	2014/15
Gas	Use (MWh)	91,911	85,332	82,435
	tCO_2e	18,782	18,102	17,298
Oil	Use (MWh)	628	552	2,833
	tCO_2e	200	176	906
Coal	Use (MWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (MWh)	61,446	59,080	61,140
	tCO_2e	35,073	33,079	37,865
Total energy CO_2e		53,056	51,358	56,071
Total energy spend		**£8,256,469**	**£8,835,331**	**£8,916,631**

Carbon emissions:
Energy usage



Trust eco savings 2014/15

As part of the Trust's continued focus on recycling and waste management, we have saved

6,268 trees, and

1,583,748kg of CO_2, and generated

2,925.63MWh of power

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

CO_2 emissions (tCO_2e) profile		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	Total	**45,289**	**48,629**	**49,980**	**48,784**	**41,450**	**43,283**	**42,732**	**43,103**
Direct	Gas	16,698	17,068	17,073	18,709	15,200	17,023	15,705	15,252
	Oil	199	516	292	276	305	169	149	764
	Coal	0	0	0	0	0	0	0	0
	Owned vehicles travel	0	0	0	0	0	0	0	0
	Leased assets (upstream)	0	0	0	0	0	0	0	0
	Anaesthetic gases	0	0	0	0	0	0	0	0
Indirect	Electricity	27,573	30,150	31,916	29,015	25,160	25,321	23,440	26,707
	Imported heat/steam	0	0	0	0	0	0	0	0
Indirect	Waste and water	414	494	307	372	421	411	407	372
	Business services								
	Capital spend	0	0	0	0	0	0	0	0
	Construction								
	Food and catering								
	Freight transport								
	Information and communication technologies								
	Manufactured fuels chemicals and gases								
	Medical instruments/equipment								
	Other manufactured products								
	Other procurement								
	Paper products								
	Pharmaceuticals								
	Travel	398	393	384	405	359	353	3,024	0
	Commissioning								
	Energy well to tank and transmission	8	7	8	7	6	6	8	9

Waste CO_2 emissions

CO_2 emissions (tCO_2e)	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	**24,908**	**5,507**	**5,300**	**5,439**	**4,628**	**4,842**	**4,976**	**6,262**
Waste recycling	500	662	674.63	1,065.39	707.5	885	959.06	2,091.2
Preparing for re-use	0	0	0	0	0	0	0	0
Composted	0	0	0	0	0	0	0	0
WEEE	27.45	57.9	57.2	16.6	22.7	12.1	11.7	10
High temperature disposal waste with energy recovery	2,300	2,270.2	2,072.9	2,060.9	1,985.1	2,289.26	2,363.74	2,497.62
High temperature disposal waste	365.9	292.91	420.89	489.85	271.7	351.96	326.7	327.3
Non burn treatment disposal waste	21,520	2,051.5	1,900.7	1,651.4	1,562.5	1,233.5	1,235.46	1,250.2
Landfill disposal waste	195	172.3	174	154.7	78.8	69.9	79.14	85.4

Annual governance statement

Statement from accountable officer, chief executive Dr Tracey Batten

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 ongoing 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 2015, 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 Trust's proposed corporate governance framework, and to acknowledge the recent alignment of health regulator's judgement frameworks, the governance statement is structured against the domains of the well-led framework: strategy and planning; capability and culture; process and structures; and measurement.

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

Strategic direction

Following a refresh of the Trust's vision and objectives undertaken and approved by Trust board in July 2014, a number of elements of the Trust's strategy have been reviewed or commenced review during the reporting period, and the key risks associated with each of these have been encompassed as appropriate in the board assurance framework and risk registers. During 2015 these are being drawn together to refresh the Trust's overall strategy; this work is planned for completion in July 2015.

The clinical strategy was approved by the board in July 2014, and aligns with relevant national specialist services strategies. In summary, the Trust plans to structure its services as follows:

- Charing Cross Hospital to evolve 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 24/7 emergency services appropriate to a local hospital
- Hammersmith Hospital to build on its role as a specialist hospital with strong research links
- Queen Charlotte's & Chelsea Hospital to build on its role as a specialist maternity, women's and neonatal care service
- St Mary's Hospital to be the major acute hospital for north west London as well as a maternity centre with consultant and midwife-led services
- Western Eye Hospital, our specialist eye service with a 24/7 A&E department, to relocate to new facilities on a redeveloped St Mary's site
- a range of out-of-hospital care across north west London.

As part of the implementation of this strategy, the Hammersmith Hospital A&E closed on 10 September 2014. The closure took place with the full backing of the clinical commissioning groups (CCGs), NHS England and the Trust Development Authority (TDA) after assurance was provided by the Trust that the plans were robust and safe. The urgent care centre at Hammersmith Hospital has now extended its hours of operation to 24/7 and new pathways and additional capacity are in place at Hammersmith, St Mary's and Charing Cross hospitals.

The outline business case for site development was approved by the Trust board in July 2014, which is, in essence, a facilities strategy to support the implementation of the clinical strategy. An informatics strategy has been discussed by the board during 2014/15, and the final strategy will be presented in July 2015. Its focus is to develop the knowledge, skills and tools required to get the right information to the right person at the right time to improve healthcare and promote health.

A revised quality strategy is approaching completion and is due to be approved by the board in July 2015, its development having been discussed at a number of board seminars and Trust board meetings. The strategy will align with the CQC quality domains: safe, effective, caring, responsive, and well-led. Its guiding principles are to: enable the Trust to achieve a 'good' CQC inspection rating from the current position of 'requires improvement' (details of the Trust's CQC inspection are included in the capability and culture section below); ensure that patients are central to outcomes; empower and support staff; reward and recognise contribution across the multi-disciplinary team; and to build a strategy that is positive and reflective. Further information on the quality strategy is detailed in the Trust's quality accounts.

To support the delivery of the strategic elements outlined above, a comprehensive estates strategy is being developed to ensure it supports and enables the Trust's vision. A version of this has been presented to board members and work on this will continue throughout 2015/16. In the spring of each year (February to May 2015 for the budget for 2015/16), the Trust board reviews and approves the annual business plan (for submission to the TDA) and expenditure budgets for the Trust. As part of this process, it reviews the quality impact assessments undertaken by the medical director and director of nursing for each of the proposed cost saving plans proposed by the divisional clinical and managerial teams.

Capacity to handle risk

The Trust board has overall accountability for the Trust's risk management approach through the executive directors. The risk management framework and policy was reviewed and updated during the reporting period. This included a risk management workshop, which saw board members consider not only potential risks to the strategic objectives, but also the risk appetite and tolerance the board would accept in the organisation. The revised 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 decisions.

While executive directors are full-time employees who manage the daily running of the Trust, the entire board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The 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 (BAF), managed on behalf of the board by the director of nursing during 2014/15, provides a high-level assurance process that 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. The BAF was reviewed and updated during the reporting period, with key performance indicators developed to monitor achievement of strategic objectives. Responsibility for maintaining the framework transfers to the Trust company secretary for 2015/16. The framework is described further in the capability and culture section on **page 39**.

Annual quality accounts

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.

The board's clinical plans and core quality priorities have been developed in consultation with a wide range of internal and external stakeholders, including senior clinical teams, Healthwatch, Health and Wellbeing boards, local authorities and clinical commissioning groups. This has taken place alongside the refresh of the Trust's quality strategy (outlined above) and the introduction of a quality improvement methodology, both of which will be finalised in quarter 2. The board receives regular reports on all aspects of quality through the key performance scorecard, and the board quality committee also receives the quality report, which analyses a broad range of quality and safety metrics. The report is also reviewed in detail at the quality committee – a committee of the board.

Some data quality indicators within the quality accounts are subject to audit, either by our internal or external auditors. The external auditor, Deloitte LLP, performs limited scope procedures on two of the indicators shown in the quality accounts. In the current year, this limited assurance opinion has been 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: foundation trust application

The timetable for the Trust's foundation trust application was put on hold following the Care Quality Commission (CQC) inspection (see capability and culture section below). A re-inspection by the CQC is anticipated within 12 months, at which point a rating of 'good' will need to be achieved to recommence the foundation trust process. Further meetings of the foundation trust programme board have been deferred until such recommencement of the process. As a committee of the board, it led and monitored all aspects of the foundation trust programme. The Trust board decided in December 2014 to defer committee meetings in the light of the delay in applying for foundation trust status. This will be reviewed as appropriate.

The Trust completed the first part of the independent financial review (IFR1), the recommendations of which formed a useful contribution to the development of the overall application. The Trust did not proceed to stage two, which would have seen the reviewers return to assess the comprehensiveness of the action plan implementation. The Trust also submitted a draft integrated business plan (IBP) to the TDA as part of the annual planning process. Grant Thornton UK LLP reported on the review they had undertaken of the board governance assurance framework (BGAF) and quality governance assurance framework (QGAF), which effectively formed the annual review of the board for 2014/15 and formed the impetus for some of the governance improvement outlined in this report. A further review of the quality governance framework by Grant Thornton UK LLP during 2014/15 showed an improvement in score to a position that demonstrated readiness (in this area) to progress to foundation trust status.

Authorisation as a foundation trust remains a development priority for the Trust. The Trust will continue to further strengthen its governance systems and processes to ensure that it can demonstrate adherence with the well-led framework which has now been adopted by all NHS regulators as the point of reference for NHS trusts and foundation trusts. In essence, delivery of the well-led framework will enable the Trust to demonstrate compliance with many of Monitor's requirements for aspirant trusts.

Significant issue: condition of the Trust estate

In developing the estate strategy, a comprehensive appraisal of the condition and performance of the estate was undertaken. The results of this appraisal were that much of the estate is condition D, in that it requires immediate attention in order to support the delivery of healthcare services in a modern, safe and effective environment. The cost of bringing the building services and engineering systems to an acceptable condition is estimated to be in excess of £600 million across the Trust's sites. The implications of this are being addressed in the estate strategy, and the current risk is included on the board assurance framework.

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 TDA and is 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.

Risk assessment

The board assurance framework (BAF) 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. The board assurance framework details the barriers and risks to achieving each of the Trust's strategic objectives, and aligns these to the risks on the corporate risk register. The key sources of control and assurances, both internal and external are reviewed for their adequacy and relevance and action plans are agreed.

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 will be presented at the public Trust board meeting. The board assurance framework is reviewed formally by the executive committee, audit, risk and governance committee and the Trust board at six-monthly intervals. It is kept under ongoing managerial review, and would be brought forward for formal review if changes were considered necessary.

