

# Annual Report

2012/2013



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## //Chairman and chief executive welcome

The last year has been challenging and eventful for both the Trust and the NHS as a whole. We ensured our hospitals were ready for the London Olympic and Paralympic Games; we prepared for the implementation of the Health and Social Care Act 2012; we worked with our commissioners to shape a vision for north-west London healthcare; and we observed and reacted to the shocking findings of the Francis report.

Day-to-day we continue to make real and tangible progress, providing a solid platform for future advancements for the year ahead. Strong clinical performance and financial stability are fundamental in securing a sustainable future for our Trust and achieving Foundation Trust status.

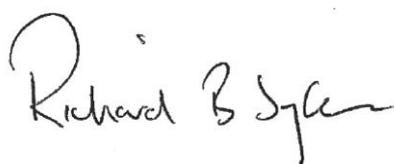
Our financial performance continues to strengthen. We achieved a year-end adjusted surplus of £9.0million<sup>1</sup> and ended the year £2.0m ahead of our cost improvement plans target. These financial successes have largely been delivered through tight cost control and our focus on cost improvement, which we will continue into the year ahead.

As an academic health science centre (AHSC), patients continue to benefit from our partnership with Imperial College London, which allows us to take the latest technology and research directly into our hospitals and communities, for example through clinical trials. This was epitomised in May 2012 by the opening of a major new Imperial College translational research facility at Hammersmith Hospital, built over four years with support from the Trust, Imperial College London, British Heart Foundation, the Medical Research Council and Wellcome Trust.

Following wide-spread consultation, a decision was taken in February by the Joint Committee of Primary Care Trusts to proceed with the *Shaping a healthier future* reconfiguration proposals put forward by NHS North West London. With our AHSC partners, Imperial College London, we welcome the proposals as good news for patients and staff.

The biggest issue currently facing the NHS is how it reacts to the recommendations from the Francis Inquiry. We are taking the report very seriously and must learn from the tragic events at Mid-Staffs. We must again review and assure ourselves that we have robust clinical governance procedures in place to deliver the highest quality of care to our patients.

Our people continue to be our biggest asset. We have personally noted the drive and commitment of colleagues across the Trust throughout this challenging year and thank them for their efforts and achievements. Working together we can build upon our progress and look ahead to a positive 2013/14 for our patients, staff and the Trust as a whole.



Sir Richard Sykes  
Chairman



Mark Davies  
Chief Executive

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<sup>1</sup> The surplus of £9.0 million is after adjusting for an impairment of £48.4 million which is a non-cash, non-operational charge mainly relating to the downward valuation of the Trust's building assets and an accounting adjustment of £0.6 million for the treatment of donated and government granted assets.

## // Overview of the year

The past year was one of the most significant in NHS history, bringing changes and challenges on an unprecedented scale. The implementation of the Health and Social Care Act radically altered the shape of healthcare in England and the landscape in which trusts such as ours operate. The creation of NHS England as the national commissioning board alongside the local Clinical Commissioning Groups changes the way in which healthcare priorities are identified and delivered – and establishes new partners that we need to work closely with in order to provide the best possible care and treatment for our patients.

The Francis report published in February, set out the full facts behind the shockingly poor care at Mid Staffordshire NHS Foundation Trust. The report also highlighted endemic failings across the healthcare system as a whole and the need for a renewed focus on patient care and respect, with greater commitment to candour and openness. Our Trust is taking the report very seriously and we are again reviewing and assuring that we have robust clinical governance procedures which are vital to delivering the highest quality of care to our patients.

At a more local level, the past year has seen the reconfiguration proposals put forward by NHS North West London through the *Shaping a Healthier Future* programme. As a Trust we support the case for change and the fundamental clinical principles – localisation, specialisation and integration. In October 2012, after carefully considering all the issues, the Trust board and the Imperial College London management board jointly decided as an academic health science centre (AHSC) to support option A as the best solution for patients.

This would mean drawing our acute services together at St Mary's Hospital, co-locating the Western Eye Hospital on the same site, and creating an enhanced, modernised A&E department. At the same time Hammersmith Hospital will focus on being a specialist hospital, whilst Queen Charlotte's & Chelsea Hospital will remain at the same site and continue to provide world class maternity and obstetrics services. Finally, Charing Cross Hospital would be developed not only as a local hospital but also with innovative walk-in and surgical services on site. We can now move forward with formulating these plans to deliver the very best and most advanced 21st century patient-focused medical care.

These plans are linked with our application for Foundation Trust (FT) status. Our application at this time reflects the significant improvement in our financial performance. We achieved a year-end adjusted surplus of £9.0million<sup>2</sup> and ended the year £2.0m ahead of our cost improvement plans target. The Trust Development Authority gave the green light for us to re-start our FT application and we are anticipating bringing forward our targeted FT authorisation date to the end of 2014. This will help us to operate more effectively on a day-to-day basis, with greater freedom to innovate and develop our services to meet the needs of our patients.

To support our FT application, and ensure the Trust's internal structure is the right shape to deliver clinical and operational excellence, we reviewed how our clinical divisions are organised during the final quarter of the year. Following consultation with staff the new organisation structure will take effect in 2013/14. We are moving to a streamlined divisional model with consistent structures, roles and responsibilities for improved centralised reporting, and aligning better to the academic structures within Imperial College and the AHSC.

The past year has also seen a number of developments at a clinical level. We continue to sustain very good performance in all our quality performance indicators, particularly venous thromboembolism assessments, infection control and stroke care, and also reported no mixed sex accommodation breaches. In November, our hyper acute stroke unit at Charing Cross Hospital was ranked first among the 150 stroke units in England in the quarterly Stroke Improvement National Audit Programme (SINAP)

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<sup>2</sup> The surplus of £9.0 million is after adjusting for an impairment of £48.4 million which is a non-cash, non-operational charge mainly relating to the downward valuation of the Trust's building assets and an accounting adjustment of £0.6 million for the treatment of donated and government granted assets.

report produced by the Royal College of Physicians. The way we record patient information and adhere to our clinical policies was assessed in August by the NHS Litigation Authority (NHSLA). We received excellent results passing 48 out of 50 standards earning us the highest rating – level three.

Throughout the year we continued to gauge the experience of patients using our I track consoles, which provide real-time patient feedback. Following the launch of the government initiated 'friends and family test' we now ask inpatients and A&E patients the additional question - 'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?' Improving patient experience continues to be a priority for the year ahead.

In spite of these important steps, we recognise that there are areas in which we need to improve. Although the Trust has continued to score well in terms of outcomes for cancer patients, our performance in terms of patient experience and waiting times, coupled with problems around data recording, were simply not acceptable.

A comprehensive cancer action plan was developed and new systems and processes put in place. We assembled a Trust-wide cancer leadership team, led by the chief operating officer, with the patient experience aspects led by the director of nursing, both supported by senior nursing and other colleagues in clinical and non-clinical roles. Since taking these steps, our cancer performance has been steadily improving month on month with a target to deliver against all eight national cancer standards by the end of the year – which we achieved in March. However, we cannot be complacent and the continued improvement of our cancer services remains a major goal for the Trust over the coming year.

In the longer term we also expect the implementation of a new patient administration system will improve data recording in the future. Throughout the year, we have been making careful preparations for the roll-out of the Cerner system which will allow us to improve data quality, patient care and our ability to recover income. It provides the opportunity to get our patient records based on a single NHS number and gives us the platform for moving towards an electronic patient record.

We continue our close partnership with Imperial College London as an AHSC to develop the tripartite mission of linking research, education and service, to improve patient care. A prime example of this could be seen in May 2012 with the official opening of the new Imperial College translational research facility at Hammersmith Hospital. This £73million centre, built over four years with support from the Trust, Imperial College London, British Heart Foundation, the Medical Research Council and Wellcome Trust, combines laboratory space for up to 450 scientists with a Trust-run facility for evaluating and developing new medical treatments through clinical trials with patients. In September, Professor David Taube, formerly the Trust's medical director, was appointed director of the AHSC - a key role that reinforces the AHSC as the organisational bridge to support innovation and change as well as research.

To equip us for a changing landscape, we have sought to add new talent to our leadership teams. In December, Professor Nick Cheshire was appointed as medical director, from his role as the Trust's clinical programme group director for circulation sciences and renal medicine. In March, Jayne Mee, an award-winning human resources specialist, joined as director of people and organisation development, and Dr Chris Harrison was appointed as deputy medical director and director of cancer and external clinical relationships. He was previously medical director at The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe.

We should also celebrate the success of our excellent clinical staff - many of whom have received national recognition over the past year - including Dr Jonathan Valabhji who, in March, was appointed by NHS England as national clinical director for obesity and diabetes. To recognise the achievements of staff and volunteers across the Trust, we continue our quarterly Outstanding Service Care and Research (OSC&Rs) awards, which culminated in May 2013 with the annual OSC&Rs awards ceremony, supported by Imperial College Healthcare Charity.

In the coming year, we will continue to put our patients first in everything we do as we continue to strive for high levels of quality care. We will work to strengthen relationships with our partners in the new NHS landscape and will listen and be responsive to our stakeholders, patients and staff.

# //About the Trust

Imperial College Healthcare NHS Trust was formed in 2007 and comprises Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye hospitals. We are one of the largest trusts in the country and in partnership with Imperial College London formed the UK's first academic health science centre (AHSC) in 2009.

We are committed to delivering world-leading clinical, acute hospital, and integrated care services and have developed a set of five values that define what we stand for as an organisation and what we expect from our staff. We will:

- ▶ **Respect** our patients and colleagues
- ▶ Encourage **innovation** in all that we do
- ▶ Provide the highest quality **care**
- ▶ Work together for the **achievement** of outstanding results
- ▶ Take **pride** in our success

Imperial College London has a campus on each of our main sites and is increasingly integrated with all our clinical specialties. The clinical sciences centre of the Medical Research Council (MRC) is also based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

The Trust is also one of eleven National Institute for Health Research (NIHR) Biomedical Research Centres. This designation is given to the most outstanding NHS and university research partnerships in the country; leaders in scientific translation and early adopters of new insights in technologies, techniques and treatments for improving health.

The advantages and benefits of partnership working for our Trust have been recognised over a long period of time. We have strong links with other biomedical research centres, AHSCs and healthcare organisations, both in the UK and internationally. We can point to several current successful collaborations including the Trust's biomedical research and patient safety work with the NIHR, our post-graduate medical education and training with other trusts in north-west London, and the Integrated Care Pilot which brings together hospitals, local councils, community and social care organisations across north-west London.

## Our objectives

### Service and research excellence

- ▶ Provide the highest quality of healthcare to the communities we serve, improving patient safety and satisfaction
- ▶ Provide world-leading specialist care in our chosen fields
- ▶ Conduct world-class research and deliver the benefits of innovation to our patients and population

### Organisational development

- ▶ Attract and retain a high-calibre workforce, offering excellence in education and professional development

### Increased efficiency and productivity

- ▶ Achieve outstanding results in all our activities

## The way we provide services

Throughout 2012/13 our clinical services continued to be organised into six clinical programme groups (CPGs), which each contain a range of specialties. Each CPG has its own management board responsible for the service and led by the CPG director. Each CPG also has a head of research and a head of education to ensure that opportunities for translational research and postgraduate education for all staff are maximised. Our infection prevention and control service operates trust-wide across all our services.

More information about CPG directors is available on our website:

[www.imperial.nhs.uk/aboutus/howweare/cpgdirectors](http://www.imperial.nhs.uk/aboutus/howweare/cpgdirectors)

### CPG1: Medicine

Director: Dr Julian Redhead

*Acute medicine, dermatology, diabetes and endocrinology, elderly medicine, emergency medicine, gastroenterology, hepatology and pancreatobiliary, human T-lymphotropic virus (HTLV), the Haven (sexual assault referral centre), HIV and genito-urinary medicine, infectious diseases, medical high dependency unit, stroke, respiratory medicine*

### CPG2: Surgery and cancer

Director: Mr Justin Vale

*Acute surgery, breast surgery, clinical oncology, endocrinological and bariatric surgery, gastrointestinal and hepatobiliary surgery, major trauma, medical oncology, palliative care, urological surgery*

### CPG3: Specialist services

Director: Dr Mark Palazzo

*Anaesthesia, critical care and theatres, ear, nose and throat (ENT), head and neck surgery, maxillofacial surgery and dentistry, medical and surgical ophthalmology, neurology and neurosurgery, orthopaedic surgery, pain medicine, plastic and reconstructive surgery, rheumatology, sports medicine*

### CPG4: Circulation sciences and renal medicine

Interim director: Dr Jamil Mayet (Professor Nick Cheshire was director until December 2012)

*Cardiology, cardiothoracic and thoracic surgery, renal medicine and transplantation, vascular medicine (including systemic rheumatology, lipid medicine and hypertension) and vascular surgery*

### CPG5: Women and children's

Director: Mr Keith Edmonds

*Paediatric, maternity, neonatology, gynaecology and reproductive medicine*

### CPG6: Clinical and investigative services

Director: Professor Martin Wilkins

*Biochemistry, clinical haematology, laboratory haematology, clinical trials, histopathology, cytology and immunology, imaging and interventional radiology, laboratory microbiology, medicines, molecular medicine and genetics, therapies*

## New structure for 2013/14

In order to ensure the Trust's internal structure is the right shape to deliver clinical and operational excellence we conducted a review in the final quarter of 2012/13 on how our clinical divisions are organised. Following consultation with staff on the new structure the changes to our organisation are scheduled to take effect in the 2013/14 financial year. We are moving to a streamlined divisional model with consistent structures, roles and responsibilities for improved centralised reporting, and aligning better to the academic structures within Imperial College and the AHSC.

## Imperial Private Healthcare

We offer the choice of private healthcare within dedicated units at the Trust. This offers world-class consultant-led care and provides the peace of mind to patients who choose to be seen privately, that they have access to a whole range of services including critical care, coronary care, state-of-the-art diagnostics and specialist operating theatres, 24 hours a day, 365 days a year. We welcome UK insured, self-paying and international patients.

Following an extensive refurbishment, the Lindo Wing at St Mary's Hospital re-opened in June 2012 and now provides the highest quality of care for surgical, medical and obstetric patients.

Our private healthcare service is an important source of revenue to the Trust which is re-invested into NHS services within our hospitals.

# //Our performance against agreed targets

## Our performance highlights 2012/13

Our focus on quality has brought benefits to patients with performance indicators demonstrating that the Trust is maintaining and improving its performance in a range of areas. The sum of these efforts regarding clinical performance is reflected in our mortality rates, which are amongst the lowest in the country, as evidenced in the fact we are in the top 20 performing trusts for Summary Hospital-Level Mortality Indicator (SHMI) ratios. The national average is calculated at 100 (the number of patients expected to die at a trust following hospitalisation) and the Trust was substantially below this at 75.8 in the latest Health and Social Care Information Centre report covering the period between October 2011 and September 2012.