As the Trust moves into 2015/16, the following two tables show what are considered to be its current key risks:

Strategic risks	Risk mitigation and controls
Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target	• New compliance and improvement framework to manage compliance and drive related quality improvements being implemented • Each CQC action has nominated executive and divisional leads for delivery • CQC intelligent monitoring is presented at the executive committee, quality committee and reported to the Trust board • Patient safety and service quality report is presented bi-monthly at the quality committee • Full review of reporting arrangements for all statutory and regulatory duties underway
Failure to maintain financial sustainability	• Active cash management and reports to finance and investment committee and Trust board • Monthly financial reporting and performance reviews for operational divisions • Regular meetings with commissioners and TDA to review contract performance • Proactively working with other major teaching hospitals to influence future national tariff
Failure to achieve and gain approval for redevelopment of hospital sites	• Regular meetings with TDA for early identification of potential issues/changes in requirements • *Shaping a Healthier Future* programme board in place, led by the commissioners (CCG) • Stakeholder engagement strategy to manage relationships with external partners • Appointment of healthcare planning resource
Failure to meet required/recommended vacancy rates across the organisation	• Deputy director of people leading recruitment process • Restructure of recruitment team and new administration support have reduced the total time to hire from advert to start date • Good progress in midwifery recruitment • All current vacancies for nursing in key areas advertised
Insufficient support for key aspects of our clinical strategy from one or more key audiences/stakeholders	• Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation • Regular review by executive committee and updates to Trust board • Regular communications training for key staff • Communications leads assigned to each clinical division to improve identification and management of potential communications issues

Operational risks	Risk mitigation and controls
Mismatch in capacity and demand increasing the risk of achieving the emergency target of 95 per cent of patients being seen and treated within four hours	• 17 additional beds opened (12 at St Mary's and 5 at Charing Cross) • Six additional emergency department consultants appointed • Discharge lounge opened • Weekly clinical risk assessment of all patients on the waiting list; all cancelled patients reviewed on an individual basis • Theatre utilisation improvement programme • Review meetings for all inpatients with a length of stay longer than 10 days • Clear escalation plans and processes to manage capacity, including participation in weekly sector operations executive
Failure of critical equipment and facilities that prejudices Trust operations and increases clinical and safety risks	• Statutory and regulatory inspections are now in place to pick up risks to continued safe operation of the Trust • Executive committee approval of backlog maintenance programme directed at addressing high risk categories • PLACE (Patient-Led Assessment of the Care Environment) undertaken to understand patient perceptions and identify priorities from a patient perspective helping and prioritise future works • Estates and facilities, health and safety, fire and compliance committee has been established to monitor compliance
Risk of increased amount of time it takes to report on a diagnostic investigation due to functionality issues with radiology information systems (RIS)/picture archive computer system (PACS)	• Close monitoring and escalation of issues • Logging and reviews of incidents • Additional radiologist sessions • Tender process underway to replace RIS/PACS
Failure to maintain operational performance standards	• Weekly elective waiting list, and targeted cancer patient list review • Tri-borough urgent care board to oversee improvements in emergency department performance and urgent care pathway • Increased investment in cancer admin and clinical support, and funding agreement with Macmillan • Clinical transformation plan includes urgent care board and weekly operational delivery group • Funded opening of additional acute medical beds and extended opening hours in the urgent care centre • Monthly 'referral to treatment' delivery plan for admission pathways
Failure to recruit to substantive posts on some medical wards	• Divisional performance review meetings monitoring vacancy rates • Bank and agency support available • Recruitment open days taking place with over-recruitment taking place where possible • Review of divisional recruitment processes to streamline process and ensure rapid turnaround of offer letters
Failure to achieve benchmark levels of medical education performance	• Education improvement action plan in place • New management and revised governance structure in place • Development of key performance indicators underway • Proactive management of recruitment and rotas, with locums filling shifts and escalation process in place in neurosurgery • Safety panel monitoring incidents weekly – chaired by medical director

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 considered manageable for that risk.

The Trust board reviews and approves the self-assessment statements required as part of the TDA's governance arrangements. A more robust process, engaging executive director and board committee sign-off will be introduced in 2015/16 as part of the developing corporate governance framework.

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 organisations 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
- a timetabled plan to transfer 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) as required and does not have any conditions on its registration at present.

The CQC inspected four of the Trust sites in September 2014. While the Trust achieved a rating of *good* in two quality domains ('*effective'* and *'caring*', noting particularly end of life care, intensive care services, maternity and children's services), the overall rating was '*requires improvement'*, with this rating also being applied to the '*safe*', '*responsive to people's needs*' and, '*well-led*'. By site, Queen Charlotte's & Chelsea Hospital was rated as '*good*' and St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital were rated as '*requires improvement*'. Most importantly, staff were consistently seen by patients as caring and compassionate and the Trust achieved some of the best results for patients, including in the specialist centres for stroke and major trauma.

While the Trust was disappointed with its overall rating of '*requires improvement*', the report was considered to be extremely constructive, and clearly sets out a number of challenges while also recognising the positive impact of work undertaken over the previous year and highlighting the great care that the Trust provides. During the quality summit hosted by the CQC at the conclusion of the inspection process, support to make improvement was offered to the Trust by a number of external stakeholders including NHS England, the TDA, Healthwatch and the clinical commissioning groups. The action plan developed by the Trust in response to the inspection findings identified where this support will be provided, and the Trust will be engaging stakeholders in activities under the Trust's new compliance and improvement framework (outlined below).

The CQC served the Trust with a warning notice on 19 September 2014 in relation to concerns about the cleanliness of premises and equipment and infection control practices in the emergency department at St Mary's Hospital. In response, an action plan was developed and implemented by the deadline (17 October) to ensure compliance in the department. Such compliance with the regulatory requirements was confirmed on 25 November when CQC carried out a follow up inspection of the emergency department at St Mary's Hospital.

No other enforcement action has been taken against the Trust by the CQC in 2014/15.

A broader action plan has been developed in response to the wider findings of the Trust's CQC inspection. The plan addresses the regulatory breaches identified (referred to as '*must do*' actions in the inspection reports) as well as areas where there are not regulatory breaches, but improvements are required (referred to as '*should do*' actions in the inspection reports). Good progress had been made by the end of March, with 45 of the 53 '*must do*' and 36 of the 37 '*should do*' actions, either completed or on track for completion. It is planned that the majority of outstanding actions will be completed by the end of September 2015.

The Trust has not participated in any special reviews or investigations by the CQC.

A compliance and improvement framework, based on the CQC's approach, has been developed and is being rolled out in 2015/16. It includes:

- quarterly director-led compliance reviews to check that our practice meets the regulatory requirements
- mock CQC inspections of the eight core services that the CQC identified for the Trust
- the introduction of a ward accreditation programme.

The framework will enable the Trust to deliver its CQC action plan and ensure that we sustain the improvements to care achieved by the action plan. Performance towards these aims will be monitored at the executive committee, quality committee and Trust board.

Emergency pathways independent review

In supporting improvement of emergency department performance, highlighted as a significant issue below, NHS England funded an external review of emergency pathways across the Trust sites, with the remit to establish the drivers of underperformance against the target of 95 per cent of patients seen and treated within four hours. The review provided a focused analysis to deliver *one version of the truth* which would enable the system to collectively address root causes rather than symptoms. It has provided a firm foundation from which to develop a comprehensive action plan to improve not only emergency department performance but also other aspects of the patient pathway. Following a week of concentrated clinical and management attention in a number of areas (the emergency department itself, enabling earlier patient discharge, reducing internal delays, and increasing efficiency of bed management) known as *breaking the cycle*, the Trust exceeded the 95 per cent target, and is now working to embed a framework for *creating a new normal*: of delivering the target, and improving emergency pathway management across the Trust.

Raising concerns

In 2014 the Trust significantly revised its raising concerns (whistleblowing) policy to clarify the obligations placed upon the Trust by the Public Interest Disclosure Act (PIDA). The central thrust of the policy is to encourage 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 PIDA:

- 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 15 new protected disclosures on its whistleblowing database, up from nine in 2013/14. The increase was considered to be due primarily to heightened awareness of the need to report concerns following the CQC inspection, 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 (four cases), drug abuse, discriminatory behaviour and bullying towards colleagues. The Trust aims to build on the top 20 per cent scores it achieved in the NHS staff survey on staff confidence in the procedures for reporting errors and incidents. On-going campaigns to encourage people to report incidents are likely to increase the number of centrally recorded protected disclosures in future years. Towards the end of the reporting period, the Trust updated its raising concerns (*whistleblowing*) policy to take into account Sir Robert Francis' recent recommendations to create a *freedom to speak up guardian* (director of people and organisational development) and a named non-executive director for raising concerns (Professor Sir Anthony Newman Taylor). 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 new version of the policy was published on 1 May 2015, and the Trust will use the launch of the new policy to promote awareness through a communications campaign which will include new 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.

Trust values

A refresh of the Trust values *innovation*, *respect*, *care*, *achievement*, and *pride* has been commissioned, and is being led by a team of Trust staff; this will be presented to the Trust board in July 2015.

Leadership development

The Trust has offered five leadership programmes to leaders and managers across the Trust from senior leader to frontline supervisor. At a senior level, 16 delegates have been part of the certificate in medical leadership run in partnership with imperial College Business School. We have four other programmes run and delivered in house. Twenty delegates have completed Horizons, our strategic leadership programme aimed at aspiring senior leaders, and 59 have been part of Aspire, aimed at our mid-career leaders. Our management programme Headstart has had 43 delegates during the year and our entry-level programme, Foundations, 56 delegates. In total, 194 people have been able to access one of the programmes and the associated coaching and support. As part of this programme they have all been able to undertake a work-based project to practise and develop their skills which have made significant contributions back to the Trust.

Emergency preparedness

The Trust participates in the annual emergency preparedness, resilience and response assurance process carried out by NHS England. In July 2014, NHS England issued a new document, *NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)*, which sets out the minimum EPRR standards NHS organisations must meet. In London, the assessment was carried out in November 2014 with results shared with individual trusts in December 2014. Against 66 measures, the Trust scored 55 '*green*' ratings, 11 '*amber*' ratings and zero '*red*' ratings giving the Trust an overall compliance rating of '*substantial*', in line with peer organisations. An action plan for the '*amber*' ratings has been prepared and its delivery is being co-ordinated by the emergency planning team.