There are some areas where the Trust has fallen short of the required targets or standards in 2012/13 which require particular attention in the year ahead to improve performance.

## Emergency departments

The Trust's emergency departments at Charing Cross, Hammersmith and St Mary's hospitals consist of both accident and emergency (A&E), and urgent care centres. Overall in 2012/13, our emergency departments had 280,017 attendees and 97.2 per cent of patients were treated, admitted or discharged within four hours, which is above the national target of 95 per cent.

The 2012 National Accident & Emergency Survey results were published by the Care Quality Commission on 6 December 2012. The survey is based on 246 patients who attended our A&E departments in March 2012 out of 850 patients that were sent the questionnaire. This equates to a response rate of 30 per cent. The results of the survey rated the Trust fourth equal among London trusts and fifth equal when benchmarked against 22 other teaching trusts nationally.

Key achievements in 2012/13 to reduce the number of non-elective admissions and A&E attendances include:

- ▶ Ambulatory care pathways being reviewed with pathways now in place for renal colic, deep vein thrombosis (DVT) and cellulitis
- ▶ Recurring admissions patient alerts link developed for chronic obstructive pulmonary disease (COPD) patients which will alert in hospital specialist and primary care providers when a known patient attends A&E
- ▶ As a key partner in the Inner North West London Integrated Care Pilot, the Trust has focused on individualised case management and fully integrated care between primary and secondary care providers for frail elderly and diabetic patients, and to date has dedicated over 350 hours of consultant time to the pilot
- ▶ Data sharing project with London Ambulance Service and Westminster GPs on real time A&E attends
- ▶ A link to allow electronic submission of A&E GP letters is now in place

Priorities in 2013/14 include:

- ▶ Maintaining the delivery of the performance targets and achieving 95 per cent target for patients being treated, admitted or discharged within four hours across all sites
- ▶ Confirming the baselines for the ambulatory care quality indicators for cellulitis and DVT and agreeing with NHS England in the first quarter of the year a trajectory for improvement throughout the year
- ▶ Further development of ambulatory care pathways for the other conditions set out by the Department of Health and College of Emergency Medicine that will provide alternative pathways to admission

- ▶ Further work to improve the performance against the timeliness quality indicators, particularly time in department for admitted patients and time to treatment
- ▶ Work with our community partners to reduce re-admissions and re-attends to our emergency departments
- ▶ Gathering feedback from A&E patients against the 'friends and family' test, which asks patients if they would recommend our facilities to friends or family members. This has now been incorporated into our real time 'I track' electronic devices that are used by patients to provide feedback on their experience

## Infection control

Compared with 2011/12, there has been a reduction in the number of Methicillin resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C.difficile*) cases in the Trust.

The number of patients who acquired an MRSA blood stream infection (BSI) in the Trust has fallen from 13 patients in 2011/12 to eight in 2012/13, against a target of nine cases for the year. The number of cases of MRSA BSI, as a rate of patients admitted to our hospitals is 1.69 cases per 100,000 bed days (using bed days data 2011-12, supplied by the Health Protection Agency).

Over the last five years there has been a significant reduction in the number of patients acquiring *C. difficile*. In 2012/13 the number of cases fell from 143 in the previous year to 86, against a target of 110. The number of cases of *C. difficile*, as a rate of patients admitted to our hospitals, is 2.02 cases per 10,000 bed days (using bed days data 2011-12, supplied by the Health Protection Agency).

Successful initiatives to reduce infection rates in 2012/13 include:

### MRSA

We continue to deliver our infection prevention and control competency based assessment programme for the insertion of intravenous devices in order to minimise infection. Standard packs for intravenous devices are in routine use so that staff can easily access everything that is required to insert the devices and minimise infection risks. We have introduced competency based training in how to take blood culture samples from patients and how to reduce the risk of contamination of the cultures while doing this. We have also introduced training to minimise any issues which could impact on the quality of testing from these samples helping us to make a correct diagnosis and provide the correct treatment.

### *C.difficile*

In collaboration with the pharmacy department, we continue to promote best practice in responsible effective prescribing and reviewed practice at clinical ward level to identify any areas for further training. We developed a new role and have recruited the Trust's first consultant antimicrobial pharmacist. In the autumn of 2012, we launched the 'Start Smart Then Focus' initiative, a national campaign to support effective management of patients requiring antibiotic treatment. We have also developed and implemented a smart phone application to enable doctors to effectively and safely prescribe antimicrobials.

We also continued to undertake mandatory reporting of Methicillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E.coli*) cases and have extended our surveillance programme for surgical site infections to more surgical specialties.

We have successfully implemented the Safety Thermometer (Harm Free Care) elements related to our service (reducing both catheter associated urinary tract infections and pressure ulcers). This means that we have achieved our CQUIN target for the collection of this data.

Statistics for infection control are provided against a backdrop of 111,023 completed MRSA screenings; 64,620 hand hygiene observations; 21,130 blood cultures taken and 8,636 stool specimens tested for the *C.difficile* toxin.

During the last year we successfully opened and established centralised endoscope reprocessing units for improved decontamination practices at Charing Cross and Hammersmith hospitals.

Progress will continue during 2013/14 through delivering and sustaining the infection prevention and control improvement plan and we will continue to monitor performance through our monthly internal performance reviews, the Trust infection prevention committee and the Trust board.

Priorities for 2013/14 include:

- ▶ Continuing to monitor and reduce the number of MRSA and *C.difficile* cases
- ▶ Continuing to deliver and sustain the infection prevention and control practice and the aseptic non-touch technique programme across the organisation
- ▶ To develop and establish a centralised endoscope reprocessing unit for improved decontamination practices at St Mary's Hospital
- ▶ Focussing on monitoring and reducing the number of MSSA and E coli cases
- ▶ Developing innovative practices for controlling and preventing healthcare acquired infections by collaborative working with the National Centre for Infection Prevention Management

### Antibiotic stewardship

Our aim is to prescribe anti-infective medication such as antibiotics safely and effectively to minimise the risks they can pose to developing healthcare acquired infections. Careful management of antibiotics remains a high priority for the Trust and is critical in optimising the clinical management of infections, as well as reducing the risk of antibiotic resistance and *C.difficile*.

Our key focus throughout the year was on areas where we felt we could do better. We set the following targets for antibiotic prescriptions in 2012/13:

- ▶ 90 per cent of prescriptions to have a reason for starting the antibiotic clearly documented within the patient's medical notes/drug chart
- ▶ 90 per cent of prescriptions to have a stop or review date on the drug chart, to minimise patients taking them for longer periods than clinically necessary
- ▶ 90 per cent of prescriptions to be prescribed in line with the Trust antibiotic policy or approved by specialists from our infection teams

We made significant progress overall:

- ▶ 91 per cent of our antibiotic prescriptions had a documented reason for starting anti-infective medication
- ▶ 74 per cent of prescriptions had a documented stop or review date. This fell short of the target but was an increase from 38 per cent in 2011/12
- ▶ 91 per cent of prescriptions were prescribed in line with the Trust antibiotic policy or approved by an infection specialist

### Infection control education and research

The Trust has continued to work closely with the National Centre for Infection Prevention and Management (CIPM), a UK Clinical Research Collaboration (UKCRC) funded initiative bringing together Imperial College London, the Trust and Public Health England, to tackle the challenge of infection and antimicrobial resistance (AMR) through a multidisciplinary programme of research and education.

In 2012/13 two successful research awards have been granted to build on the success of the smart phone application for antibiotic prescribing. These include the 'enhanced prescribing through case based reasoning' smartphone app and the 'cross-sector point of care' smartphone application to optimise antibiotic prescribing. Both involve close collaboration with the Trust and in particular the antibiotic review group, the latter is a collaboration with the Imperial College London Faculty of Engineering, while the former will involve primary care and HPA Scotland.

CIPM was successful in securing a Biomedical Research Centre (BRC) Clinical Research Fellowship which will also involve close working with the Trust and was fundamental to a successful application to the Health Foundation for an infection surveillance project which will use NHS sickness absence data to develop syndromic surveillance. The centre has also been awarded a further Health Foundation grant 'Spotlight on HCAI', and a Tropical Health and Education Trust grant 'Reducing neonatal mortality and maternal and paediatric infection through improved patient safety'.

During the year, CIPM hosted the first joint UKCRC Translational Infection Research Initiative Symposium which saw members of other UKCRC centres at St George's and Cambridge come together for a day event at Hammersmith Hospital.

## **18 week referral to treatment time target and waiting times for cancer and diagnostics**

In January 2012 the Trust board took the rare step of approving a reporting break for data relating to the 18 week referral to treatment (RTT) time target and waiting times for cancer including two week waits and diagnostics. This decision was taken after reviews of the administration of waiting lists conducted by the NHS Intensive Support Team and Trust staff identified anomalies in the data. This included patients recorded as waiting that had already been treated, patients who may have still been waiting for treatment and duplicate entries of individual patients. The temporary break allowed time to establish new robust systems and processes that enable everyone to have confidence in the data.

An independent waiting list clinical review group was established to conduct an extensive patient level review of whether any harm had occurred in identified groups of patients. The waiting list clinical review group developed the framework for the review and is confident to report that no patient was identified as suffering harm due to a delay in treatment.

Following the reporting break, a number of actions were agreed after the publication of the recommendations from the NHS Intensive Support Team, recommendations from the waiting list clinical review, recommendations from the external governance review (Hannifin, Sept 2012) and recommendations from the Deloitte review (March, 2012). These actions were managed through the Trust Elective Access Programme and reported to the Trust board. The majority of these actions have now been completed although some are still on-going such as development of a long term approach of delivering training to staff on the referral to treatment targets.

Alongside the clinical review, the reporting systems used within the Trust were rebuilt to accurately reflect patient waiting times. Following positive assurance from the NHS Intensive Support Team, reporting for cancer including two week waits, and diagnostics recommenced in June 2012 and for the 18 week referral to treatment (RTT) time target in July 2012.

Since reporting resumed the Trust has:

- ▶ Met the six week diagnostic test each month (since June 2012)
- ▶ Steadily improved performance against the eight national cancer targets, from achieving just three of the eight targets in June 2012, to all eight of the targets in March 2013
- ▶ Improved RTT performance from July to November 2012 when all three standards (admitted performance, non-admitted performance and incompletes) were achieved at aggregate Trust level. Since November these standards have been achieved by an increasing number of specialties (as well as at Trust level) and by March, all but four specialties were achieving these standards. Work is continuing in these areas to ensure all standards are consistently being met as early as possible

The Trust has taken a number of steps in 2012/13 to improve its cancer performance as a whole, these include:

- ▶ Establishing a Trust-wide cancer leadership team, which continues to work with staff to improve patient experience and performance. The team is led by the chief operating officer, with the patient experience aspects led by the director of nursing, both supported by senior nursing and other colleagues in clinical and non-clinical roles
- ▶ Further strengthening the cancer leadership team with the appointment of Dr Chris Harrison in March 2013 as deputy medical director and director of cancer and external clinical relationships. Dr Harrison was previously medical director at The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe
- ▶ Holding a continuing series of workshops to be held every 100 days bringing staff working on cancer care together to share good practice and update on progress
- ▶ Setting nine core cancer action plan activities, along with specific activities for each cancer team
- ▶ Launching a 'Cancer Brief' document, which is circulated to staff involved in cancer care every two months to update them on progress and the latest initiatives

## Venous thromboembolism risk assessment

The Trust recognises the seriousness of venous thromboembolism (VTE) and we continue to work across the organisation to reduce this risk to our patients.

To tackle this problem, NICE has published clinical guideline 92 '*venous thromboembolism - reducing the risk*' and clinical guideline 144 '*venous thromboembolic diseases*'. The Department of Health framework '*commissioning for quality and innovations*' links the uptake of risk assessment with payments.

In August 2012, VTE performance against NICE guidance was audited as part of the overall assessment undertaken by the NHS Litigation Authority (NHSLA). The Trust successfully achieved level three compliance (further details of the NHSLA assessment are below). As per NHSLA requirements, the current Trust VTE guidelines are being reviewed and updated to create a single document based around the NICE pathways for VTE.

The Trust has satisfied the 2012/13 CQUIN VTE target achieving more than 90 per cent assessment of VTE risk for all patients within 24 hours of admission to hospital. This target has been attained by weekly audits of individual ward and CPG rates of VTE assessment. We have made a major investment of time and resource to bring underperforming areas up to target. For example, maternity rates above 90 per cent have now been achieved. Our VTE data is reported monthly and uploaded via UNIFY2, the Department of Health's performance data collection system.

VTE has also been part of the NHS Safety Thermometer for 2012/13 and this monthly spot audit has repeatedly demonstrated high levels of harm-free care.

There will be two new VTE-related CQUIN indicators for 2013/14:

- ▶ Proportion of all adult inpatients that have had a VTE risk assessment on admission to hospital, using the clinical criteria of the national tool (threshold >95 per cent)
- ▶ Number of root cause analyses on confirmed cases of pulmonary embolism or deep vein thrombosis

The VTE clinical lead and task force group spearhead our VTE performance across the Trust and report to clinical chiefs of service, our network of VTE champions and the clinical standards group.

## Performance indicators 2012/13

The table below sets out the Trust's national and local indicators performance managed during 2012/13. Data is for the full year except where indicated. These are based on standard NHS calculations.

Performance indicator	Threshold 2012/13	Trust performance 2012/13	Trust performance 2011/12
<b>Quality</b>			
<b>Mortality:</b>			
Summary Hospital-Level Mortality Indicator (SHMI) ratios <sup>3</sup>	n/a	75.8 against national average of 100 (latest published figure for October 2011-September 2012 period)	Not reported in 2011/12 annual report (reported as 70 for Hospital Standardised Mortality Rate)
<b>Infection prevention and control:</b>			
MRSA Bloodstream Infection Bacteraemias	<9 cases	8 cases	13 cases
<i>C.difficile</i> Post 72 Hours	<110 cases	86 cases	142 cases
<b>Eliminating mixed sex accommodation:</b>			
Elimination of mixed-sex accommodation, except when it is clearly in the patient's overall best interests, or reflects their personal choice	0 cases	0 cases	99.9%
<b>Stroke care:</b>			
Patients with high risk of stroke who experience a TIA are assessed and treated within 24 hours	>60%	99.5%	98%
Patients who spend at least 90% of their time in hospital on a stroke unit	>90%	99.4%	99.8%
<b>Venous thromboembolism:</b>			
All adult inpatients who have had a venous thromboembolism risk assessment to reduce avoidable death, disability and chronic ill health from venous thromboembolism	>90%	91.2%	83.5%
<b>Research and development</b>			
Raise the proportion of patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%	≥1%	21% (Q3 – this is the most recent data available)	Not reported in 2011/12 annual report
<b>Safety Thermometer</b>			
Harm free care	-	96.7%	Not reported in 2011/12 annual report
<b>Operations</b>			
<b>Accident and emergency – four hour maximum waiting time:<sup>4</sup></b>			
Trust – all types (1, 2 & 3)	>95%	97.2%	97.9%
Hammersmith Hospital		97.9%	
Charing Cross Hospital		97.4%	
St Mary's Hospital		96.9%	
Trust – Type 1	>95%	94.6%	95.8%
Hammersmith Hospital		95.0%	96.6%
Charing Cross Hospital		93.7%	94.3%
St Mary's Hospital		94.8%	96.2%

<sup>3</sup> Also see performance highlights on page 10

<sup>4</sup> Also see emergency departments section on page 10

Performance indicator	Threshold 2012/13	Trust performance 2012/13	Trust performance 2011/12
LAS patient handover - within 60 mins	100%	99.99%	100%
LAS patient handover - within 30 mins	>95%	98.85%	97.3%
LAS patient handover - within 15 mins	>85%	94.56%	90.4%
LAS patient breaches handover - >60 mins	0 cases	3 cases	4 cases
<b>Accident and emergency – clinical quality indicators:</b>			
<b>Unplanned re-attendance rate within seven days<sup>5</sup></b>	<5%		
Hammersmith Hospital		6.71%	5.13%
Charing Cross Hospital		7.43%	3.32%
St Mary's Hospital		6.42%	0.74%
<b>Left department without treatment</b>	<5%		
Hammersmith Hospital		0.98%	0.35%
Charing Cross Hospital		1.6%	0.61%
St Mary's Hospital		3.97%	3.96%
<b>Time to initial assessment – ambulance cases (95<sup>th</sup> percentile)</b>	<15 mins		
Hammersmith Hospital		15 mins	21 mins
Charing Cross Hospital		18 mins	21 mins
St Mary's Hospital		27 mins	20 mins
<b>Time to treatment in department (median)</b>	<60 mins		
Hammersmith Hospital		58 mins	42 mins
Charing Cross Hospital		58 mins	37 mins
St Mary's Hospital		75 mins	68 mins
<b>Cancer<sup>6</sup></b>			
All cancer two week wait	93%	93.8%	Not reported in 2011/12 annual report
Two week GP referral to first outpatient - breast symptoms	93%	94.5%	

<sup>5</sup> The main drivers for A&E re- attends include paediatric patients, homeless people and patients with alcohol or mental health problems. We are working with our community partners to identify alternative facilities for some of these patients. Systems integration was undertaken in 2011-12 to produce an integrated dashboard and enable reporting on A&E CQIs, which began part way through 2011/2012.

<sup>6</sup> Cancer and RTT data is for month 12 only as full year data is unavailable due to the Trust's reporting break. Also see 18 week referral to treatment time target and waiting times for cancer and diagnostics on page 13.

Performance indicator	Threshold 2012/13	Trust performance 2012/13	Trust performance 2011/12
First definitive treatment within one month (31 days) of a cancer diagnosis	96%	98.2%	
31 day standard to subsequent cancer treatments - surgery	94%	94.5%	
31 day second or subsequent treatment - drug	98%	98.4%	
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment - radiotherapy treatment	94%	98.8%	
All cancer two month urgent referral to treatment wait	85%	86.1%	
62-day wait for first treatment following referral from an NHS cancer screening service	90%	100%	
<b>Referral to treatment</b>			
Admitted clock stops within 18 weeks	90%	91.17%	Not reported in 2011/12 annual report
Non-admitted clock stops within 18 weeks	95%	97.02%	
Incomplete pathways within 18 weeks	92%	95.04%	
<b>Elective access – diagnostics</b>			
Patients waiting six weeks or more for a diagnostic test	<1%	0.08%	Not reported in 2011/12 annual report
<b>Maternity</b>			
Women who have seen a midwife by 12 weeks and 6 days of pregnancy who were referred on time	>90%	96.18%	94.4%
<b>Delayed transfer of care</b>			
Average number of acute adult patients per day whose transfer of care was delayed	3.5%	1.74%	Not reported in 2011/12 annual report
<b>Quality, innovation, productivity and prevention</b>			
Average elective length of stay	<3.4 days	3.3 days	3.4 days
Average non-elective length of stay	<4.5 days	4.4 days	4.7 days
Day case rate <sup>7</sup>	>80%	76.3%	75.9%
New to follow up outpatient ratio	<1.67	2.41	2.39
Theatre utilisation rate	>81%	78.9%	77.8%
<b>Workforce</b>			
Bank and agency spend as percentage of paybill (12 month rolling)	<7%	7.76%	8.9%
Vacancy rate	<7%	9.77%	12.1%
<b>Turnover rate (year end)</b>	<9%	10.28%	8%
<b>Sickness rate (12 month rolling)</b>	<3.4%	3.57%	3.5%
<b>Staff appraisal rate</b>	>85%		
Non-medical staff		82.29%	66%
Consultants		66.67%	54.3%
<b>Statutory and mandatory training</b>	>95%	79.43%	54%

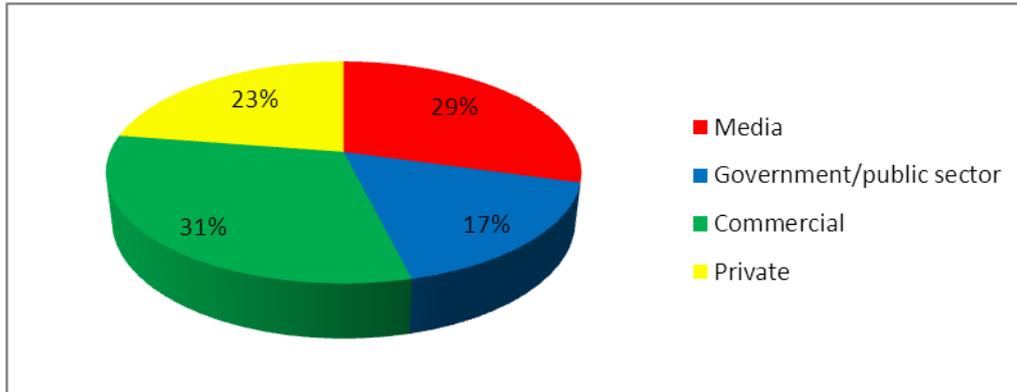
<sup>7</sup> The day case rate shows the percentage of recent operations that were carried out as day cases.

## Freedom of information requests

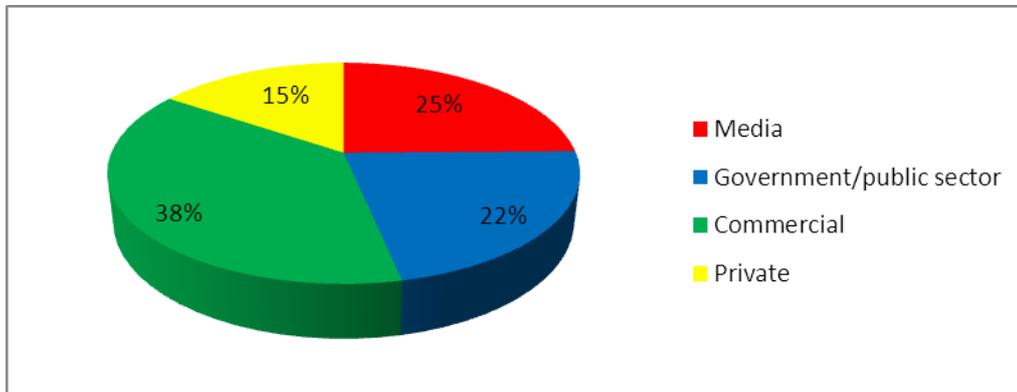
The Freedom of Information (FOI) Act 2000 is part of the government’s commitment to greater openness in the public sector. The Act aims to support the development of a new culture of openness in the NHS. NHS organisations are required to provide a response to an FOI request within 20 working days, unless the request is exempt, in which case this must be explained.

Number of FOI requests	2012/13	2011/12
Total	454	452

### FOI request sources 2011/12



### FOI request sources 2012/13



## External reviews

### The NHS Litigation Authority (NHSLA)

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

These standards are very important because they provide the Trust with the infrastructure to further improve patient safety, help us develop a highly competent and capable workforce, and ensure that we have the best environment possible for patients and staff across all areas of the organisation. The standards are specifically developed to reflect issues that arise in the negligence claims reported to the NHSLA and include aspects of care such as blood transfusion, consent to treatment and hand hygiene, as well as the safety and security of our buildings, corporate and local induction, and how we learn from incidents, complaints and claims.

The NHSLA standards contain 50 criteria that are updated each year. Following the NHSLA's assessment of our acute services in August 2012, the Trust received excellent results passing 48 out of 50 standards earning us the highest rating – level three. The Trust was also assessed for maternity services provided at St Mary's and Queen Charlotte's & Chelsea hospitals - and gained level three status, meeting 46 of the 50 standards.

## Care Quality Commission (CQC)

All health and social care services in England are required to register with the Care Quality Commission (CQC). The Trust is currently registered 'without conditions' to provide services at the following sites:

Five main sites:

- ▶ Charing Cross Hospital
- ▶ Hammersmith Hospital
- ▶ Queen Charlotte's & Chelsea Hospital
- ▶ St Mary's Hospital
- ▶ Western Eye Hospital

Seven renal satellite units:

- ▶ Brent Renal Centre
- ▶ Ealing Renal Satellite Unit
- ▶ Hayes Renal Centre
- ▶ Northwick Park Renal Centre
- ▶ St Charles & Hammersmith Renal Centre
- ▶ Watford Renal Centre
- ▶ West Middlesex Renal Centre

The Trust conducts leadership walk rounds as a bi-monthly programme to review each hospital site against the essential CQC standards. These walk rounds have helped us to identify any training and actions required to meet the standards and have been positively received by all areas visited.

The Trust is subject to periodic reviews by the CQC, the last of which was during January 2013 at St Charles & Hammersmith renal satellite units. The CQC's assessment of the Trust following that review was that the satellite units were meeting all the essential standards of quality and safety reviewed.

The satellite units were reviewed against Outcome 1 – respecting and involving people who use the services, Outcome 4 – care and welfare of people who use the services, Outcome 8 – cleanliness and infection control, Outcome 13 – staffing, and Outcome 17 – complaints. We were found to be fully compliant in meeting the standards expected of us. They found the units they inspected to be clean and that the Trust had the correct systems in place to prevent and control the risk of infection. The report highlights the positive patient experience, with patient's giving examples of how they felt involved in their own care and how clean the environment was.

The Trust had a further three planned inspections at Western Eye, Hammersmith and Queen Charlotte's & Chelsea hospitals. We were found to be compliant with all of the essential standards reviewed.

In addition, a responsive review was undertaken at St Mary's Hospital and a follow-up national dignity and nutrition inspection at Charing Cross Hospital.

Over the past year, the CQC has visited all of the Trust's main sites and two renal satellite units and has assessed the Trust against all of the essential standards of care. All of the sites inspected were found to be compliant, in line with the Trust's own compliance submission. There are no outstanding actions.

## Emergency preparedness

The Trust's emergency plans were once again assessed as 'green', the highest level, by NHS London in 2012. This was despite the unique challenges for emergency planning posed by London hosting the world's largest sporting event, the London 2012 Olympic and Paralympic Games. Led by our Olympic task and finish group, we began planning for the Games in June 2011, to ensure the Trust:

- ▶ met the NHS Bid Commitment to the Games
- ▶ continued to provide business as usual for staff, patients, services, and suppliers
- ▶ met additional pressures during the Games

This work was tested with a table top exercise and highlighted as best practise by NHS London. Staff engagement with the plans and enthusiasm for Olympic planning resulted in a very successful Olympics for the Trust and London as a whole. A number of legacy changes have since been made within the Trust in light of learning from the Olympics.

A prolonged winter, including the wettest December in 15 years and the coldest March since 1962 resulted in capacity issues across north-west London, compounded by sporadic norovirus outbreaks. Although it was a difficult winter for the Trust, forward planning and a table top exercise minimised the impact.

For 2013/14 the emergency planning team will focus on the following:

- ▶ Working with ICT to support the implementation of Cerner, the new patient administration system
- ▶ Trust-wide working to support business continuity during the restructure of the Trust's clinical divisions
- ▶ Preparing for major summer events that will impact on the Trust, including the new Prudential RideLondon cycle race

## Patient quality and safety initiatives

### Falls

It is important that we do everything that we can to reduce the number of slips, trips and falls in our hospitals. This is not always possible, in particular where patients are regaining their mobility, but the objective is always to minimise the risk as much as possible and reduce harm.

We have continued to remain below the national reported falls average of 5.6 per 1,000 bed days. There were no falls resulting in severe harm, meeting the target of less than nine cases per year.

The National Health Service Litigation Authority (NHSLA) assessment included falls risk assessments and observed that appropriate care plans were in place to reduce the risk of falls. We were found to be compliant with this standard.

We aim to continue to improve our falls performance using nursing forums to promote best practice and monitoring falls by number, type, severity of harm and location to learn from them and share information with clinical teams. We review our compliance with our falls care bundle through our 'back to floor Friday' audit schedule and have achieved 90 per cent compliance. Falls are also included as a national reporting requirement for Quality Accounts 2013/14 and is one of the four priorities within a new national initiative called the 'Safety Thermometer'<sup>8</sup>.