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 that 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). This 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 a stage 2 independent audit conducted in October 2014 and in February 2015. 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 three 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 that 95 per cent of staff must undertake approved information governance training on an annual basis. If the Trust fails to reach this target, it must submit an unsatisfactory information governance toolkit return. In the 2014/15 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 2014/15. 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 79 incidents that occurred during the 2014/15 are set out below:

Total number of reported IG SIRIS 01/04/14 – 31/03/15	Number
Level 2 serious incidents (reported to Department of Health and Information Commissioner's Office)	0
Level 1 IG SIRIS (internally reported)	55
Level 0 IG SIRIS (near misses)	24
Total	**79**

Never events

The Trust reported three never events in 2014/15. 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. One never event relating to a retained vaginal swab occurred in 2013/14, but was reported in April 2014. Between March and August 2014 we reported two never events, as well as two serious incidents, where patients had been fed through misplaced nasogastric or nasojejunal tubes. The main cause of these incidents was due to the chest x-ray, used to confirm the position of the tube, being misinterpreted. The Trust has taken a range of actions to prevent similar events occurring, including introducing a new standard operating procedure, retraining, and amending the nasogastric tube policy.

Significant issue: chief inspector of hospitals inspection

As outlined above, the findings of the CQC inspection was *requires improvement*. A re-inspection by the CQC is anticipated within 12 months at which point a rating of good will need to be achieved to recommence the foundation trust process. As described in the section on emergency pathways independent review above, a detailed action plan has been developed and is being implemented.

Process and structures

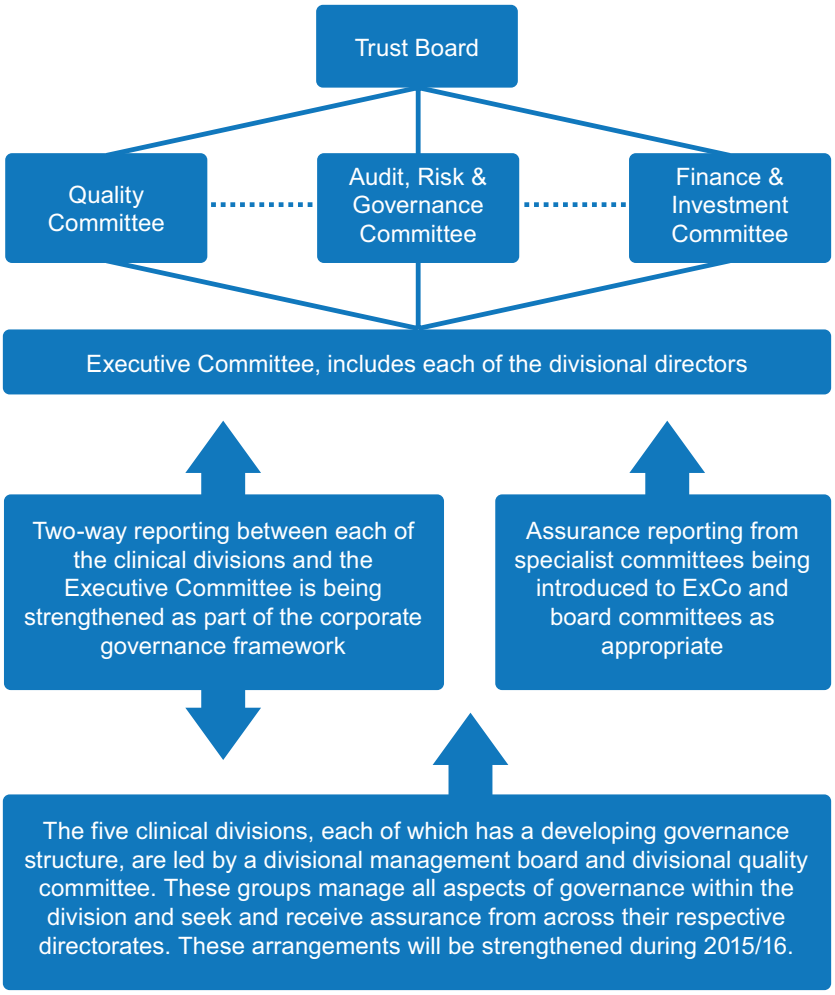
How reporting lines, structures and accountabilities support the effective oversight of the organisation

Trust board

Details of the Trust board and its committees are contained within the directors' report on page 50. As noted earlier, the Grant Thornton UK LLP review of the board governance assurance framework (BGAF) and quality governance assurance framework (QGAF) effectively formed the annual review of the board for 2014/15, and formed the impetus for some of the governance improvement outlined in this report. A further review of the quality governance framework by Grant Thornton UK LLP during 2014/15 showed a notable improvement in score, which will be further strengthened during 2015/16 with the implementation of the quality strategy and quality methodology. The Trust will ensure that the corporate governance assessments underway using the *well-led* framework dovetail with the quality strategy and methodology.

Risk and control framework

The Trust is seeking to further strengthen the assurance framework arrangements by systematising the assurance 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 below.

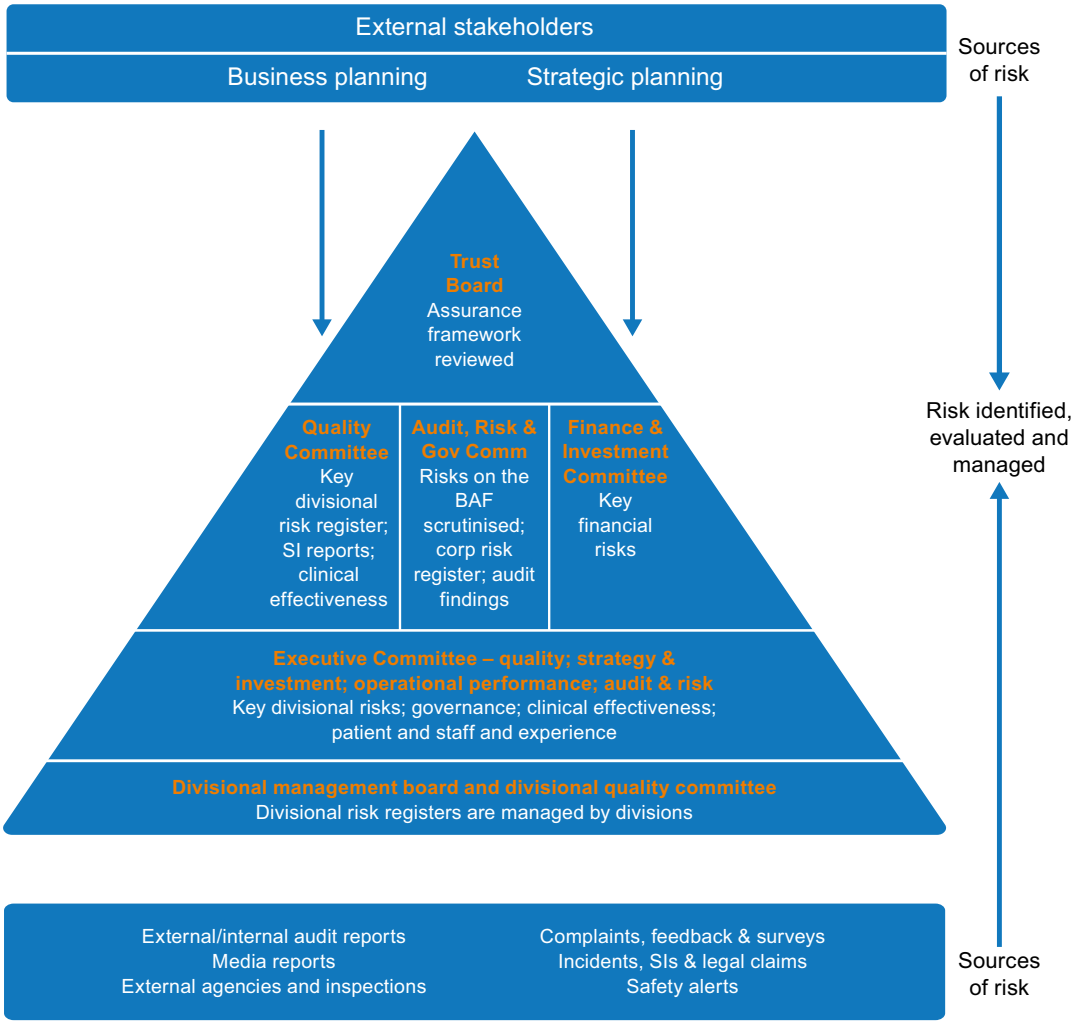


The table articulates the way in which the clinical divisions link into the corporate assurance framework. Further consideration is being given to strengthening both the quality and operational meetings at executive level.

As outlined above 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 recorded at directorate level, identifying 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; whose key role is to support the division in identifying and mitigating risks.

Risks are identified through feedback from many sources, such as proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, whistleblowing, stakeholder/partnership feedback, and internal and external assurance assessments. 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 director 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, are also being agreed as the indicators of progress towards having the revised quality strategy in place for 2015/17. These metrics will be provided 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.

A strategic health and safety committee was introduced in 2014/15 which 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.

Following identification of a risk relating to access to out-of-date policies, the arrangements for development of policies and clinical guidelines (including the relevant policies) have been reviewed and substantially strengthened. All 18,000 documents on the Trust intranet have been reviewed (12,000 of which are now archived) and an audit mechanism has been put in place to ensure currency for the future.

The standing orders and financial instructions were reviewed, revised and approved by the Trust board and audit, risk and governance committee respectively. The delegations of financial authority were also reviewed and revised, and will be presented for approval as part of a wider schedule of board delegation of responsibilities during the summer.

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.

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 key performance indicators have been developed that will support an understanding of progress toward achieving the Trust's strategic objectives. As part of the development of the corporate governance assurance framework, the Trust will undertake a review of arrangements against the five domains of the code: leadership, effectiveness, accountability, remuneration, and relationships with shareholders (commissioners/partners).

Significant issue: emergency department performance against targets

The Trust achieved the target of 95 per cent of all patients seen and treated within four hours of arrival for quarters 1 and 2 of the year. However it has struggled to continue to achieve the target. Performance in quarters 3 and 4 was 91.2 and 91.9 per cent respectively, with a full year position of 93.67 per cent. Significant clinical and management attention continues to be paid to address and improve this position. This includes opening of additional capacity at St Mary's Hospital, recruiting additional staff, and improving discharge arrangements to increase available beds for patient admissions.

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 Deloitte LLP.

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, thus far, ensured that appropriate managers have been briefed and have reviewed the internal audit plan to ensure coverage of these data sets in planned audits. Whilst the existing arrangements are considered to deliver compliance, the Trust has developed enhanced reporting arrangements for 2015/16 to further enhance these arrangements.