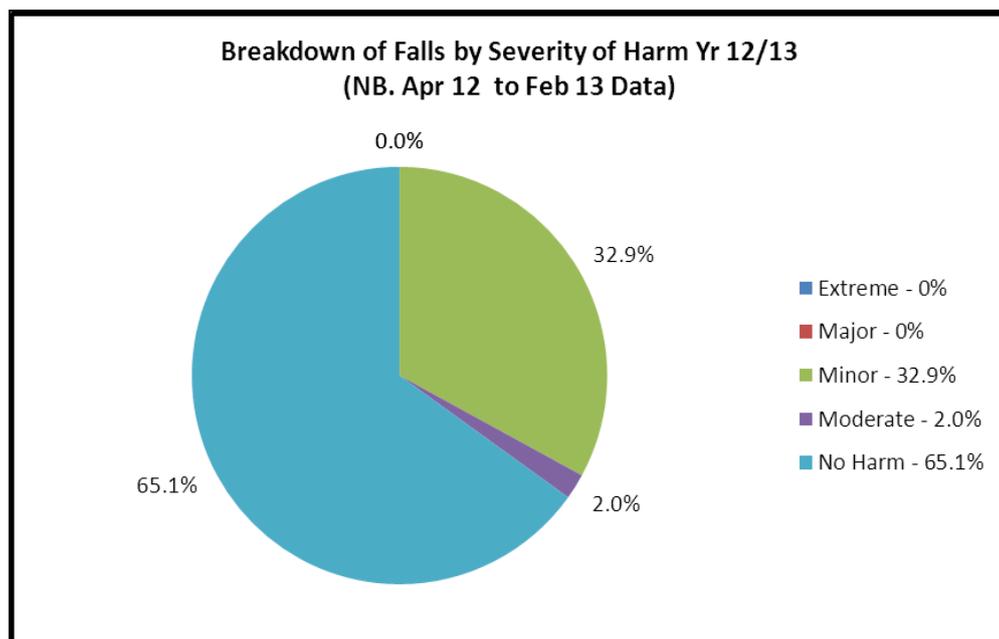
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<sup>8</sup> The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care

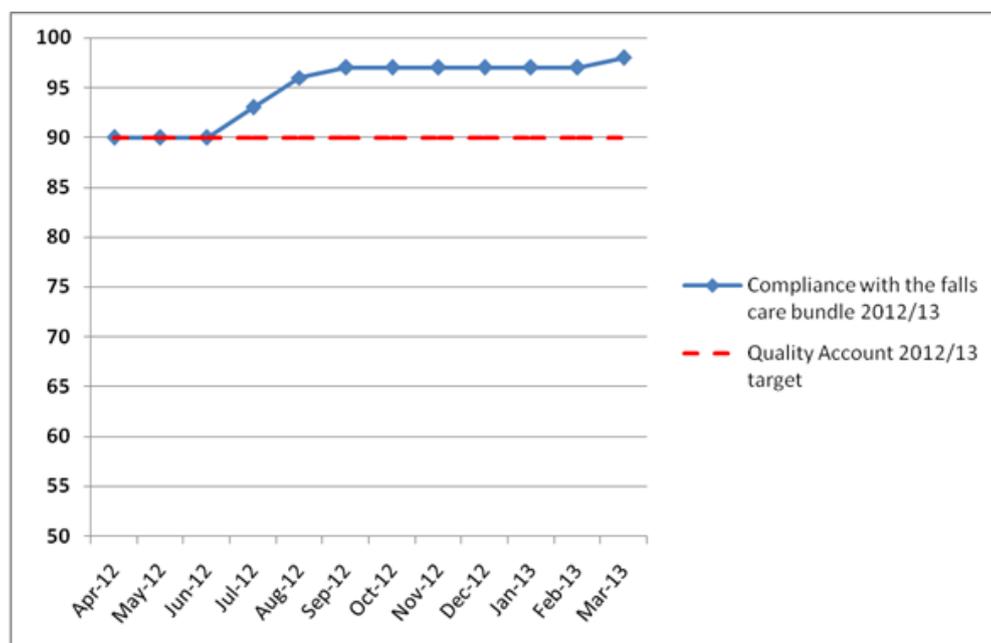
## Falls results 2012/13

Indicator	Q1	Q2	Q3	Q4	Target
Remain below the national average of reported falls	3.98	3.65	3.54	3.75	Below 5.6 per 1,000 bed days
To reduce the number of patient falls that result in severe harm	0	0	0	0	<9 cases

## Falls by severity of harm 2012/13



## 2012/13 Compliance with falls care bundle<sup>9</sup> against the 90 per cent target



<sup>9</sup> The falls care bundle comprises a risk assessment that takes place within 24 hours of a patient's admission to hospital. Any patient triggering and deemed at risk will generate a more detailed assessment.

## Learning from adverse events<sup>10</sup>

An important measure of an organisation's safety culture is its willingness to report adverse events, learn from them and deliver improved care.

During 2012/13 the Trust has been engaging in a number of activities to support this priority:

- ▶ Meetings with CPG based quality and safety coordinators to facilitate improvement in reporting and encourage feedback to all staff on key themes and trends
- ▶ Ensuring that all staff receive appropriate training in use of the Datix<sup>11</sup> system and are encouraged to report
- ▶ Ensuring each ward has incident reporting and learning from incidents on their ward meeting agendas as well as their CPG quality and safety meeting agendas
- ▶ Using incident reporting information to investigate links with failure to rescue
- ▶ Promoting the benefits of incident reporting at all training sessions (corporate governance, Datix, medics, local training, etc.)
- ▶ Linking incident trends and themes to service improvement
- ▶ Monitoring level of staffing incidents and acting in a timely manner to address areas of concern
- ▶ Using incident reporting data to drive quality improvement, for example, falls and medication incidents

During the year the Trust's figures show that the number of incidents resulting in major harm has remained low when compared to national benchmark data. The risk and patient safety team continues to support clinical staff in this area.

The Trust has built on previous work with a number of initiatives:

- ▶ Launch of the SBAR<sup>12</sup> reporting process for escalation of patients
- ▶ Launch of the new national early warning reporting system for the monitoring of at risk patients
- ▶ Review of the Trust transfer policy following a number of incidents relating to the movement of patients around the various sites
- ▶ Thorough and robust action plans following retained swab never events
- ▶ Review of patient identification and failure to rescue incidents at the Trust clinical risk committee

## Complaints

Complaints and feedback about our patients' experience continue to provide a rich source of data for the Trust describing the experience of patients, their relatives and friends. Learning is shared so that we improve our services and to help ensure we continue to put the patient at the centre of everything we do.

During 2012/13 the central complaints team continued to work closely with our patient advice and liaison services (PALS). The Trust investigated 838 formal complaints, 93 per cent of which were provided within the timescale agreed by the patient. PALS dealt with 3,678 informal concerns in the year.

The Trust recognises that the landscape for complaint management is changing fast. Last year we decided to strengthen the management of the central complaints team so that we could start to implement the complaint recommendations set out in the Francis report. This will help us move forward so that we can strengthen our ties with our stakeholders and more importantly review how we learn from complaints.

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<sup>10</sup> Also see annual governance statement, page 49

<sup>11</sup> Datix is a web-based system for incident reporting

<sup>12</sup> SBAR stands for: Situation, Background, Assessment, Recommendation, and is a technique used for prompt and appropriate communication in healthcare organisations

## Quality accounts

### What are quality accounts?

The quality accounts are annual reports to the public from providers of NHS healthcare about the quality of the services they deliver. The primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide.

We are committed to continually improving the quality of the services we provide to our patients and our quality accounts are a report of:

- ▶ How well we are doing against the targets we are set by the Department of Health, our local primary care trusts (PCTs) and their successor organisations, and those we set ourselves as an organisation
- ▶ How well we are doing when compared to similar healthcare providers
- ▶ Where we need to focus to improve the quality of the services we provide
- ▶ Our priorities for the coming year (2013/14)

### How did we decide on our priorities?

Our priorities were developed in consultation with senior clinical and management staff across each of the Trust service delivery areas: patients, members of the public, shadow foundation trust members, Local Involvement Network (LINKs), PCTs and council overview and scrutiny committees.

A wide consultation took place with Trust staff and key stakeholders in February 2013 to develop and agree the Trust priorities for inclusion in the quality accounts. The priority areas were proposed based on national and local targets and Trust improvement priorities were based on incident rates and performance.

Progress against these priorities is measured and reported through the monthly clinical programme group (CPG) level scorecard based on the indicators from the quality accounts. This is so staff can be more involved in measuring their performance and help us to track how well we are doing against our improvement targets. We review the scorecard at our monthly quality and safety committee, quarterly at the governance committee, and exception reports go to the Trust board. Progress reports are made available on our website.

### Summary of quality priorities 2013/14

Our three priority areas are set out in the table below. Further priority improvement targets have been identified for each area:

<b>Patient safety</b>	<ul style="list-style-type: none"><li>▶ To ensure high performance against the Safety Thermometer</li><li>▶ To reduce healthcare acquired infections</li><li>▶ To be compliant with the Trust anti-infective policy</li><li>▶ To use reporting of patient safety incidents to bring about improvements in care and reducing harm</li><li>▶ To be compliant with the dementia CQUIN target</li></ul>
<b>Clinical effectiveness</b>	<ul style="list-style-type: none"><li>▶ To remain better than the national average for mortality rates as measured by the summary hospital level mortality indicator (SHMI)</li><li>▶ To reduce the number of re-admissions to hospital within 28 days of discharge</li><li>▶ To increase patient satisfaction as measured by patient reported outcome scores (PROMs)</li></ul>

<b>Patient experience</b>	<ul style="list-style-type: none"><li>▶ To improve patient satisfaction with waiting times to be seen in outpatient clinics</li><li>▶ To improve the responsiveness to inpatient needs</li><li>▶ To have caring and compassionate staff</li><li>▶ To remain above national average for staff who would recommend the Trust to friends/family needing care</li><li>▶ To meet the Department of Health target for the family and friends test</li></ul>
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# //Our relationships and collaborations

## Working in partnership

During 2012/13 we worked in partnership with many organisations involved in the health and wellbeing of our patients. Our dedication to working in partnership stems from the Trust's formation in 2007, when we committed to transform healthcare in north-west London, nationally and internationally through the sharing of research, best practice and education.

The Trust and Imperial College London have long recognised the benefits of successful partnership working having formed the UK's first Academic Health Science Centre (AHSC) in 2009.

Our new leadership team has strengthened external relations through the development of open and constructive engagement and closer partnership working which benefits patients, families and carers. We can point to several successful collaborations both on-going and newly established during the course of the year. In future years we can also look forward to the opportunities for research presented by the Imperial West development at Hammersmith.

### Academic and research partners

Imperial College Health Partners was formed in June 2012 as an exciting development to rapidly increase the size and scope of research studies and the speed that medical breakthroughs are brought into everyday clinical practice. This means more patients can benefit more quickly from the latest medical innovations. The partnership is a limited company bringing together north-west London healthcare providers, including acute and specialist hospital, mental health, and community care services, working in partnership with Imperial College London. The partners will drive practical improvements and the adoption of quality, innovative healthcare delivery for the local population and also patients across the UK and beyond through best practice sharing.

The Trust is one of 11 National Institute for Health Research (NIHR) comprehensive Biomedical Research Centres (BRC). The NIHR provides the NHS with the support and infrastructure needed to conduct first-class research funded by the government and its partners, alongside high-quality patient care, education and training. Its aim is to support outstanding individuals working in world-class facilities in both the NHS and universities, who are conducting leading-edge research focused on the needs of patients.

The BRC designation is given to the country's most outstanding NHS and university research partnerships; leaders in scientific translation and early adopters of new insights in technologies, techniques and treatments for improving health.

The NIHR Patient Safety Translational Research Centre is a partnership between the Trust and Imperial College London, and is one of only two centres of its kind in the UK. The centre promotes improvements in the safety, quality and effectiveness of healthcare services. It also brings together a range of clinical and scientific disciplines to foster research.

The Trust also works in partnership with several external experts through the designated research centres based at our hospitals that prioritise specific medical areas including: Medical Research Council; Cancer Research UK; Wellcome Trust; and British Heart Foundation.

### Local healthcare partners

In 2012/13 the majority of our services were commissioned on behalf of our local population by primary care trusts (PCTs), primarily: NHS Ealing; NHS Hammersmith and Fulham; NHS Westminster; NHS Brent; NHS Kensington and Chelsea; and NHS Hounslow. Through NHS North West London, the PCTs together formed one of the largest health economy areas in the UK, commissioning in excess of £3.5billion of health services.

As we can provide very specialist care not available in all acute hospital trusts, our services have also been commissioned by PCTs from across London and have attracted referrals from around the country.

The public consultation for NHS North West London's programme of service change, *Shaping a healthier future*, ran for 14 weeks between July and October 2012. The Trust and Imperial College London reached a joint decision as an AHSC on our response to the proposals. The Trust worked closely with the *Shaping a healthier future* programme team throughout the development of the proposals to ensure any changes reflect the healthcare needs of the local population.

As a result of major changes to the way the NHS is organised in England, we saw the transition in commissioning of health services with PCTs being replaced by Clinical Commissioning Groups (CCGs). Local councils also started preparing for their strengthened role in tackling public health issues with new Health and Wellbeing Boards being formed to link their work with that of the CCGs. Another important reform was the creation of Healthwatch bodies, formed out of the local involvement networks or LINKs, set up to enable patients to have their say about the NHS.

As we all adjust to these new sets of relationships within the NHS, the Trust has sought to work more closely with GPs to provide the best possible all-round service for our patients. We have improved information about the services we provide at our hospitals and developed tailored referral information and forms. Our bi-monthly 'GP Services Bulletin' is intended to be a helpful resource highlighting services at each of our hospital sites and sharing information about common conditions.

### **Local education and training boards**

National policy on the arrangements for education and training in the NHS has seen networks of healthcare providers form into Local Education and Training Boards (LETB). These boards plan the workforce and commission training from universities and other education providers. The North West London LETB is part of Imperial College Health Partners.

We are playing an important role in driving up standards in post-graduate medical training, having won a bid to become the lead provider for training in nine key specialties. In August 2012, the Trust became north-west London's lead provider for training in cardiology, respiratory medicine, diabetes and endocrinology, geriatric medicine, gastroenterology, renal medicine, clinical radiology, obstetrics and gynaecology, and trauma and orthopaedics.

### **Partners in cancer care**

Maggie's London, a specialist centre offering support for people affected by cancer, is located at Charing Cross Hospital. It was the first purpose-built Maggie's Cancer Caring Centre in England. In addition, we have worked with other external experts in the field of cancer care, Macmillan Cancer Support and the National Cancer Action Team, who have helped improve patient access and experience, and provided the Trust with on-going guidance and advice.

### **Charitable partnerships**

The Trust receives a great deal of valuable support from Imperial College Healthcare Charity, an independent charity that raises and manages charitable funds for all five of our hospitals. The charity works with the Trust to use the donations given by patients and visitors to support great science, excellent patient care and a healthier community.

The Friends of Charing Cross Hospital, Friends of Hammersmith Hospital and Friends of St Mary's Hospital are three independent charitable and voluntary organisations that support a wide range of hospital departments and facilities. The Friends organisations run shops and refreshment facilities in our hospitals.

Other charitable organisations we receive support from include: COSMIC (Children of St Mary's Intensive Care); Leuka, which aids leukaemia research at Hammersmith Hospital; and the Winnicott Foundation which supports the Winnicott Baby Unit at St Mary's Hospital for babies born prematurely or needing intensive care.

## Patient and public involvement

In July 2012, the Trust launched a patient and carer experience strategy. The strategy is comprised of three sections; our patient experience objectives; the patient experience charter; and plans for delivery and monitoring of the strategy. The strategy was developed in close collaboration with a group of key external stakeholders. The stakeholder group were asked to identify the most important factors that would lead to a good patient experience. These factors were then translated into nine common themes. These patient experience themes are cross referred to the NICE framework for patient experience to ensure that there is a good correlation with agreed national best practice.

Since the launch of the strategy, much of the focus in the Trust has been to measure the compliance of the inpatient wards against the patient experience charter and the underpinning actions. The aim is to ensure that all wards achieve full levels of compliance with the charter and retain the levels going forward.

The Trust also launched the national friends and family test (FFT). We currently include an FFT survey as a stand-alone survey for inpatient wards and accident and emergency (A&E) departments. To support the implementation in A&E we have developed patient opinion zones at appropriate points on the patient exit routes from the departments. The purpose of the zones is to highlight the importance of obtaining feedback from patients and to report back the previous results. Measurement of the FFT scores began in March. Going forward, this will be used as a key measure of patient experience with all wards expected to achieve a target level.

A further area where we have developed significantly is involving patients both in their direct experiences of our services and helping the Trust in shaping and developing services. A good example of this type of approach has been the introduction of the Macmillan Values Based Standards across some of our cancer inpatient services. Through this initiative we have been working directly with patients to obtain their views about the services. The re-design approach also involves having similar discussions with staff and bringing both perspectives together to identify new methods and ways of working that will contribute to a better patient experience. We hope to further develop and expand this approach in 2013/14.

## Developing and engaging with our shadow foundation trust membership to improve the quality and safety of our services

The Trust has maintained and nurtured an effective working relationship with shadow foundation trust members. The members are patients and local people who have signed up in support ahead of our Foundation Trust (FT) application and are representative of those who use our services. We continue to explore further opportunities to improve our services by seeking and acting on the views of our shadow members and other important community groups.

Since 2010 the membership office has been actively encouraging CPGs and directorates to involve members in their work. As a result shadow members have been given the opportunity to participate and get involved in the following ways:

- ▶ Shadow members helped to shape the priorities in our quality accounts and develop ways to make the document more reader friendly. They also helped determine our improvement priorities as part of the quality accounts engagement process
- ▶ Patient representatives on complaint review panels
- ▶ Patient representatives on patient environment action teams (PEAT)
- ▶ Shadow members were recruited to take part in designing a research study looking at how effective savings may be made
- ▶ Shadow members were recruited to review inpatient guides and inpatient literature, providing comments and input
- ▶ Acted as patient representative on our medicine (CPG1) patient panel
- ▶ Reviewed the readability of templates for letters to patients

- ▶ Gold members were invited to apply for a trustee vacancy on the Imperial College Healthcare NHS Charity Board
- ▶ Acted as patient representatives on a research project grant application for a study on the peri-operative pathway experience
- ▶ Acted as patient representatives on the 'sleep stakeholder group', part of a research programme looking at sleep disturbances
- ▶ Acted as patient representatives in the design of a study on infection prevention and control
- ▶ Attended the Trust's patient experience strategy review workshop
- ▶ Acted as patient representative on the nutrition steering group
- ▶ Shadow members were invited to volunteer to visit patient areas and encourage patients to use the I-track survey tool
- ▶ Attended workshops to develop priorities with the quality accounts

In addition, shadow members were invited through the Trust to attend the following events:

- ▶ NHS North West London public engagement event '*Shaping a healthier future*' looking at the vision and the proposed changes to the north-west London sector
- ▶ Hammersmith & Fulham LINK to join the Hammersmith & Fulham Clinical Commissioning Group as a patient representative

We have continued to explore further opportunities to improve our services by seeking and acting on the views of our shadow members and other important community groups.

The current programme is to obtain FT authorisation by Monitor by the end of 2014 and we plan to increase the frequency and variety of communications with members throughout 2013/14.

## Significant relationships influencing our performance

### Achievements in cleaning and catering services

The Trust continues to deliver excellent cleaning and catering standards in partnership with ISS Facilities Services Healthcare (ISS). Cleaning standards for 2012/13 were maintained, with 98 per cent of cleaning audits in clinical areas achieving their respective pass marks. The cleanliness of the environment was commended during Care Quality Commission (CQC) inspections.

2012/13 has seen a continued focus on patient experience, responding to patient feedback to adapt our catering services and menus to reflect the needs of individual patient groups instead of a single solution approach.

Standardising procedures across all our sites has also been an important theme during 2012/13; identifying and rewarding best practice from individual units then implementing these examples on all our sites.

ISS and the Trust have continued to work in partnership to deliver excellent, customer focused service, in particular hostess staff being encouraged to actively engage with patients. Out of all ISS staff, 99 per cent have attended customer service training, with 'I care' customer service becoming part of the induction programme for all new employees.

Patient survey results for interaction with ISS staff demonstrate the effect this training and development is having on the experience of our patients. All categories have improved year-on-year for the last three years.

## ISS customer services survey results

Survey Numbers	Patient		Trust staff			
2011/12	367		469			
2012/13	199		132			

Question	Excellent 2011/12	Excellent 2012/13	Average 2011/12	Average 2012/13	Poor 2011/12	Poor 2012/13
Greeting	78%	83%	16%	13%	6%	3%
Friendliness	81%	83%	11%	13%	8%	3%
Answer Qs	78%	81%	16%	14%	6%	2%
Knowledgeable	77%	82%	16%	13%	7%	3%
Courteous	84%	85%	11%	10%	5%	3%
Overall	81%	82%	13%	13%	6%	3%

## Trade unions – working in partnership

The Trust has put in place an effective Trust-wide and local partnership arrangement with trade unions. Through the Joint Negotiation and Consultation Partnership, the Trust has harmonised its key workforce policies and is currently developing a new partnership agreement.

The Trust works in partnership with the following trade unions:

- ▶ Federation of Clinical Biochemists
- ▶ British Dietetic Association
- ▶ British and Irish Orthoptic Society
- ▶ Royal College of Midwives
- ▶ Society of Radiographers
- ▶ Unite the Union
- ▶ British Association of Occupational Therapists
- ▶ British Medical Association
- ▶ Chartered Society of Physiotherapy
- ▶ Royal College of Nursing
- ▶ Unison

## Initiatives with other organisations

### Integrated Care Pilot

The Inner North West London (INWL) Integrated Care Pilot (ICP) is an ambitious programme that was launched in 2011/12 in the boroughs of Westminster, Hammersmith and Fulham, and Kensington and Chelsea, and has since been joined by Hounslow. The aim of the programme is to bring together health and social care providers through a shared vision of collaborative and proactive working with a defined high risk group of patients, namely those over 75 and people with diabetes.

Key components of the pilot are population risk stratification, targeted and proactive care planning, information sharing, and collaborative multi-disciplinary working. Over the last two years the ICP has supported GPs to produce some 25,000 unique care plans, and over 250 multi-disciplinary case conferences have been held across the four boroughs discussing approximately 1,700 complex patients.

2012/13 has been characterised by further implementation and consolidation of the pilot and the year ahead will be critical as the ICP seeks to work with provider partners, including Imperial College London, to develop, decentralise and embed the current model within local structures. This will meet the central aim of sustaining and developing integration efforts to support the vision for north-west London.

The Trust has been closely involved with the pilot since its inception, with members of staff continuing to play integral roles. Three of the Trust's senior staff are clinical co-chairs of locality multi-disciplinary groups and three senior staff are ICP committee chairs.

## Centres for Health

The Centres for Health at Charing Cross and Hammersmith hospitals were launched in 2009 after successfully securing a five year contract, which is now in its last year. The centres are managed by a partnership (Partnership for Health) between three organisations: Imperial College Healthcare NHS Trust (as lead contractor) and London Central & West Unscheduled Care Collaborative (LCW) who are the primary care provider and offer the day-to-day operational management of the centres. The other partner is Central London Community Healthcare NHS Trust (CLCH), who provide nursing leadership and emergency nurse practitioners.

The centres offer urgent care walk-in services seven days a week, which run 24 hours a day at Charing Cross Hospital and between 8.00am and 10.00pm at Hammersmith Hospital. In addition, there is one GP practice that covers both sites, with surgeries located adjacent to the urgent care centres. Both GP surgeries offer extended opening hours from 8.00am to 8.00pm, seven days a week.

In the year 2012/13 over 78,500 unscheduled patients were seen by GPs and nurses within the urgent care centres, which represents an increase of 2.6 per cent on the previous year. Of these patients, 80 per cent were seen and discharged within two hours and 99.9 per cent were seen and discharged within four hours. The urgent care centres have also consistently met the other A&E clinical quality indicator targets. Approximately 87 per cent of patients that walk into the urgent care centres are seen by a GP and of these only 12 per cent are diverted to A&E following triage.

The number of patients on the GP practice list continues to steadily grow from approximately 4,300 patients in 2011/12 to over 6,000 by the end of 2012/13. The GP practice offers patients a high level of accessibility by offering patients a standard appointment slot of 15 minutes (as opposed to the standard 10 minutes) and longer opening hours. The practice has also recruited more GPs to manage the growing list size to ensure patients can see their GP seven days a week from 8.00am to 8.00pm. The practice continues to make good progress in meeting key performance indicators laid out in the service contract and indicators within the Quality and Outcome Framework (QOF).

## Public health projects

### Health promoting hospitals

As part of the requirement of our Health Promoting Hospital Trust accreditation by the World Health Organisation, there has been a continuous stream of health promotion activity during the year and a group has been leading on developing a Health Promoting Hospitals strategy for the Trust.

### Smoking cessation

A new and innovative system called 'Click to Quit' is now functioning across the Trust to help smokers to kick the habit. This system includes an online training resource for frontline staff to learn up-to-date information to pass on to our patients in the form of brief advice.

An additional part to the system is the referral mechanism. If a patient agrees to be referred to their local stop smoking service, the electronic system will send an automated message to the service closest to their home postcode. The patient will then be contacted by a local stop smoking specialist to discuss their quit options. This system ensures that patients are having important discussions with their clinicians and that patients are referred to their local stop smoking service with speed and ease.

## VitalSigns

The Trust's directorate of public health & primary care have launched a smartphone app (in Apple format) and a dedicated website specifically to support NHS staff to stay fit and healthy. The VitalSigns app includes a range of health and wellbeing tools, such as a self-assessment to find out how happy you are. In addition, the app also features workplace information, for example, the inter-hospital staff hopper bus timetables and details of occupational health services.

The app can be downloaded by searching for 'VitalSigns' in the Apple app store. VitalSigns can also be accessed by visiting the web version [www.vitalsigns.nhs.uk](http://www.vitalsigns.nhs.uk).

## //Research

It has been another year of success and achievement for research at the Trust. Our research strategy is driven in close collaboration with Imperial College London through our academic health science centre (AHSC) partnership.

Following the largest single award for biomedical research in the country, we have completed the first full year of work in the new National Institute for Health Research (NIHR) Imperial Biomedical Research Centre (BRC). More than 600 individual research projects were active during 2012/13, and more than 250 new experimental medicine studies were approved. Our NIHR-supported clinical research studies recruited 10,000 patients in 2012, and a further 37,000 volunteers participated in the Cohort Study on Mobile Communications (COSMOS) which aims to identify if there are any health issues linked to long-term mobile phone use.

### Imperial Clinical Phenotyping Centre

One of the key BRC-funded initiatives is the Imperial Clinical Phenotyping Centre. The new centre based at St Mary's Hospital and directed by Professor Jeremy Nicholson, brings together a unique collection of state-of-the-art technologies that analyse the chemical make-up of a tissue or body fluid sample to provide rapid diagnostic information. The profile of chemicals present in a sample provides a read-out of the patient's disease classification and severity. This information can inform doctors how the disease will progress in an individual patient or how the patient is responding to a particular therapy.

The centre also incorporates technologies deployed in the operating theatre to give surgeons useful diagnostic information in real-time. One of the tools is the 'intelligent knife', which analyses the smoke produced when the electrically-heated surgical blade cuts into tissue during an operating procedure. Research has shown that the profile of the chemicals in the smoke provides detailed information about the disease state of the tissue. The centre is jointly funded by the NIHR Imperial BRC and industrial partners, including the Waters Corporation and Bruker Spectrospin GmbH.

### MRC-NIHR Phenome Centre

In 2012, Professors Jeremy Nicholson and Paul Elliott, in collaboration with colleagues at King's College London and major instrument suppliers, received a £10 million award from the Medical Research Council (MRC) and NIHR to establish the MRC NIHR Phenome Centre. Closely linked to the work of the BRC and the Imperial Clinical Phenotyping Centre, the MRC NIHR Phenome Centre will provide researchers from across the UK with the analytical technology they need to study the links between a person's metabolism, their environment, and the diseases they develop. In the long-term this will lead to better diagnostic tests and tailor-made drugs for individual patients.

The centre is a partnership between industry, research funders and our researchers. In addition to the grant, there are significant contributions of staff, equipment, and technical support from the Waters Corporation and Bruker Biospin GmbH. Both companies will work with the centre to develop the technology and establish a major training centre.

### NIHR Patient Safety Translational Research Centre

NIHR Patient Safety Translational Research Centres drive improvements in patient safety and in the safety of NHS services. The centres are partnerships between universities and NHS trusts and pull relevant advances in basic research into a more applied setting.

Following an open competition, the NIHR has funded two Patient Safety Translational Research Centres for five years, which started from August 2012. One of these was awarded to the Trust, and is worth £7.2m over five years. It is led by Professor Charles Vincent (director) and Professor the Lord Ara Darzi (clinical lead). The Centre will carry out research to advance and refine new ways of improving safety in hospitals, GP surgeries and in the community, which will translate into real benefits for patients, including the reduction of prescription errors, improving diagnosis of cancer and rare diseases, and reducing accidents during surgery.

## Public showcase of research

On 1 November 2012, the NIHR Imperial BRC opened its doors to patients, healthcare professionals, students and members of the local community providing an opportunity to explore the variety and breadth of translational research being undertaken in the BRC.

Visitors had the chance to partake in hands-on displays that included liver monitoring, DNA extractions, neurological visual tasks, handling a biopsy gun and the operation of a robotic system used in surgical procedures. The event was also attended by our partners from the Royal Brompton and Harefield NHS Foundation Trust Cardiovascular and Respiratory Biomedical Research Units, and colleagues at the North West London Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

Attendees were invited to tour the purpose-built NIHR/Wellcome Trust Imperial Clinical Research Facility and witness first-hand the instrumentation and techniques employed there. A lively forum also took place including panellists representing Imperial College London, the Trust and the NIHR, which considered how to increase the opportunities for patient involvement in research and the research process.