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

- Data are collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have 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 above. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

Significant issue: data quality issues following implementation of a patient administration system

A new patient administration system (PAS) went live across the Trust early in the reporting period. While the switch to the new system was successful and demonstrated an enormous team effort by our staff, there was, post implementation, an anticipated issue in relation to data quality. The data quality issue stemmed from the more complex workflows staff were required to enter into the new system in relation to patient activity. This resulted in under-recording of patient activity which had a consequent impact on the Trust's revenue. Commissioners agreed to extend our data freeze dates to enable retrospective correction of the data entry issues to appropriately record activity and therefore earn the appropriate revenue. The action plan developed to address the issue saw data quality key performance indicators tracking to the anticipated trajectory by December 2014. By February 2015 most indicators were back to or better than the levels recorded before the implementation of the PAS, and the Trust proceeded with the piloting and planning of the roll out of clinical documentation and electronic prescribing. Early clinical feedback has been extremely positive.

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 significant assurance that the internal controls are operating effectively within the fundamental financial systems as a whole. In other internal audits carried out (and listed in appendix 3), a range of assurances from significant assurance to limited assurance has been given. 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, NHSLA risk management standards assessment 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 can also confirm that, having taken all appropriate steps to be aware of any relevant audit information that should be communicated, and to the best of my knowledge, there is no relevant audit information of which our external auditor, Deloitte LLP has not been made aware.

I consider that any significant issues are included in the report, namely: foundation trust application; condition of the Trust estate; CQC inspection by chief inspector of hospitals; emergency department performance; and data quality issues following implementation of a patient administration system. Action to address each of these areas is detailed in the relevant section of the governance report.

Signed: Date: 2 June 2015

Dr Tracey Batten
Chief executive

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 consists of the chairman, seven non-executive directors, 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, complete 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.

As of November 2014, trusts were required to ensure that they did not appoint any person to a non-executive or executive director level post unless they were: of good character; had the necessary qualifications, skills and experience; were able to perform the work that they are employed for after reasonable adjustments are made; and could supply information as set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All Trust board directors have signed a self-certification against these requirements and, as new appointments are made, robust checks will be implemented.

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 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 accounts, and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, and strategy.

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

- Dr Tracey Batten joined the Trust on 7 April 2014, as chief executive, replacing Professor Nick Cheshire and Bill Shields as acting joint chief executives
- Steve McManus was made deputy chief executive in August 2014
- Alan Goldsman was appointed as interim chief finance officer from 5 January 2015, following the secondment of Bill Shields to Royal Cornwall Hospitals NHS Trust
- Sir Thomas Legg resigned as a non-executive director on 31 December 2014
- Sir Gerald Acher was made deputy chairman in January 2015
- Dr Andreas Raffel was made a substantive non-executive director on 1 January 2015
- The Trust board currently has one non-executive director vacancy.

The Trust board at 31 March 2015 was as follows:

Member	Position
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
Professor Chris Harrison	Medical director
Professor Janice Sigsworth	Director of nursing
Alan Goldsman	Interim chief financial officer

Disclosure to auditor

As director 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 him 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 2014 – 31 March 2015

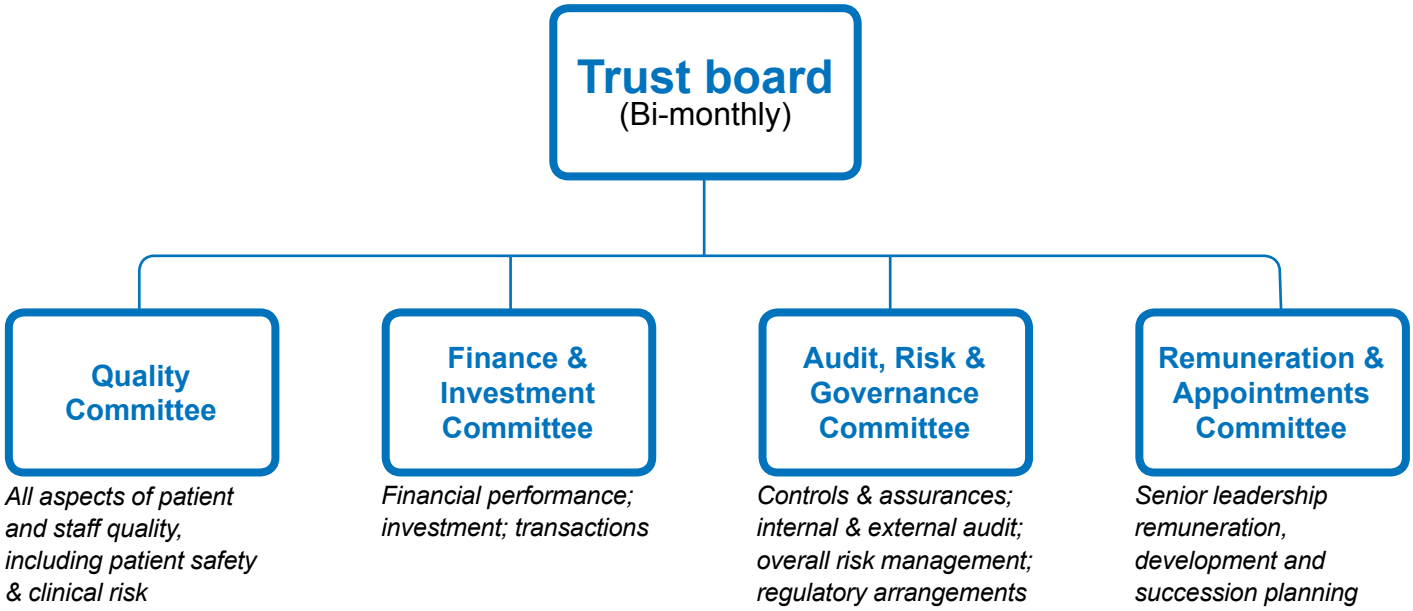
The Trust board met eight times in the reporting period. Attendance at the Trust board and attendance at and role of the board committees is described below:

Member*	Attendance (actual/possible)
Non-executive directors**	
Sir Richard Sykes, chairman	8/8
Sir Thomas Legg	3/5
Sir Gerald Acher	8/8
Jeremy Isaacs	7/8
Dr Rodney Eastwood	8/8
Dr Andreas Raffel	7/8
Sarika Patel	7/8
Executive directors	
Dr Tracey Batten, chief executive	8/8
Steve McManus, deputy chief executive and chief operating officer	8/8
Bill Shields, chief financial officer	5/5
Alan Goldsman, interim chief financial officer	3/3
Professor Janice Sigsworth, director of nursing	7/8
Professor Chris Harrison, medical director	8/8

* Changes to the board membership are outlined above in capability and culture
** There was one vacant non-executive post as at 31 March 2015

Board committee meetings: 1 April 2014 – 31 March 2015

The board has a total of four committees (see strategy and planning section above for a note on the foundation trust programme committee) 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 board, the audit, risk and governance committee minutes are a standing item on each Trust board agenda.



Non-executive Chair

Prof Sir Anthony Newman Taylor
Sir Gerald Acher
Dr Rodney Eastwood
Dr Tracey Batten
Prof Chris Harrison
Prof Janice Sigsworth
Steve McManus

Attending
Jayne Mee
Prof Tim Orchard
Prof Jamil Mayet
Prof TG Teoh
Dr Naresh Kikkeri

Sarika Patel
Dr Andreas Raffel
Jeremy Isaacs
Dr Rodney Eastwood
Dr Tracey Batten
Alan Goldsman
Steve McManus

Attending
Ian Garlington
Sandra Easton
Jonathan Evans

Non-executive Only

Sir Gerald Acher
Prof Sir Anthony Newman Taylor
Sarika Patel
Dr Andreas Raffel

Attending
Dr Tracey Batten
Alan Goldsman
Steve McManus
Prof Chris Harrison
Prof Janice Sigsworth

Jeremy Isaacs
Sir Richard Sykes
Dr Andreas Raffel

Attending
Dr Tracey Batten
Jayne Mee

Chairperson of each committee in bold

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
Sir Thomas Legg	1/5
Professor Sir Anthony Newman Taylor	5/6
Sarika Patel	6/6
Dr Andreas Raffel	5/6

During 2014/15, the committee 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 had 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 in 2014/15 is included as appendix 3 of the annual report. 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 at each meeting. The committee has undertaken a number of in-depth reviews, including Cerner implementation data quality issues (details in the annual governance statement), radiology information system and picture archiving computer systems (RIS/PACS) concerns (where close management and clinical attention has minimised risk of patient harm; this is reviewed via the corporate risk register) and pharmacy medication issues (where there have been significant improvements). It also reviews the work of 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 also 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 that 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.

In addition to the regular reports made to the Trust board, the committee will prepare an annual report covering 2014/15 for submission to the Trust board in July 2015, reporting on the activities above. An annual plan has been developed for the committee, which ensures that there are no key omissions in the committee's programme.

The committee is amending its terms of reference for 2015/16, creating a part 1 (covering audit items remaining non-executive director member only), and a part 2 (with non-executive and executive director members).

During the reporting period the Trust's external audit services have been provided by Deloitte LLP. The committee has received and reviewed progress reports from Deloitte 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.

In line with good corporate practice, the Audit Commission (the organisation which appoints the Trust's auditors) have rotated the external audit provider, and from the financial year 2015-16, the Trust's external auditor is BDO LLP.

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 board. It also seeks and provides assurance in relation to patient and staff experience, and health and safety and in 2015/16 will monitor performance in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the Care Quality Commission and ensure that there is a clear compliance framework against these.

The committee met nine times during the reporting period.

Member	Attendance (actual/possible)
Professor Sir Anthony Newman Taylor (chair)	8/9
Sir Gerald Acher	4/9
Sir Thomas Legg	5/6
Dr Rodney Eastwood	7/9
Dr Tracey Batten	8/9
Prof Janice Sigsworth	8/9
Prof Chris Harrison	8/9
Steve McManus	9/9

Discussion included preparing for the chief inspector of hospitals visit and reviewing the action plan designed to address short-comings identified. A number of in-depth reviews were also undertaken in areas of potential quality concern.

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 five times during the reporting period.

Member	Attendance (actual/possible)
Sarika Patel (chair)	5/5
Dr Rodney Eastwood	1/1
Jeremy Isaacs	4/5
Dr Andreas Raffel	4/5
Bill Shields	4/4
Alan Goldsman	1/1
Steve McManus	3/5

Discussion included: the financial position including delivery of cost improvement plans and financial recovery plans; review of key business cases, private patient developments, and major tenders.