## Rare diseases and the NIHR BioResource

The Trust is playing an active role with other Biomedical Research Centres and Units in the establishment of the NIHR BioResource, a national initiative which will provide considerable new capacity for the carrying out of new clinical research studies. The BioResource will contain biological samples and associated clinical information from thousands of patients and healthy volunteers. It will initially focus on exploring the genetic causes of rare diseases, with a view to diagnosing these conditions at an earlier stage and then tailoring treatment for patients.

In 2012/13, the Trust also received funding to develop systems and processes to support the sharing of electronic patient data. This will benefit research and widen participation in clinical studies by making it easier to identify patients with common conditions and characteristics.

## //Education

The year has been marked by innovation, enhanced partnerships and a focus on educating for the future. Our key 2012/13 achievements around education are:

- ▶ Several awards for excellence in education
- ▶ Increase in research capability of nurses, allied health professionals, pharmacists and doctors
- ▶ Launch of innovative schemes in integrated care, technology enhanced learning and simulation
- ▶ Established our reputation as Lead Provider for postgraduate medical education in core medicine and surgery and higher medical specialties
- ▶ Maintained enormous success in national awards from NIHR for academic fellowships and lecturers
- ▶ Improved outcomes in the GMC national trainees' survey and a very positive GMC inspection at the end of 2012
- ▶ Established two academic posts with Bucks New University, a professor of nursing and a reader
- ▶ Established the first AHSC-based GP training programme (Imperial GP Scheme)
- ▶ Significant income generation to fund educational programmes

We have consolidated our Lead Provider status for postgraduate medical training and are bidding for further specialities across the north-west London sector and London. This will allow the Trust to lead in the development of enhanced training programmes for doctors. We have raised a significant amount of educational income which has enabled us to innovate. During the year, we further increased our simulation activity, launched the Lead Provider website and launched Moodle as our virtual learning environment. Our focus going forward is to harness the learning opportunities afforded by service re-configuration and minimise any adverse effects during changes in the north-west London NHS landscape. We wish to ensure the Trust remains or becomes the first choice training centre for doctors in postgraduate training across all specialties.

This year we launched our new nursing and midwifery strategy for 2013-16 '*Everyone counts*', which includes a work stream on supporting and developing our staff, as well as embedding our nursing and midwifery research and education strategy 2011-14. To help increase research capacity and capability we jointly established two academic posts with Bucks New University, a professor of nursing and a reader, and cemented our undergraduate partnership working with Kings College London.

We continue to deliver regular cohorts of the trainee nursing assistant development programme to prepare unregistered staff to work at the bedside, and twice-yearly cohorts of a bespoke internship programme for newly qualified nurses. There has been a further increase in the number of nurses and midwives with degrees and masters' degrees, and those currently with a PhD or doctorate or studying for one.

In addition, there is more of a focus on integrating patient safety into education to achieve our aim of enabling clinical and non-clinical capability of all staff to deliver safe and effective patient care. Our focus going forward is to integrate the recommendations of the Francis report and work with our partner universities on improving practice.

The Trust increased mandatory training compliance, provided vocational training for bands 1-4 and hosted a large apprentice programme with the Trust featured as 'base practice site' at the NHS London Apprentice Conference.

We have 26 academic foundation trainees, 103 National Institute of Health Research (NIHR) academic clinical fellows, 294 clinical research training fellows and 28 NIHR clinical lecturers. Two nurses are in receipt of NIHR fellowship and post-doctoral awards. The first cohort of Nursing MRes students graduated in May 2012. We also saw the start of the first PhD/preceptorship nursing post in vascular surgery. Among allied health professions and pharmacists, there are five currently undertaking PhDs with one completed in January 2013.

We piloted the use of QR codes in clinical areas to improve just-in-time learning and embarked on a mobile learning project. Our innovations in simulation have continued this year with its use in communication training, leadership development and sequential simulation across the integrated care patient pathway. *Training Tomorrow's Trainers Today*, won the prestigious Elisabeth Paice Award and continues to be rolled out across north-west London. *Today's Doctors Tomorrow's Leaders*, for junior doctors was highly commended as the best clinical leadership initiative in London.

Our local, national and international partnerships are critical to educational excellence. We have developed strong educational partnerships with trusts in north-west London through our director of nursing and Lead Provider networks, the Health Innovation Education Cluster (HIEC) and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC). The pharmacists and dietitians continue to have international educational partnerships and nursing and midwifery are part of an international learning collaboration with other AHSC and aspiring AHSC nursing colleagues in Australia, Singapore and Sweden.

# //Sustainability

The Trust recognises the need to operate as a financially and socially responsible organisation, minimising its impact on the environment in order to deliver the highest quality healthcare to the communities we serve, now and into the future. This report has been prepared in line with guidance issued by the NHS Sustainable Development Unit and the Department of Health.

## Carbon and energy management

Our board approved carbon management plan continues to steer us towards achieving our 2015 NHS carbon reduction target of 25 per cent.

A further £2million has been invested in energy efficiency measures in 2012/13, specifically building management system (BMS) improvements at Hammersmith Hospital, steam trap replacements at Charing Cross Hospital and lighting upgrades across the Trust through the support of Salix Finance. As a direct result of this investment, electricity consumption is down by approximately three million kWh, a 4.4 per cent drop against the previous year's figures, while normalised gas consumption, after adjustments for the unseasonably cold weather, has decreased by a further 2.5 per cent.

As a participant in the CRC Energy Efficiency Scheme, the Trust was ranked 203rd in the publicly available performance league table out of 2,097 member organisations and more notably fourth out of other large acute hospitals. We were also successful in renewing the Trust's Certified Emissions Measurement and Reduction Scheme (CEMARS) certification, enabling us to benefit from the Early Action Metric. The Trust's carbon emissions under EU Emissions Trading Scheme (EU ETS) were also independently verified to CICS Carbon Verified Assurance Mark standard.

## Waste

Developing and expanding the recently implemented non-infectious clinical waste stream has been a real focus for 2012/13. This alternative waste stream is sent for energy recovery (burned to produce electricity) instead of undergoing energy intensive treatment processes and eventually being sent for landfill. The Trust has seen CO<sub>2</sub> emission reductions in excess of 184,600 kilogrammes (kg), trebling last year's achievement.

We have also seen a three per cent increase in non-clinical waste recycled and a five per cent reduction in waste sent to landfill, equating to a further 21,800kg reduction in CO<sub>2</sub> emissions.

Working with our waste management providers, the Trust has reduced the number of waste vehicle movements by 104 per year and over 6,000 miles, giving us an indirect CO<sub>2</sub> emissions reduction of 8,300kg.

## Travel and transport

Active travel roadshows were held in preparation of the anticipated travel disruption due to the London 2012 Olympics. The Trust worked with partner organisation 'Living Streets' to distribute over 1,000 walking and cycling maps prior to the start of the Olympics. Over 200 staff took up the opportunity to borrow a pedometer during this period and we continue to run the 'I heart' pedometer and bicycle loan initiatives in support of our Trust staff health and wellbeing programme, and our commitment to NHS North West London's 2012 health legacy.

This year also saw the introduction of a transport assessment centre, reducing the number of journeys being undertaken by patients who are ineligible for patient transport.

## Priorities for 2013/14

- ▶ Maximise return on investment through continuous commissioning of the building management system and other energy saving initiatives
- ▶ Reaffirm governance arrangements for sustainability reporting within the Trust and the requirement for a sustainable development management plan
- ▶ Minimise waste through reducing reliance on plastic based packaging and replacing with cardboard based alternatives
- ▶ Support the medical directorate to increase staff participation in physical activity through the promotion of active travel such as walking and cycling

For further detail on the Trust's sustainability, please consult appendix one.

## //Staff experience

In 2012/13 the Trust continued to work towards improving the staff experience, including implementing a comprehensive action plan created in response to the 2011 annual national NHS staff survey.

### The 2011 annual national NHS staff survey

Each year a selection of our staff are asked to take part in the annual national NHS staff survey to collect views about working for the Trust. The survey's results are reported to the Trust board and used to create key objectives and actions to drive improvement in staff experience.

The Trust received results from the 2011 staff survey in March 2012. These were then interpreted and acted upon throughout 2012/13.

In the 2011 survey the Trust registered some of the highest scores in the country for:

- ▶ Staff having well-structured appraisals
- ▶ Staff agreeing that their role makes a difference to patients
- ▶ Recommending the Trust as a place to work and have treatment
- ▶ Satisfaction with quality of work and patient care

There were also big improvements in key priority areas such as:

- ▶ Staff receiving health and safety training in the last 12 months (44 per cent to 60 per cent)
- ▶ Staff having equality and diversity training in the last 12 months (29 per cent to 42 per cent)
- ▶ Fewer staff reporting that they are working extra hours

However, the 2011 staff survey results also made clear that there were many areas that required improvement to achieve our goal of providing the highest standards. These included:

- ▶ Quantity of appraisals
- ▶ Perceived equality of opportunity in relation to career progression
- ▶ Health and safety training
- ▶ Flexible working

Actions taken to address areas for improvement include:

- ▶ A strong, clear focus on staff appraisals
- ▶ Development of a comprehensive plan to promote equality in the workplace
- ▶ Provision of training on the effective management of bullying and harassment
- ▶ The development of a staff health and well-being strategy
- ▶ The development of innovative ways of tracking on staff experience

The 2012 staff survey was conducted in October 2012. The Trust received the results in March 2013, which are being processed and interpreted, and action plans will be initiated in response to the findings.

### The 2012 staff engagement action plan

The staff engagement action plan was created to reflect the reality of the working experiences of the Trust's staff. It provides a guide to the initiatives that have been created to improve staff experience, including professional and personal development, improving health and wellbeing and boosting recognition.

Follow up activities and objectives as a result of staff survey responses included:

- ▶ Increase awareness and take-up of flexible employment opportunities
- ▶ Promote shared values and behaviours
- ▶ Offer a comprehensive employment package that motivates and recognises outstanding performance
- ▶ Develop a supportive, motivational, engaging workplace culture through the development of excellent leadership and management skills
- ▶ Ensure staff are appraised and have personal development plans
- ▶ Create a workplace culture in which staff treat each other with dignity and respect
- ▶ Actively promote safety, staff health and wellbeing
- ▶ Advance equality and the valuing of diversity throughout our workforce
- ▶ Promote staff recognition schemes

### The staff experience group

Progress towards meeting our staff engagement plan is overseen by our staff experience group. The group, which meets on a quarterly basis, is chaired by the director of people and organisation development. The meetings attract a cross-section of staff including line managers, trade union representatives, and representatives from human resources and communications.

### Recognition schemes

The Outstanding Service Care & Research awards (OSC&Rs) were created in 2008 and are funded and supported by Imperial College Healthcare Charity. They are presented to individuals or teams who best embody each of the Trust's values of respect, innovation, care, achievement and pride.

OSC&Rs prizes are awarded quarterly and the fourth annual OSC&Rs ceremony was held in May 2013 to announce the overall winners in each category for the 2012/13 financial year.

There are also recognition awards for each of the Trust's clinical programme groups (CPGs), supported by Imperial College Healthcare Charity. The scheme allows the Trust to locally recognise and reward its staff for their contribution to Trust priorities and for going over and above the everyday scope of an individual or team's role in helping to improve the patient and staff experience. Both the OSC&Rs and CPG recognition awards are well received by staff and managers, and continue to attract a large number of nominations.

### Accessible leadership and responding to staff

The Trust continues to follow a policy of visible and accessible leadership, with senior management engaging with staff at all levels. Examples include:

- ▶ **Open Hour** – the chief executive holds a monthly 'Open Hour' session which all staff are invited to attend. These sessions provide a general update on the Trust's performance, vision and strategy, and includes an additional member of the senior management team presenting and answering questions about a specific part of the Trust's business
- ▶ **Team Brief staff sessions** – the chief operating officer holds monthly lunchtime sessions at each of our main hospital sites to complement the 'Team Brief' document which managers receive at the start of each month to outline progress and key actions for the month ahead
- ▶ **Back to the floor Fridays** – nurses and midwives above band 7 return to clinical practice in uniform every Friday to undertake work relevant to their role. This initiative provides strengthened and visible clinical nurse and midwife leadership

- ▶ **I track visits** – the Trust chairman and chief executive regularly visit departments and wards across the Trust to meet staff to discuss the results of our I track patient experience surveys. Full and frank two-way conversations are had with staff about their results, issues affecting patient experience, where improvements can be made and where new initiatives have improved patient experience

## Staff health and wellbeing

In 2013/14 the Trust will be taking forward staff health and wellbeing in several ways:

- ▶ We have launched the VitalSigns smart phone app for the iPhone. This is the outcome from a Department of Health funded project in which the Trust and University College London Hospitals NHS Foundation Trust formed a successful partnership to bid to become a health and wellbeing pathfinder for London. The app contains a variety of health and wellbeing modules including sensible drinking, stopping smoking, and good mental health. It also contains useful work information such as the Trust hopper bus timetable. There is also a modified version available on a new website [www.vitalsigns.nhs.uk](http://www.vitalsigns.nhs.uk). It is intended that the app will improve the reach of health and wellbeing initiatives for staff, friends and family and that better informed staff will make better health advocates when caring for patients. This will be evaluated at a later date.
- ▶ We will be launching a physical fitness campaign (IMove) in 2013. The aim is to increase the amount of physical activity undertaken by staff in whatever way they want, with a view to improving overall levels of health and wellbeing. The campaign will be run by the office of the medical director and will be based on partnership working between Imperial College (Energia) and Greenwich Leisure Limited (GLL), a community interest company that is a preferred provider for the north-west London health legacy – a follow up from the 2012 Olympic Games. The campaign will promote a variety of ways of improving physical activity, making use of the vast array of resources available within Imperial College as well as the reach of GLL who have gyms across Greater London. There will be a series of health events in the Trust to accompany the campaign.
- ▶ A health and well-being committee will be established to provide a strategic direction for health and well-being activity, to coordinate the variety of initiatives that are or will take place and to evaluate the effects of initiatives. The committee will establish a governance framework with outcomes reported to the Trust's management board. We will take forward the Health Promoting Hospital initiative and contribute to the Trust's stakeholder management by coordinating and managing engagement with local health and wellbeing boards.

# //Annual Governance Statement 2012/13

## 1. Scope of responsibility

### Accountable officer responsibilities

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Imperial College Healthcare NHS Trust's aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

## 2. Capacity to handle risk

As accountable officer I have overall responsibility for risk management but day-to-day management has been delegated to a director level lead for risk. The lead for risk is responsible for reporting on the development and progress of risk management and for ensuring that the risk management strategy is implemented, evaluated effectively and that staff are trained and equipped to manage risk appropriately to their authority and duties. We have appointed to the vacant post of director of governance and assurance, with effect from 1 July 2013. The director of nursing has led on risk management in the meantime.