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 once during the reporting period, where it ratified the appointment of medical director and discussed market salary benchmarking for the executive directors.

Member	Attendance (actual/possible)
Jeremy Isaacs (chair)	0/1
Sir Richard Sykes	1/1
Dr Andreas Raffel	0/0
Sir Thomas Legg	1/1

Foundation trust programme board

As outlined in strategy and planning section of the annual governance statement, meetings of the foundation trust programme board have been deferred until the recommencement of the FT process.

The committee met five times in the reporting period, and considered the drafts of the integrated business plan, the independent financial review and the constitution.

Member	Attendance (actual/possible)
Dr Rodney Eastwood (chair)	5/5
Sir Thomas Legg	2/5
Professor Sir Anthony Newman Taylor	3/5
Dr Tracey Batten	5/5
Bill Shields	4/5
Steve McManus	4/5
Professor Janice Sigsworth	4/5
Professor Chris Harrison	4/5

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 that 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 that may conflict with their management responsibilities. This register is updated at each board meeting. The register as at 31 March 2015 is included at appendix 4, and is available to the public on the website at **www.imperial.nhs.uk**. The 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 on **page 60**. The Trust's external audit and details of their remuneration and fees are set out in note 3 of the accounts. Exit packages and severance payments are detailed in notes 6 and 7 of the accounts, and the Trust off-payroll engagement disclosures, shown in appendix 5 are in accordance with HMRC requirements.

Cost allocation and charges for information

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

Equality disclosures

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

Better payment for suppliers

The Trust supports the Prompt Payment Code, which applies the following principle to payment practices: pay suppliers on time, give clear guidance to suppliers; and encourage good practice. The Trust's performance is summarised in the table in note 8 of 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 on **page 36**.

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. Further details on the Trust's complaint handling are included in the strategic report on **page 14**.

Signed: Date: 2 June 2015

Dr Tracey Batten
Chief executive

Remuneration report

Overview

The remuneration package and conditions of service for the executive team are agreed by the remuneration committee, a Trust board committee that consists of three non-executive directors and the chairman.

Each year, the remuneration committee considers the performance and development of the executive directors and agrees the ratings given. The remuneration committee considers the matter of succession planning for the chief executive, and the board considers the other executive directors.

The notice period for executive directors is six months and there are no additional arrangements for enhanced termination payments or compensation for early termination of contract.

The remuneration committee met to review the remuneration of each director in June 2014. The review is informed by executive salary surveys, periodic assessments conducted by independent remuneration consultants, benchmarking salary awards and terms and conditions applying to NHS foundation trusts. The benchmarking comparisons indicated that no salary reviews were required this year.

Median pay

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

The banded remuneration of the highest paid director of the Trust in the financial year 2014-15 was £342,500 (2013-14 – £252,500). This was 9.46 times (2013-14 – 7.33) the median remuneration of the workforce which was £36,188 (2013-14 – £34,430). The highest paid director has changed from the prior year and this individual's remuneration included a non-recurrent allowance of £49,860. Excluding these payments, the highest paid director's remuneration was 8.08 times the median remuneration of the workforce.

In 2014-15, no employee (2013-14 – one at £260,765) received remuneration in excess of the highest paid director.

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

Remuneration report for 2014/15

Salaries and allowances	Salary	Other remuneration	Bonus payments	Expense payments (taxable)	Exit packages	Pension related benefits	Total remuneration	Total remuneration excl. pension-related benefits
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(Total to nearest £00)		(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
Name	£000	£000	£000	£00	£	£000	£000	£000
Sir Richard Sykes, chairman	20 - 25	0	0	0	0	n/a	20 - 25	20 - 25
Sir Thomas Legg, non-executive director [1]	0 - 5	0	0	0	0	n/a	0 - 5	0 - 5
Jeremy Isaacs, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sir Gerald Acher, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Rodney Eastwood, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Prof Sir Anthony Newman Taylor, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sarika Patel, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Andreas Raffel, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Tracey Batten, chief executive [2]	290 - 295	0	0	499[2]	0	n/a	340 - 345	340 - 345
Bill Shields, chief financial officer/chief executive [3]	170 - 175	0	0	0	0	Left	170 - 175	170 - 175
Alan Goldsman, chief financial officer [4]	0	90 - 95	0	0	0	n/a	90 - 95	90 - 95
Steve McManus, chief operating officer	185 - 190	0	0	0	0	20 - 22.5	210 - 215	185 - 190
Prof Nick Cheshire, medical director/chief executive [5]	0 - 5	0 - 5	0	0	0	Left	0 - 5	0 - 5
Prof Janice Sigsworth, director of nursing	155 - 160	0	0	0	0	20 - 22.5	180 - 185	155 - 160
Prof Chris Harrison, medical director	85 - 90	150 - 155	0	0	0	17.5 - 20	260 - 265	240 - 245
Marcus Thorman, chief financial officer [6]	0 - 5	0	0	0	0	Left	0 - 5	0 - 5

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 31 March 2015	Total accrued lump sum at age 60 to accrued pension at 31 March 2015	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 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)			
Name	£000	£000	£000	£000	£000	£000	£000
Sir Richard Sykes, chairman	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas Legg, non-executive director [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 Acher, 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, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarika Patel, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Andreas Raffel, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr 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

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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 31 March 2015	Total accrued lump sum at age 60 to accrued pension at 31 March 2015	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 March 2014	Real increase in cash equivalent transfer value
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 31 December 2014.
[2] Dr Tracey Batten joined the board on 7 April 2014. £49,900 – taxable relocation costs on appointment.
[3] Bill Shields left the joint chief executive role on 6 April 2014 and reverted to the chief financial officer role. He left the board on 4 January 2015.
[4] Alan Goldsman joined the board on 5 January 2015. The amount under 'other remuneration' above is payable to Alan Goldsman Limited and is net of VAT.
[5] Professor Nick Cheshire left the board on 6 April 2014.
[6] Marcus Thorman left the board on 6 April 2014.

Remuneration report for 2013/14

Salaries and allowances	Salary	Other remuneration	Bonus payments	Expense payments (taxable)	Exit packages	Pension-related benefits	Total remuneration	Total remuneration excl. pension-related benefits
	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(total to nearest £00)		(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
Name	£000	£000	£000	£00	£	£000	£000	£000
Sir Richard Sykes, chairman	20 - 25	0	0	0	0	n/a	20 - 25	20 - 25
Sir Thomas Legg, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Jeremy Isaacs, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sir Gerald Acher, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Rodney Eastwood, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Prof Sir Anthony Newman Taylor, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Sarika Patel, non-executive director	5 - 10	0	0	0	0	n/a	5 - 10	5 - 10
Dr Andreas Raffel, associate non-executive director [1]	0 - 5	0	0	0	0	n/a	0 - 5	0 - 5
Mark Davies, chief executive [2]	140 - 145	80 - 85	0	0	148,200	Left	375 - 380	375 - 380

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Salaries and allowances	Salary	Other remuneration	Bonus payments	Expense payments (taxable)	Exit packages	Pension-related benefits	Total remuneration	Total remuneration excl. pension-related benefits
Bill Shields, chief financial officer/chief executive [3]	220 - 225	0	10 - 15	2	0	60 - 62.5	295 - 300	235 - 240
Steve McManus, chief operating officer	165 - 170	0	0	211	0	180 - 182.5	365 - 370	185 - 190
Prof Nick Cheshire, medical director/chief executive [4]	85 - 90	160 - 165	0	0	0	60 - 62.5	310 - 315	250 - 255
Prof Janice Sigsworth, director of nursing	155 - 160	0	0	0	0	22.5 - 25	180 - 185	155 - 160
Prof Chris Harrison, medical director [5]	35 - 40	75 - 80	5 - 10	0	0	New board member	115 - 120	115 - 120
Marcus Thorman, chief financial officer [6]	75 - 80	0	5 - 10	0	0	New board member	85 - 90	85 - 90

Pension benefits	Real increase in pension at age 60	Real increase in lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2014	Total accrued lump sum at age 60 related to accrued pension at 31 March 2014	Cash equivalent transfer value at 31 March 2014	Cash equivalent transfer value at 31 March 2013	Real increase in cash equivalent transfer value
Name	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000
Sir Richard Sykes, chairman	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas Legg, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a

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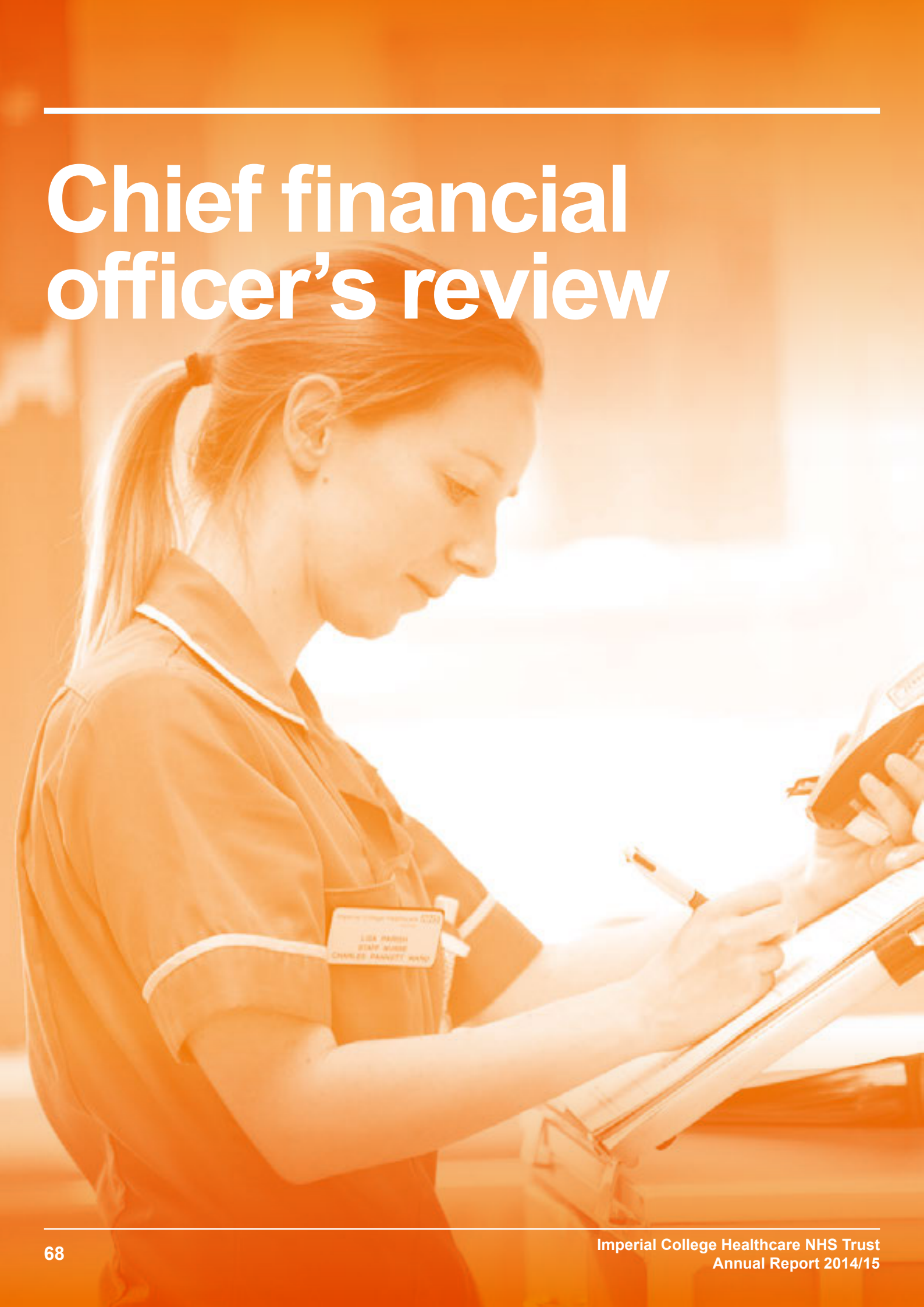
Jeremy Isaacs, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pension benefits	**Real increase in pension at age 60**	**Real increase in lump sum at age 60 related to real increase in pension**	**Total accrued pension at age 60 at 31 March 2014**	**Total accrued lump sum at age 60 related to accrued pension at 31 March 2014**	**Cash equivalent transfer value at 31 March 2014**	**Cash equivalent transfer value at 31 March 2013**	**Real increase in cash equivalent transfer value**
Sir Gerald Acher, 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, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarika Patel, non-executive director	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Andreas Raffel, associate non-executive[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Davies, chief executive[2]	Left	Left	Left	Left	Left	Left	Left
Bill Shields, chief financial officer/chief executive[3]	2.5 - 5	10 - 12.5	60 - 65	180 - 185	1,028	939	89
Steve McManus, chief operating officer	7.5 - 10	25 - 27.5	50 - 55	160 - 165	910	743	167
Prof Nick Cheshire, medical director/ chief executive[4]	2.5 - 5	10 - 12.5	50 - 55	155 - 160	1,011	919	92
Prof Janice Sigsworth, director of nursing	0 - 2.5	5 - 7.5	65 - 70	200 - 205	1,251	1,182	65
Prof Chris Harrison, medical director[5]	New board member	New board member	50 - 55	160 - 165	1,076	New board member	New board member
Marcus Thorman, chief financial officer[6]	New board member	New board member	30 - 35	95 - 100	445	New board member	New board member

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

Chief financial officer's review



Chief financial officer's review

The Trust has once again successfully met the statutory financial performance targets and has delivered efficiency savings of £39.7m (out of a planned £49.3m) in 2014/15. The table below summarises the key financial performance metrics:

Statutory financial duties

Duty	Requirement	Achievement
1. Breakeven duty	To ensure total expenditure does not exceed income	Achieved – surplus of £15.4m, after adjusting for impairments
2. External financing limit (EFL)	To remain within DH borrowing limit	Achieved – cash outflow of £6.2m
3. Capital absorption rate of 3.5 per cent	To pay a dividend of 3.5 per cent to the DH	Achieved
4. Capital resource limit (CRL)	To ensure capital expenditure is within the limit set by DH	Achieved – Net spend of £32.9m

Capital expenditure (excluding externally funded schemes) for the period was £32.9m; 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 total operating income was £1,000.6m; an increase of £21.3m compared to the previous year. This increase includes Project Diamond funding of £24.4m. This payment reimburses the Trust for the excess costs of treating specialist patients not funded in national tariff. New 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. Sales of non-essential assets also contribute to this income growth.

The total operating expenditure was £1,109.9m including an asset impairment of £123.8m and donated asset adjustment of £0.9m. After adjusting for the impairment and donated asset adjustment, overall expenditure has increased by £21.0m when compared to the previous year. This increase has been driven by the cost of delivering additional activity, the cost improvement programme, and new investment in increased staffing levels on wards and in the Trusts A&E departments.

Expenditure growth also includes costs associated with inflation and other NHS policy driven cost pressures; including pay uplifts and increments awarded to staff under the national pay bargaining arrangements, new medicines and medical technology approved by the National Institute of Clinical Excellence (NICE), legislative changes for clinical compliance and governance, and for the implementation of a new patient administration system (Cerner).

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 reduction of £166.0m in the value of the Trust asset base; resulting in an in-year impairment of £123.8m. This impairment has no cost or cash impact and is excluded from the Department of Health's assessment of the Trust's breakeven duty.

The Trusts efficiency programme focussed on new initiatives that aimed to deliver savings in excess of 4.5 per cent of costs deemed influenceable in the short and medium-term planned turnover (£39.7m achieved). These were carefully planned and implemented through the Trust's 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. Key themes were for clinical pathway redesign, medicines management, negotiating better prices with suppliers and reviewing supply chain arrangements, exploiting commercial opportunities to increase income and reducing overheads.

Capital expenditure

The Trust continues to invest in its capital infrastructure to help achieve its strategic service objectives. During 2014/15 the Trust invested a total of £36.5m to modernise its estate, deal with backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2014/15 included:

- backlog maintenance £6.3m
- medical equipment £8.6m
- IT investment £5.1m
- imaging investment £4.2m

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 £43.3m. This is £12.3m less than the level anticipated when the cash plan was developed at the start of the financial year and, for the most part, this is because the Project Diamond funding will now be received in the next financial year.

Financial outlook

The five year forward view strategy document published by NHS England calls for improvements of approximately £22bn from within the health service. With a further £8bn promised by the end of this new parliament from the taxpayer the financial challenge to the whole health service has been clearly set out. The Trust recognises that this means thinking very differently about its services and how these must provide value for money if it is to meet its share of that challenge and if the Trust is to make the major investments in its estate and services that are needed.

The requirement to reform NHS tariffs is crucial and, now that Project Diamond funding is at an end, the Trust will be working with other major acute trusts and Monitor to support the independent tariff review to inform the 2016/17 tariff; in particular for complex and specialist services. The expectation is that tariffs will be revised to better reflect the cost of providing services in hospitals.

The Trust's forward plans must provide for new cost increases, including for example, clinical negligence premiums, which have increased dramatically, and the removal of quality incentive payments (CQUIN). This has meant that, before dealing with the new financial challenges and investments required in 2015/16, the Trust must identify approximately £25m more improvement to its financial bottom line than expected in its previous long-term planning assumptions.

In response, the Trust has set a challenging target for improving productivity and cost reduction and has constructed a programme totalling £36.1m; about 4.7 per cent of 'influenceable' spend. 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 have been 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 cannot be confident that sufficient improvements in a single year will deliver a plan to break even on income and expenditure. A planned deficit of £18.5m has been set, which, along with a capital programme of £47m can be paid for by the current and expected cash available over the next 12 months.

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 sector-wide implementation business case has been formally presented to the NHS Trust Development Authority and NHS England for review. The financing of the case, as it stands, is still to be agreed and has significant financial challenges for the Trust in future years.

All of this means that in 2015/16 the Trust will be significantly expanding its approach to delivering long-term financial sustainability. The Trust, with support from its CCGs, has set aside funding for investment in a programme of clinical service transformation. This will mean changing the way services are delivered at every level of the organisation and will involve front line staff, patients and key stakeholders even more in making improvements that will improve the quality and value of services.

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

We have examined the summary financial statements contained within the strategic report for the year ended 31 March 2015 which comprise the summary statement of comprehensive income, the summary statement of financial position, the summary statement of changes in taxpayers' equity, the summary statement of cash flows and related notes 1 to 9.

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

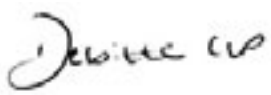
Respective responsibilities of directors and auditor

The directors are responsible for preparing the annual report. The directors are also responsible for the maintenance and integrity of the corporate and financial information included on the company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

Our responsibility is to report to you our opinion on the consistency of the annual report with the full annual financial statements. We also read the other information contained in the annual report as described in the contents section and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the summary financial statements. We conducted our work in accordance with bulletin 2008/3 issued by the auditing practices board. Our report on the Trust's full annual financial statements describes the basis of our audit opinion on those financial statements, the directors' remuneration report, the strategic report and the directors' report.

Opinion

In our opinion the summary financial statements contained within the annual report are consistent with the full annual financial statements of the Trust for the year ended 31 March 2015.



Deloitte LLP
St Albans
4 June 2015

Statement of accounts

Statement of comprehensive income for year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Gross employee benefits	3	**(553,389)**	(526,157)
Other operating costs	3	**(541,775)**	(536,127)
Revenue from patient care activities	1	**795,699**	774,430
Other operating revenue	2	**204,915**	204,882
Operating deficit		**(94,550)**	(82,972)
Investment revenue		**231**	202
Other gains and (losses)		**213**	(171)
Finance costs		**(812)**	(857)
Deficit for the financial year		**(94,918)**	(83,798)
Public dividend capital dividends payable		**(14,351)**	(18,778)
Deficit for the year		**(109,269)**	(102,576)
Other comprehensive income			
Impairments and reversals taken to the revaluation reserve		**(39,342)**	(3,545)
Net gain on revaluation of property, plant and equipment		**232**	5,929
Total comprehensive income for the year*		**(148,379)**	(100,192)
Financial performance for the year			
Deficit for the year		**(109,269)**	(102,576)
Impairments (excluding IFRIC 12 impairments)		**123,818**	117,142
Adjustments in respect of donated gov't grant asset reserve elimination		**856**	562
Adjusted retained surplus		**15,405**	15,128