## 3. Governance framework

The Trust has well established integrated governance arrangements and a formal reporting structure that supports board to ward information.

### 3.1 Board and committee structure

The role of the board is corporate responsibility for the Trust's strategies, actions and finances. As an NHS trust board, it is the custodian of a national asset, provides stewardship and remains publicly accountable. Following the appointment of Sir Richard Sykes as chairman and Mark Davies as chief executive, the Trust board has been further strengthened with the appointment of new non-executive directors and executive directors. This has helped to bring a diversity and range of capabilities and capacities to bear on Trust board business and Trust-wide leadership.

The board has an assurance framework system in which significant risks to the Trust's major objectives are managed. The board assurance framework helps to drive the board agenda and focus.

Reporting to the board are committees responsible for audit and risks; governance; finance; and remuneration.

The board met a total of six times in public in 2012/13: May 2012, July 2012, September 2012, November 2012, January 2013 and March 2013. Throughout the year attendance was monitored and full attendance occurred with the exception of one non-executive director having two authorised absences and one executive director had one authorised absence.

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

- ▶ Non-executive director, Ellen Schroder until 30 April 2012
- ▶ New non-executive director, Sir Gerald Acher from 1 April 2012
- ▶ New non-executive director, Dr Martin Knight from 1 April 2012 to 1 March 2013
- ▶ New non-executive director, Dr Rodney Eastwood from 1 April 2012
- ▶ Non-executive director, Hon Angad Paul until 30 September 2012
- ▶ New non-executive director, Professor Sir Anthony Newman Taylor from 1 October 2012
- ▶ Medical director, Professor David Taube, until 31 August 2012
- ▶ Acting medical director, David Mitchell from 1 September 2012 until 30 November 2012
- ▶ Medical director, Professor Nick Cheshire from 1 December 2012
- ▶ Chief operating officer, Steve McManus from 20 August 2012
- ▶ Non-executive director, Sarika Patel from 1 January 2013

### 3.2 Board performance and key areas of focus

In addition to formal board meetings, the Trust board also undertakes regular workshops and seminars to review strategy in more detail.

The board work programme has supported a sound system of internal control through the following activities: a regular monthly review of financial standing, management and reporting, focusing on risks to the planned position, variance of plan, a detailed review of cost improvement programmes (CIP), performance against the capital expenditure programme, cash balances and forecasts.

Performance reports provided assurance to the board on a number of national and local targets. Where improvement actions were necessary, these were highlighted. Areas of importance included waiting list management and performance against targets.

The board maintained up to date knowledge on matters of strategic risk and controls related to challenges within the local health economy and changes to national policy.

The board monitored matters related to healthcare acquired infections and the actions to address local risks. Improvement actions were implemented throughout the year including but not limited to the following:

- ▶ A comprehensive training programme in aseptic non-touch technique
- ▶ Antibiotic stewardship, to optimise antimicrobial prescribing, including the national 'Start Smart then Focus' initiative
- ▶ Continued Trust-based strain typing of *C.difficile* to enhance understanding of local epidemiology and potential transmission
- ▶ Sustained minimising of the risk of cross-infection through enhancing hand hygiene and decontamination of equipment

All risks related to patient safety and service quality were reviewed quarterly including adverse events, complaints, claims and serious incidents monitored by number, grade, severity, themes and follow up of improvement actions.

Performance indicators within the quality accounts were reviewed on a quarterly basis and demonstrated progress against a number of priority areas for patient safety, clinical effectiveness and patient experience, notably in achieving our targets related to infection prevention and control, patient falls resulting in severe harm, venous thromboembolism (VTE) risk assessments and responsiveness to

patients' needs. The Trust benefited from the advice and support of a number of key stakeholders in developing and actioning these priority indicators.

The board received assurance on the effectiveness of the audit and risk committee, finance committee and governance committee through reports of the work carried out at each of the meetings from direct reports to the board.

The board approved compliance declarations for safeguarding children and young people, eliminating mixed sex accommodation in March 2013 and met the equality delivery scheme deadline.

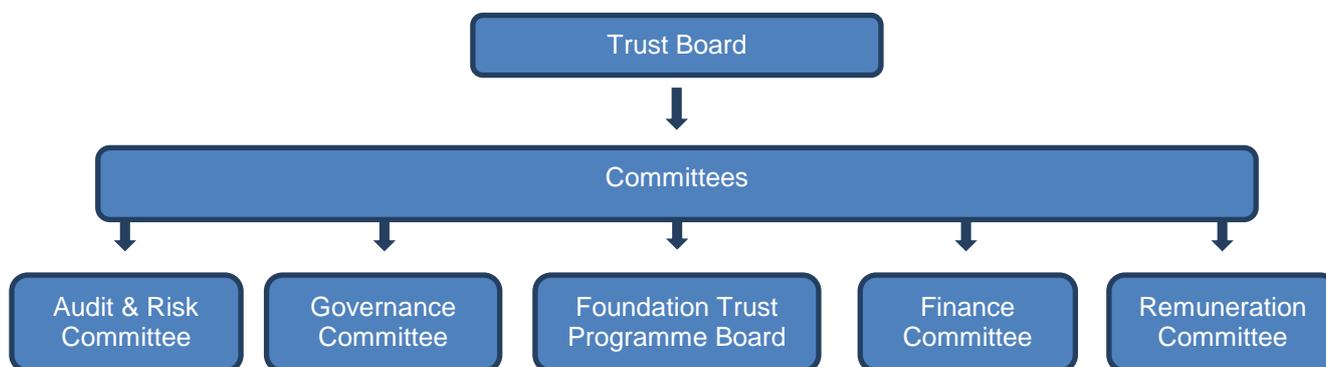
The board received regular patient experience updates related to local and national patient surveys, and reports from the patient experience committee which is responsible for driving the improvement in patient experience within the Trust. It also monitored and approved improvement actions related to the annual staff survey and reviewed the annual whistleblowing report.

The Trust has now received formal approval to apply for Foundation Trust (FT) status. The current programme is to obtain FT authorisation by Monitor by the end of 2014. The Trust will work alongside the NHS Trust Development Authority (TDA) and will be subject to independent external review and a formal review by Monitor, the regulatory body responsible for authorising and regulating foundation trusts. The board will have oversight of the application process, working through a non-executive director-led FT programme board which will have an integral role in the process.

As part of the FT application the Trust is looking to strengthen the non-executive directors' experience giving them a better understanding of the Trust. The chairman and some non-executive directors already take part in visits to clinical areas and services and this programme is being developed and enhanced to achieve a more structured basis.

### 3.3 Committees of the board: performance and key areas of focus

The board was supported by the following committees.



#### 3.3.1 Audit and risk committee

Following the Trust board meeting on 28 March 2012 the audit committee became the audit and risk committee and new terms of reference were agreed during the year.

The audit and risk committee has primary responsibility for all aspects of internal control including a key focus on financial standing, reporting, management, financial risk and value for money. It retains an oversight function for clinical risk.

The audit and risk committee met five times in 2012/13: April 2012, June 2012, September 2012, December 2012 and March 2013. All meetings were quorate and in accordance with its terms of reference.

The audit and risk committee approved the internal audit programme based on risks identified in the assurance framework. In total, 32 audits were concluded: six returned limited assurance; 12 adequate assurance; and 14 substantial assurance. Where only limited assurance is provided there is a follow up audit six months later, further details of which are in the following table:

<b>Audit</b>	<b>Date issued</b>	<b>Date for review</b>	<b>Update</b>
Capital projects	April 2013	TBC	Issued as draft. Expected to be finalised by w/e 20/04/13
Safeguarding vulnerable adults	November 2012	May 2013	Final
Policy development	April 2013	September 2013	To be issued as final on 15/04/13
Research	April 2013	TBC	To be issued as draft on 15/04/13
Change control	December 2012	May 2013	Final
Pseudonymisation	January 2013	July 2013	Final

The audit and risk committee receives reports from the external auditor in respect of their audit of the Trust's financial statements. The external auditors also report to the audit committee on the findings from procedures they perform in respect of the Trust's quality account and the arrangements the Trust has in place to deliver economy, efficiency and effectiveness through its use of resources.

Internal audits included reviews of the Trust's financial systems including accounts receivable and procurement together with audits of the NHS Litigation Authority (NHSLA), clinical guidance around NICE guidance and the business systems around private patients and overseas visitors.

Tender waiver reports were presented at the meetings in June 2012 and September 2012, highlighting the period from April 2012 to September 2012 to ensure compliance with policies.

The committee reviewed financial management reports, including debtors' and creditors' schedules, and the results of counter fraud activities. The work of the finance committee was monitored, with a report going to the December meeting. The committee received the annual audit letter.

The committee sought assurance that the processes supporting clinical governance were effective through reports received from the quality and safety committee, progress against the Trust priority clinical audit programme and the work of the governance committee.

The committee reviewed the board assurance framework, the corporate risk register and the quality accounts. It reviewed risks around nursing quality, junior doctor local inductions, use of doctors at night, the implementation of Cerner (the new patient information system), escalation beds and clinical risk assessments on CIPs. It also received harm free care reports which triangulated workforce, experience, infection and nurse sensitive indicators.

### **3.3.2 Governance committee**

The governance committee provides the leadership and strategy that integrates all aspects of governance processes. It supports the Trust in providing safer, high quality care in the best environment which meets business objectives, manages the risks necessary to innovation in healthcare and uses accurate clinical information to bring about improved outcomes ensuring regulatory compliance.

The governance committee met five times in 2012/13: April 2012, August 2012, September 2012, October 2012 and February 2013. Not all of the meetings were quorate, with the August and September meeting not having a member with substantial clinical expertise as required in the terms of reference. However, the deputy director of nursing was present at both those meetings and was the delegated deputy for the director of nursing.

The committee sought assurance on the Trust's risk management processes by reviewing the top ten highest scoring risks of CPGs and corporate directorates, approving the escalation of those with the potential to impact at an organisational level to the corporate risk register. Clinical directors and corporate directors were required to attend the meetings and present the risk registers.

The committee had oversight of the NHSLA project and action plan which saw the Trust maintain its level three compliance, passing 48 out of the 50 standards. The Trust also achieved level three Clinical Negligence Scheme for Trust (CNST) in respect of maternity services, passing 46 out of 50 standards. The committee monitored statutory and mandatory training and reviewed the risk assessment of the CIP programme. In September it reviewed its terms of reference and those of the quality and safety committee. Finally, it received reports from its sub-committees in accordance with terms of reference, including reports on risk management related to health and safety, patient experience and equality and diversity.

### **3.3.3 Foundation Trust programme board**

The Foundation Trust (FT) programme board was established in February 2013 to direct the Trust's FT preparation activities and provide assurance to the Trust board around the progress of the underpinning work programme. The programme board has met twice in 2012/13: 21 February 2013 and 14 March 2013, and will continue to meet monthly until FT authorisation is achieved. The programme board is chaired by the lead non-executive director for the FT programme and comprises a further three non-executive directors, all five executive directors and selected senior management representatives. The programme board receives monthly updates from the programme team that manages and executes the FT programme on a day-to-day basis and reviews key deliverables that will support the Trust's application.

### **3.3.4 Finance committee**

The finance committee provides detailed review and scrutiny of the medium and longer term financial issues facing the Trust. The role of the committee is to focus on trends in performance and the impact of such trends on the Trust's future performance. In particular, the committee concentrates on the financial risk profile of the Trust and the measures that are needed to assess and manage financial risk.

The finance committee was reconvened under a new chair and therefore only met three times in 2012: September 2012; December 2012; and March 2013. All meetings were quorate in accordance with its terms of reference.

The committee reviewed the proposals on the clinical strategy, a long term strategic financial review, the single operating model, a bid for a potential merger and an update in the long-term financial model. In addition, the committee reviewed the draft financial plan and the risks associated with it. Finally, the committee oversaw the development of the Foundation Trust timetable and a review of the proposal to accelerate the timetable for FT status.

### **3.3.5 Remuneration and appointments committee**

The remuneration and appointments committee determines the appointment, remuneration, terms of service and performance of the executive directors. The committee met once on 27 June 2012.

## **3.4 Corporate governance code**

### **3.4.1 Code of Conduct and Code of Accountability**

All board members have signed the NHS Code of Conduct and Code of Accountability which is renewed annually.

### **3.4.2 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions**

The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were adhered to over the course of the year and no suspensions recorded. Cost controls and delegated spending limits were reviewed and were ratified by the board in May 2012 which reflected changes in the

organisational structure, the need for tighter control and reduced delegated spending limits, introduction of international financial reporting standards (IFRS), and the publication of the revised NHS Audit Committee Handbook. The Trust operates NHS Standards of Business Conduct policies on declaration of interests and receipt of gifts and hospitality which were implemented and monitored during the year.

### **3.4.3 Bribery Act 2010**

Following the introduction of the Bribery Act 2010 in July 2011, at the May 2012 board meeting the Trust board approved the Counter Fraud, Bribery and Corruption Policy and Response Plan. As accountable officer, I will not tolerate any forms of bribery or fraudulent activities by Trust staff, those contracted to undertake work for it or anyone acting on its behalf. Further details are provided in section 5.2.1.

### **3.4.4 Register of interests and hospitality register**

The register of interests and the hospitality register declarations were updated as part of the annual schedule as set out in the policies. An annual review of the policies was conducted and these were ratified at the Trust board meetings in January and March 2012, with a review date of January 2014 and March 2014 respectively. Compliance with the policy was audited and received assurance. The Trust board received the declarations of interests of key staff as set in the policy. Compliance was reviewed by internal audit.

## **4. Risk assessment**

### **4.1 How risk is assessed**

The board approved risk management strategy provides the framework for integrated risk management, as part of the overall arrangements for clinical and corporate governance. It provides a comprehensive approach to the management of non-clinical, patient safety, financial, environmental, performance, strategic, partnership, performance and reputational risk. The strategy was reviewed and ratified at the September 2012 Trust board meeting.

The Trust identifies risks using a risk assessment process based on a 5x5 risk scoring matrix for likelihood and consequence. For each risk assessed, mitigating actions are identified and responsibility for completion allocated to an assigned lead. Risk registers are maintained at local levels within clinical programme groups (CPGs) and corporate directorates and are reviewed at a minimum annually. Management of risk is determined by severity.

All local risk registers are collated to form the Trust-wide risk register so that risks can be viewed in totality. An escalation process ensures that senior teams review risks scoring 12 and above and present the top ten highest scoring risks to the governance committee who approve risks for inclusion in the corporate risk register. This is reported to the board to ensure progress is monitored at the highest level.