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

Statement of financial position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	9	**429,639**	595,639
Intangible assets		**4,086**	1,413
Trade and other receivables		**0**	0
Total non-current assets		**433,725**	597,052
Current assets			
Inventories		**13,458**	14,214
Trade and other receivables		**122,117**	96,256
Cash and cash equivalents		**43,333**	50,449
Net current assets		**178,908**	160,919
Non-current assets held for sale		**0**	0
Total current assets		**178,908**	160,919
Total assets		**612,633**	757,971
Current liabilities			
Trade and other payables		**(134,458)**	(128,280)
Provisions		**(27,629)**	(25,091)
Borrowings		**(806)**	(1,475)
DH capital loan		**(1,226)**	(1,226)
Total current liabilities		**(164,119)**	(156,072)
Net current assets		**14,789**	4,847
Total assets less current liabilities		**448,514**	601,899
Non-current liabilities			
Trade and other payables		**0**	0
Provisions		**(13,175)**	(17,149)
Borrowings		**(307)**	(1,113)
DH capital loan		**(18,370)**	(19,596)
Total non-current liabilities		**(31,852)**	(37,858)
Total assets employed		**416,662**	564,041
FINANCED BY			
Public dividend capital		**697,288**	696,288
Retained earnings		**(282,729)**	(175,475)
Revaluation reserve		**2,103**	43,228
Total taxpayers' equity		**416,662**	564,041

Statement of changes in taxpayers' equity for the year ending 31 March 2015

	Public dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2014	**696,288**	**(175,475)**	**43,228**	**564,041**
Changes in taxpayers' equity for 2014-15				
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**
Balance at 1 April 2013	**696,088**	**(72,899)**	**40,844**	**664,033**
Changes in taxpayers' equity for the year ended 31 March 2014				
Retained deficit for the year	0	(102,576)	0	(102,576)
Net gain on revaluation of property, plant, equipment	0	0	5,929	5,929
Impairments and reversals	0	0	(3,545)	(3,545)
New permanent PDC received – cash	200	0	0	200
Net recognised revenue/(expense) for the year	**200**	**(102,576)**	**2,384**	**(99,992)**
Balance at 31 March 2014	**696,288**	**(175,475)**	**43,228**	**564,041**

Statement of cash flows for the year ended 31 March 2015

	2014-15	2013-14
	£000	£000
Cash flows from operating activities		
Operating deficit	**(94,550)**	(82,972)
Depreciation and amortisation	**33,834**	36,346
Impairments and reversals	**123,818**	117,142
Donated assets received credited to revenue but non-cash	**0**	(562)
Interest paid	**(812)**	(859)
Dividend paid	**(14,366)**	(18,317)
Decrease in inventories	**756**	3,438
Increase in trade and other receivables	**(25,846)**	(31,258)
Increase /(decrease) in trade and other payables	**584**	(618)
Provisions utilised	**(3,381)**	(3,271)
Increase in movement in non cash provisions	**1,945**	8,158
Net cash inflow from operating activities	**21,982**	27,227
Cash flows from investing activities		
Interest received	**231**	205
(Payments) for property, plant and equipment	**(28,263)**	(30,381)
(Payments) for intangible assets	**(2,672)**	(123)
Proceeds of disposal of assets held for sale (PPE)	**3,307**	1,006
Net cash outflow from investing activities	**(27,397)**	(29,293)
Net cash outflow before financing	**(5,415)**	(2,066)
Cash flows from financing activities		
Gross temporary and permanent PDC received	**1,000**	200
Other loans received	**0**	64
Loans repaid to DH - capital investment loans repayment of principal	**(1,226)**	(1,226)
Other loans repaid	**(1,475)**	(1,849)
Net cash outflow from financing activities	**(1,701)**	(2,811)
Net decrease in cash and cash equivalents	**(7,116)**	(4,877)
Cash and cash equivalents (and bank overdraft) at beginning of the period	**50,449**	55,326
Cash and cash equivalents (and bank overdraft) at year end	**43,333**	50,449

Notes to the summarised financial statements

1. Revenue from patient care activities	2014-15 £000	2013-14 £000
NHS Trusts	**654**	651
NHS England	**306,746**	299,878
Clinical Commissioning Groups	**424,032**	418,367
Foundation Trusts	**3,098**	3,881
Department of Health	**96**	938
NHS Other (including Public Health England and Prop Co)	**0**	0
Non-NHS:		
Local authorities	**9,815**	9,327
Private patients	**43,068**	34,331
Overseas patients (non-reciprocal)	**3,244**	2,282
Injury costs recovery	**2,067**	1,641
Other	**2,879**	3,134
Total revenue from patient care activities	**795,699**	774,430

Injury cost recovery reflects actual rates of collection

2. Other operating revenue	2014-15 £000	2013-14 £000
Recoveries in respect of employee benefits	**5,818**	6,240
Patient transport services	**0**	0
Education, training and research	**127,043**	119,482
Charitable and other contributions to revenue expenditure - non-NHS	**140**	68
Receipt of donations for capital acquisitions - Charity	**133**	809
Receipt of Government grants for capital acquisitions	**209**	26
Non-patient care services to other bodies	**30,581**	37,512
Income generation	**3,765**	4,427
Rental revenue from operating leases	**7,001**	6,096
Other revenue	**30,225**	30,222
Total other operating revenue	**204,915**	204,882
Total operating revenue	**1,000,614**	979,312

3. Operating expenses

	2014-15 £000	2013-14 ‘£000
Services from other NHS trusts	**10,411**	8,872
Services from CCGs/NHS England	**446**	1,729
Services from other NHS bodies	**286**	313
Services from NHS foundation trusts	**9,624**	6,639
Total services from NHS bodies*	**20,767**	17,553
Purchase of healthcare from non-NHS bodies	**6,667**	3,497
Trust chair and non-executive directors	**66**	66
Supplies and services - clinical	**193,323**	199,404
Supplies and services - general	**37,203**	37,905
Consultancy services	**13,370**	16,778
Establishment	**7,384**	7,208
Transport	**12,214**	11,692
Business rates paid to local authorities	**3,063**	3,366
Premises	**37,655**	36,152
Hospitality	**81**	46
Insurance	**541**	578
Legal fees	**627**	188
Impairments and reversals of receivables	**10,296**	4,633
Inventories write down	**356**	771
Depreciation	**33,348**	35,955
Amortisation	**486**	391
Impairments and reversals of property, plant and equipment	**123,818**	117,142
Audit fees	**278**	261
Other auditor’s remuneration	**25**	58
Clinical negligence	**16,173**	13,251
Research and development (excluding staff costs)	**23,619**	17,235
Education and training	**1,386**	2,000
Change in discount rate	**(50)**	0
Other	**(921)**	9,997
Total operating expenses (excluding employee benefits)	**541,775**	536,127
Employee benefits		
Employee benefits excluding board members	**552,037**	524,507
Board members	**1,352**	1,650
Total employee benefits	**553,389**	526,157
Total operating expenses	**1,095,164**	1,062,284

*Services from NHS bodies does not include expenditure which falls into a category below.
Other expenses above includes a credit of £6,069k (2014 - £2,592k) relating to net movement in provisions and £3,283k relating to the release of accruals.
Other auditor’s remuneration represents £25k for board development support non-audit services.

4. Staff numbers

	2014-15 Total number	2014-15 Permanently employed number	2014-15 Other number	2013-14 Total number
Average staff numbers				
Medical and dental	**1,837**	1,793	44	1,718
Administration and estates	**2,437**	2,012	425	2,177
Healthcare assistants and other support staff	**1,275**	1,248	27	1,187
Nursing, midwifery and health visiting staff	**3,563**	3,440	123	3,540
Scientific, therapeutic and technical staff	**1,403**	1,261	142	1,369
TOTAL	**10,515**	**9,754**	**761**	**9,991**
Of the above – staff engaged on capital projects	25	10	15	10

5. Staff sickness absence and ill health retirements

	2014-15 number	2013-14 number
Total days lost	**61,065**	55,958
Total staff years	**8,889**	8,657
Average working days lost	**6.87**	6.46

The staff sickness figures above are supplied by the Department of Health and are based on the 2014 calendar year.

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

6. Exit packages agreed in 2014-15

Exit package cost band (including any special payment element)	2014-15 *Number of compulsory redundancies	2014-15 *Number of other departures agreed	2014-15 Total number of exit packages by cost band	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed	2013-14 Total number of exit packages by cost band
Less than £10,000	2	0	2	3	8	11
£10,000-£25,000	5	0	5	7	8	15
£25,001-£50,000	3	0	3	9	4	13
£50,001-£100,000	3	2	5	6	6	12
£100,001-£150,000	0	0	0	1	1	2
£150,001-£200,000	0	0	0	0	1	1
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	13	2	15	26	28	54
Total resource cost (£s)	**452,549**	**144,973**	**597,522**	1,050,871	1,056,184	2,107,055

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

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

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

7. Exit packages – other departures analysis

	2014-15		2013-14	
	Agreements number	**Total value of agreements £000**	Agreements number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	**0**	**0**	0	0
Mutually agreed resignations (MARS) contractual costs	**0**	**0**	0	0
Early retirements in the efficiency of the service contractual costs	**0**	**0**	19	538
Contractual payments in lieu of notice	**0**	**0**	3	254
Exit payments following employment tribunals or court orders	**2**	**145**	7	264
Non-contractual payments requiring HMT approval*	**0**	**0**	0	0
Total	**2**	**145**	29	1,056

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

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

The remuneration report includes disclosure of exit payments payable to individuals named in that report.

8. Better payment practice code – measure of compliance

	2014-15		2013-14	
	number	**£000**	number	£000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**141,792**	**385,458**	138,068	326,576
Total non-NHS trade invoices paid within target	**126,897**	**345,409**	128,594	311,626
Percentage of NHS trade Invoices paid within target	**89.50%**	**89.61%**	93.14%	95.42%
NHS payables				
Total NHS trade invoices paid in the year	**4,112**	**35,089**	3,450	24,779
Total NHS trade invoices paid within target	**3,631**	**30,943**	2,923	24,393
Percentage of NHS Trade Invoices paid within target	**88.30%**	**88.18%**	84.72%	98.44%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

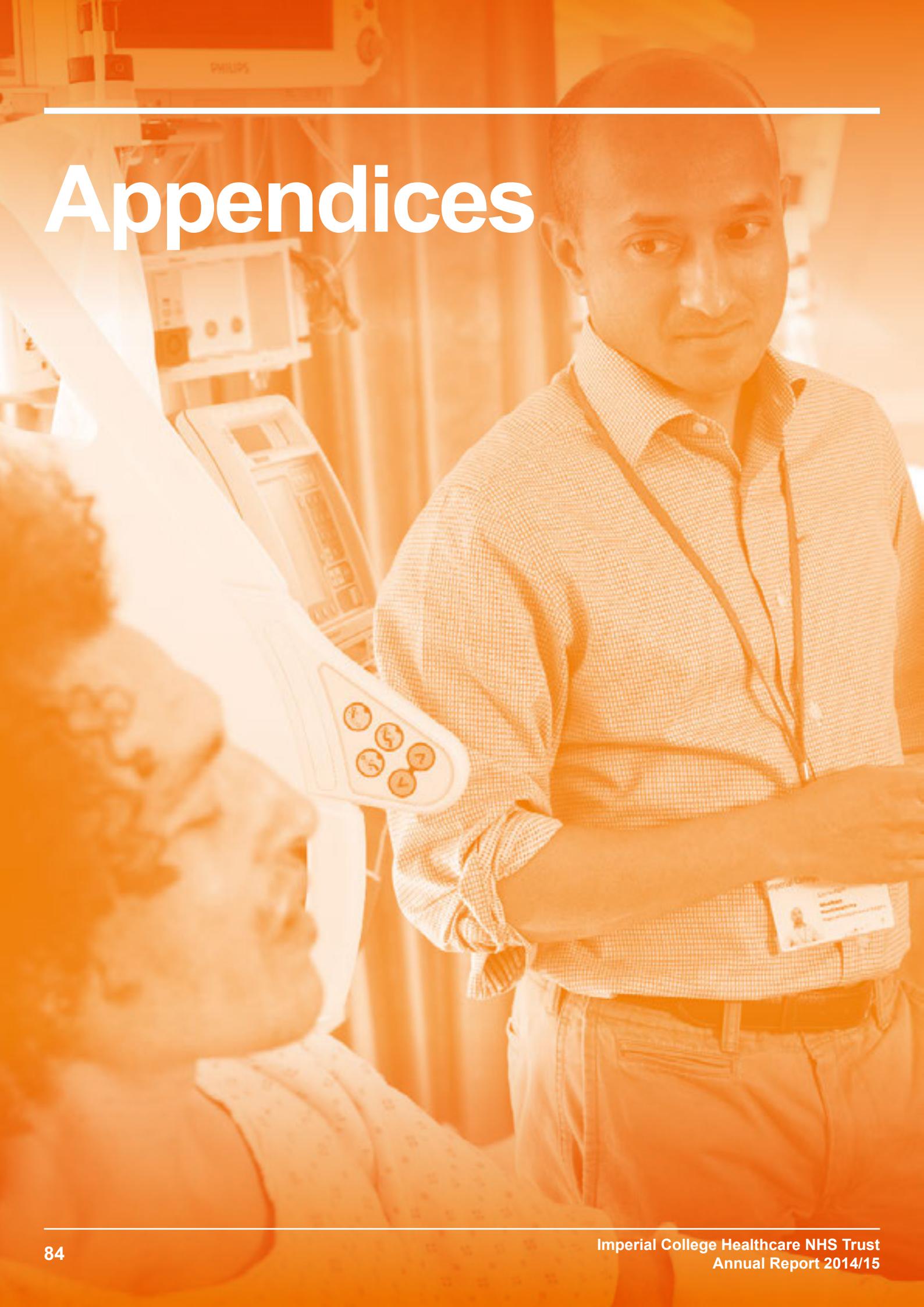
9. Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 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 and 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	(37,500)	(1,702)	(140)	0	0	0	0	(39,342)
Reversal of impairments	0	0	0	0	0	0	0	0
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**
Reclassifications	0	0	0	0	0	0	0	0
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	0	9,830	0	0	0	0	0	9,830
Reversal of impairments	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**

The financial statements were approved by the board on 27 May and signed on its behalf by Dr Tracey Batten, chief executive, Imperial College Healthcare NHS Trust on 2 June 2015.

Dr Tracey Batten, Chief Executive
Imperial College Healthcare NHS Trust

Appendices



Appendix 1: Glossary of terms

Adjusted retained surplus
This is the surplus excluding impairment charges against which the Trust's financial performance is judged (see 'statement of comprehensive income' of the accounts)

Employee benefits
Includes all pay expenditure

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

Gains on revaluations
Gains made due to the revaluation of assets

IFRS
International Financial Reporting Standards

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

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

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

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

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

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

Payables
Monies owed by the Trust as at 31 March 2015

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

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

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

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

Receivables
Monies owed to the Trust as at 31 March 2015

Retained earnings
The value of the cumulative income and expenditure deficit

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

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

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

The financial statements included in this annual report are a summary of the information in the full financial accounts, which are available on request from:
Finance directorate
Imperial College Healthcare NHS Trust
Salton House
St Mary's Hospital
Paddington
London W2 1NY
Telephone: 020 3312 7159

Appendix 2: Staff diversity profiles as at 31 March 2015

Gender – all	Headcount
Female	7,085
Male	2,969
Total	**10,054**

Gender – senior managers	Headcount
Female	211
Male	157
Total	**368**

Gender – board of directors	Headcount
Female	3
Male	9
Total	**12**

Gender – executive team	Headcount
Female	4
Male	5
Total	**9**

Age group	Headcount
16-19 years	9
20-29 years	2,030
30-39 years	2,944
40-49 years	2,693
50-59 years	1,796
60 years and over	582
Total	**10,054**

Ethnic origin	Headcount
White – British	2,933
White – Irish	326
White – any other white background	1,179
Mixed – white and black Caribbean	56
Mixed – white and black African	64
Mixed – white and Asian	64
Mixed – any other mixed background	162
Asian or Asian British – Indian	750
Asian or Asian British – Pakistani	120
Asian or Asian British – Bangladeshi	84
Asian or Asian British – any other Asian background	1,081
Black or black British – Caribbean	372
Black or black British – African	852
Black or black British – Any other black background	480
Chinese	165
Any other ethnic group	529
Undefined	401
Not stated	436
Total	**10,054**

Appendix 3: Internal audit reports issued 2014/15

Review	Comment
Duplicate payments	Substantial assurance
Pharmacy/medicines management	Substantial assurance
Payroll	Substantial assurance
Commissioning and SLAs	Reasonable assurance
Theatres procedures	Reasonable assurance
Estates – medical devices (quarter 1/2)	Reasonable assurance
Sharps reporting	Reasonable assurance
Infection control	Reasonable assurance
CQC inspection support (quarter 2/3) – EoL	Reasonable assurance
CQC inspection support (quarter 2/3) – OP	Reasonable assurance
Financial policies and procedures	Reasonable assurance
General ledger and feeders	Substantial assurance
Income and debtors	Substantial assurance
Estates – operational review	Reasonable assurance
Research	Substantial assurance
Stock control	Substantial assurance
Human resources	Substantial assurance
Temporary staffing	Limited assurance
Statutory and mandatory training	Reasonable assurance
Policy development/compliance	Reasonable assurance
Education	Reasonable assurance
Bank and treasury	Substantial assurance
Capital asset accounting	Substantial assurance
Risk management	Reasonable assurance
Validation of Imperial College staff related recharges	Limited assurance
Information governance toolkit return and compliance part 2	Substantial assurance
Informatics – access controls (active directory)	Reasonable assurance
Informatics – registration authority	Limited assurance
Informatics key performance indicators	
Mixed sex 10 days	Substantial assurance
Dementia 10 days	Substantial assurance
Cerner post implementation review – stage 2	Reasonable assurance
IT capital projects governance	Reasonable assurance
Applications lifecycle	Reasonable assurance

Appendix 4: Directors' register of interests

Sir Richard Sykes, chairman
- Chairman, Royal Institution of Great Britain
- Chairman, Careers Research Advisory Centre since 2008
- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Chancellor, Brunel University
- Non-executive chairman, NetScientific

Sir Gerald Acher, non-executive director
- Chairman, Littlefox Communications Ltd
- Deputy chairman , Camelot UK Lotteries Ltd
- President, Young Epilepsy
- Trustee, KPMG Foundation
- Trustee, Motability 10 Anniversary Trust
- Vice chairman, Motability

Dr Rodney Eastwood, non-executive director
- Visiting fellow, Faculty of Medicine of Imperial College
- Governor, Chelsea Academy (a secondary school)
- Consultant, Mazars
- Trustee, London School of ESCP Europe (a pan-European Business School)
- Member, editorial advisory board of HE publication
- Member of the board of trustees, RAF Museum
- Chairman, audit committee, Society of Biology

Jeremy M Isaacs, non-executive director
- Director, Food Freshness Technology Holdings Ltd
- Director, JRJ Group Ltd
- Director, JRJ Investments Ltd
- Director, JRJ Jersey Ltd
- Director, JRJ Team General Partner Ltd
- Director, Kytos Ltd
- Director, Support Trustee Ltd
- Director/NED chairman, Marex Spectron Group Ltd
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust

Professor Sir Anthony Newman-Taylor, non-executive director
- Chairman, Colt Foundation
- Chairman, Independent Medical Expert Group, Armed Forces Compensation Scheme, MoD
- 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 London
- Member, Bevan Commission, Advisory Group to Minister of Health, Wales
- Rector's Envoy for Health, Imperial College London
- Trustee, Rayne Foundation

Sarika Patel, non-executive director
- Board member, Centrepoint
- Board member, London General Surgery
- Board member, Royal Institution of Great Britain
- Partner, Zeus Capital

Dr Andreas Raffel, non-executive director
- Member of council, Cranfield University
- Member of the international advisory board, Cranfield School of Management
- Non-executive director, Olswang LLP
- Senior adviser, Rothschild
- Trustee, Beyond Food Foundation

Dr Tracey Batten, chief executive
- Trustee, The Point of Care Foundation

Alan Goldsman, interim chief financial officer
- Director, Alan Goldsman Limited

Steve McManus, chief operating officer
- Chair, National Neurosciences Managers Forum
- COO/Director of Operations Network, Foundation Trust Network

Professor Janice Sigsworth, director of nursing
- Honorary professional appointments, King's College London, Bucks New University and Middlesex University
- Trustee, Foundation of Nursing Studies

Dr Chris Harrison, medical director
- Director, RSChime Ltd
- Non-executive director, CoFilmic Ltd
- Vice chair, London Clinical Senate Council

Appendix 5: Off-payroll engagements

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	11
Of which, the number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	4
for between two and three years at the time of reporting	2
for between three and four years at the time of reporting	1
for four or more years at the time of reporting	0

The Trust confirms all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. The Trust has contracts with limited companies and not with private individuals.
For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	11
Number of new engagements which include contractual clauses giving Imperial College Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	8
Number for whom assurance will be requested	10
Of which:	
assurance has been received	4
assurance has not been received	6
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	16

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

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

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

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Imperial College Healthcare NHS
NHS Trust

Charing Cross Hospital
Fulham Palace Road
London
W6 8RF
020 3311 1234

Hammersmith Hospital
Du Cane Rd
London
W12 0HS
020 3313 1000

Queen Charlotte's & Chelsea Hospital
Du Cane Rd
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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