The Trust is currently undertaking a review on the risk management process and structure. The review will inform any changes required to the strategy, risk register and the board assurance framework to ensure that risk is undertaken in a uniform way and properly embedded within the Trust.

### **4.2 Organisational risk profile**

#### **4.2.1 Regulatory risk - Care Quality Commission (CQC)**

The Trust is registered with CQC at the following sites 'without conditions' for its five main sites and seven renal dialysis satellite units:

Main sites:

- ▶ Charing Cross Hospital
- ▶ Hammersmith Hospital
- ▶ Queen Charlotte's & Chelsea Hospital
- ▶ St Mary's Hospital
- ▶ Western Eye Hospital

Renal dialysis satellite units:

- ▶ Brent Renal Centre
- ▶ Ealing Renal Centre
- ▶ Hayes Renal Centre
- ▶ Northwick Park Renal Centre
- ▶ Watford Renal Centre
- ▶ West Middlesex Renal Centre
- ▶ St Charles and Hammersmith Renal Centres

The Trust has continuously monitored compliance with all essential standards throughout the year. At year end position the Trust is compliant with all 16 CQC outcomes.

The Trust had one reactive CQC inspection during 2012/13. St Mary's Hospital was inspected in May 2012 and reviewed against Outcome 4 - Care and welfare of people who use services; Outcome 14 - Supporting staff; and Outcome 16 - Assessing the quality of service provision. We were found to be compliant with all the outcomes reviewed, with no actions required.

An additional four planned inspections were undertaken by CQC at the following locations:

- ▶ Western Eye Hospital - October 2012
- ▶ Hammersmith Hospital - November 2012
- ▶ Queen Charlotte's & Chelsea Hospital - December 2012
- ▶ St Charles and Hammersmith Renal Satellite Units - January 2013

Charing Cross Hospital was inspected in January 2012 for Outcome 6 - Cooperating with other providers; and Outcome 8 - Cleanliness and infection control, and was found to be compliant with no actions required.

As part of the national dignity and nutrition programme, CQC conducted follow up inspections nationally. They inspected Charing Cross Hospital in August 2012 against Outcome 1- Respecting and involving people who use services; Outcome 5 - Food and nutrition; Outcome 7 - Safeguarding; Outcome 13 - Staffing; and Outcome 21 - Records. We were found to be compliant against all of the outcomes reviewed with no actions required.

A report on CQC visits was presented to the Trust board in January 2013. It was noted that the report confirmed that the CQC had now visited all of the Trust's main sites and two renal satellite units. All of the sites inspected were found to be compliant with the Essential Standards of Quality and Safety, in line with the Trust's own compliance submission. There are no outstanding actions.

The Trust continuously monitors the indicators within the CQC Quality and Risk Profile and reviews quarterly updates on changes in levels of risk at the management board. The current risk profile is 'low compliance failure'. None of the 16 individual outcomes have a red (high risk of compliance failure) rating.

#### **4.2.2 Financial risk**

The Trust uses the Monitor approach to financial risk rating (FRR) and has currently self-assessed as FRR 3.

#### **4.3 Corporate risk register 2012/13**

Progress was made in identifying new risks for management at board level and in reducing levels of risk.

### 4.3.1 New risks in the corporate risk register

- ▶ Failure to learn from never events related to retained swabs and therefore not minimising repeat occurrences
- ▶ Unrest and uncertainty amongst staff following CPG restructure resulting in a possible loss of control over the management of the organisation

## 4.4 Data security

### Management of risk related to information governance

Information governance risks are managed using the following structures and processes:

- ▶ The chief information officer is the executive responsible for information governance and is also designated as the senior information risk officer (SIRO)
- ▶ The Caldicott committee has oversight of the clinical records committee, information security committee and data standards committee
- ▶ Sanjay Gautama is the Caldicott guardian
- ▶ The Caldicott guardian is the chair of the Caldicott committee
- ▶ The governance committee receives an annual and half yearly report from the Caldicott guardian that provides detail on the Trust information governance return and the activities of the information governance/Caldicott team and the Caldicott committee
- ▶ The Caldicott committee is responsible for the ratification of Trust-wide information governance policies and their communication to all staff
- ▶ The information security committee is responsible for the oversight of the ICT risk register and the computer audit programme managed in partnership with our internal auditors, Parkhill Audit
- ▶ The ICT risk register encompasses all information management, clinical records, ICT and information governance risks. It is informed by project risk registers and feeds into the Trust corporate risk register
- ▶ During 2012/13 there were no information governance incidents that met the criteria for reporting as serious incident

## 5. The risk and control framework

The system of internal control is designed to develop a risk aware culture; to generate an organisation that is continually learning and improving. Things can go wrong; the question is how to mitigate against that happening. As we continue to develop a risk aware culture we will create a safe and sustainable organisation, one that is proactive rather than reactive. The system aims to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place at the Trust for the year ending 31 March 2013 and up to the date of approval of the annual report and accounts.

### 5.1 Prevention of risks<sup>13</sup>

- ▶ The board agenda is shaped by the key risks with the potential to challenge the organisation
- ▶ The assurance framework is used to develop priority areas of work within the internal audit annual plan
- ▶ The audit and risk committee has responsibility for primarily all aspects of financial risks, it has delegated the responsibility for non-financial risk to the governance committee and it retains oversight of clinical risk and clinical audit

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<sup>13</sup> Also see learning from adverse events on page 22

- ▶ The Trust is committed to a zero tolerance approach to fraud and uses examples of counter fraud as training scenarios for staff training and in awareness campaigns. Risk of fraud is included on the corporate risk register
- ▶ The governance committee brings together and is responsible for all aspects of non-financial risk and is chaired by a non-executive director
- ▶ The quality and safety committee reviews performance alerts, clinical effectiveness, clinical audit and quality and safety scorecards
- ▶ The health, safety, security and fire committee reviews all aspects of health and safety related risk
- ▶ Backlog maintenance programmes are in place at each site
- ▶ Prioritisation criteria are in place for capital investments
- ▶ The Trust infection control committee has local leads and monitors internal targets and national requirements, ward level reports which aggregate performance with workforce data
- ▶ A Trust-wide risk register is developed from local risk assessments
- ▶ A corporate risk register is reviewed twice a year and shows improvements in reducing levels of risk through management actions
- ▶ CIPs at clinical programme group and corporate directorates levels are assessed for delivery risk and the impact of the CIPs on the risk of impact on quality and safety of services. These are then reviewed at monthly performance management meetings
- ▶ A CIP board assesses and manages associated risks
- ▶ Business plans include a risk assessment
- ▶ Staff responsibilities are defined and leads are in place for clinical risk and safety in all designated areas
- ▶ Comprehensive mandatory training and induction programmes are in place
- ▶ Workforce reports include a trigger system for identifying areas of concern
- ▶ An online adverse event reporting system is available across the Trust
- ▶ The Trust's priority clinical audit programme includes national and local priorities with progress reports reviewed by the audit committee
- ▶ Serious incidents are reported to NHS London (NHS England from April 2013) and other appropriate bodies
- ▶ Clinical outcomes are monitored at the clinical standards committee with CPG lead clinicians
- ▶ The Trust-wide patient experience committee
- ▶ The Trust-wide equality and diversity committee
- ▶ Clinical risk is monitored at the clinical risk committee with CPG lead clinicians
- ▶ Clinical safety lead for new electronic records implementation (Cerner)
- ▶ Monitoring of clinical incidents reported to the National Patient Safety Agency (NPSA)
- ▶ Monitoring of reporting compliance with NICE guidance
- ▶ Monitoring of compliance with safety alerts to NHS London (NHS England from April 2013)
- ▶ CQC quality and risk profile reports are reviewed. The last report rated the Trust a 'low' risk organisation
- ▶ Planned inspection reports from the CQC are reviewed and action plans implemented
- ▶ Regular leadership walk-arounds are part of the internal quality assurance process, involving teams of senior Trust staff including representatives from the nursing directorate, corporate services, CPG lead nurses, CPG management teams, ISS Mediclean and estates. They review the environment, the knowledge and experience of staff members and the quality of care experienced by patients. A short summary report of each walk-around is published with actions plans as required. This is an annual rolling programme to ensure that each site is visited across all Trust sites

## 5.2 Deterrents to risks

### 5.2.1 Fraud deterrents

The Trust had previously achieved a level three – health body performing well – in the annual qualitative assessment for 2010/11 by NHS Protect which subsequently suspended the qualitative assessment process for 2012/2013. A review of the process is currently underway and a number of potential replacement reviews are currently being piloted. The Trust volunteered to participate in the test pilot for the new assessment trialling one of three types of evaluations. NHS Protect, a government agency concerned with identifying and tackling crime across the health service, attended the Trust on 2 October 2012 for a ‘focused evaluation’ as part of the pilot programme.

The Trust has in place two accredited Local Counter Fraud Specialists. Articles featured on the intranet and within Trust publications regarding successful sanctions and general counter fraud news, fraud and bribery awareness talks are delivered along with a dedicated stand at the marketplace during every monthly induction. A Counter Fraud and Bribery Act intranet site is in place.

The following additional activities have taken place to detect fraud:

- ▶ Risk assessment conducted and pro-active reviews carried out in areas identified at a high risk to fraud
- ▶ Counter fraud champions and contacts

### 5.3 Management of both manifest and potential risks

Following proactive risk assessment outlined in section four, the Trust assigns operational and executive leads to deliver agreed action plans to mitigate risk based on severity of risk, and monitors residual risk levels until they are as low as reasonably possible through local, corporate management forums and up to board level.

## 6. Review of the effectiveness of risk management and internal control

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. The head of internal audit opinion for 2012/13 is significant assurance. Senior clinicians and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided evidence that the effectiveness of controls to manage risks to the organisation in achieving its principal objectives have been reviewed. My review is also informed by the following evidence:

- ▶ Care Quality Commission (CQC) registration without conditions, results of inspections and the continuous monitoring process
- ▶ NHSLA Level 3 Risk Management Standards (general and maternity)
- ▶ Achievement of new and existing performance targets
- ▶ Financial performance reports
- ▶ External audit reports
- ▶ Internal audit progress reports
- ▶ Counter fraud annual report
- ▶ Audit and risk committee reports
- ▶ Governance committee reports
- ▶ Declarations made to the register of interests and the hospitality register and reviews
- ▶ The risk and patient safety quarterly reports to the board
- ▶ Infection control reports to the board and action plans to reduce the numbers of MRSA and *C.difficile* cases to required levels
- ▶ Specific service level accreditation, such as those in pathology

- ▶ Participation in national audits and the trust priority clinical audit programme
- ▶ Benchmarked hospital standardised mortality ratio (HSMR) showing the Trust as one of the top performers
- ▶ Quarterly review of clinical negligence claims to the board
- ▶ Monitoring of Trust adverse event data as part of the quality and safety scorecard
- ▶ Clinical outcomes
- ▶ Compliance reports on NICE guidance and safety alerts
- ▶ A whistleblowing policy, process and annual review
- ▶ Progress reports on the Trust's work programmes to improve the patient and staff experience and equality and diversity work
- ▶ Business continuity plans
- ▶ Risk based approach to investment decisions, including investment in business critical functions
- ▶ Feedback from key stakeholders
- ▶ Senior management team, clinical programme group directors and senior staff through their responsibilities for internal control and risk management
- ▶ The contribution of all staff in maintaining effective risk management practices as set out in their job descriptions and professional codes

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, audit committee, governance committee and the head of internal audit opinion.

## 6.1 Significant issues 2012/13

### a. Waiting list management <sup>14</sup>

In January 2012, the Trust board took the rare step to approve a reporting break for data relating to the 18 week referral to treatment (RTT) time target and waiting times for cancer including two week waits and diagnostics. An independent waiting list clinical review group was established to conduct an extensive patient level review of whether any harm had occurred in identified groups of patients. The group was made up of senior clinicians external to the Trust working in partnership with senior clinicians and managers from the Trust. It developed the framework for the review and reported that no patient was identified as suffering harm due to a delay in treatment. The review found that no patient died as a result of an extended delay on the waiting list.

Alongside the clinical review, the reporting systems used within the Trust were rebuilt to accurately reflect patients' waiting times. Following positive assurance from the NHS Intensive Support Team, reporting for cancer, including two week waits and diagnostics, recommenced in June 2012 and for the 18 week RTT time target in July 2012.

The Trust has tracking lists in place for RTT and cancer patients as recommended by the NHS Intensive Support Team. These lists are reviewed weekly and enable each patient's pathway to be monitored and progressed as appropriate.

Since reporting resumed in 2012, the Trust has:

- ▶ Met the six week diagnostic test each month (since June 2012)
- ▶ Steadily improved performance against the eight national cancer targets, from achieving just three of the eight targets in June 2012, to achieving all eight targets in March 2013

<sup>14</sup> Also see 18 week referral to treatment time target and waiting times for cancer and diagnostics section on page 12

- ▶ Improved RTT performance from July to November 2012 when all three standards (admitted performance, non-admitted performance and incompletes) were achieved at aggregate Trust level. Since November the three standards have been achieved by more and more specialties (as well as at Trust level). By March, all but four specialties were achieving these standards

The Trust continues to work to improve performance across these three key access standards and ensure performance is sustainable.

#### **b. Information governance (IG) toolkit**

As the return was 'unsatisfactory' due to non-achievement of the target for IG training in 2011/12, the Trust implemented an improvement plan to reach the target by the end of the 2012/13 financial year. Part of the plan was to move the training to a more accessible e-learning training platform and compliance reporting became more frequent and robust. The Trust declared a 98 per cent compliance rate for salaried staff against a year-end target of 95 per cent achieving NHS Information Governance Toolkit Level 2 compliance.

#### **c. Never events**

The number of never events related to retained swabs has reduced from five in 2011/12 to two during 2012/13. The reduction has been achieved following robust investigation of each case and an audit process regarding compliance with the WHO checklist in the operating environment. The Trust-wide swab count policy was re-launched which includes the designation of responsibility for key staff. The cases reported this year have both been in maternity services and actions have been taken to ensure compliance in the labour rooms. A central system is being set up to record that appropriate staff have read and understood the swab count policy. This will be used to enforce that staff cannot be involved in an operative environment without first committing to their understanding of our policy.

#### **d. Cancer patient experience survey results**

In August 2012, the annual National Cancer Patient Experience Survey results were published, placing the Trust at the bottom of the national league table for a second consecutive year. As a result, the Trust initiated a number of immediate diagnostic actions including discussions with the national cancer director, development of a cancer management team led by the Trust's chief operating officer, and visits to other improving organisations. The diagnostic actions were completed in September and an extensive improvement programme was initiated which has included quarterly cancer experience workshops with all key MDT members, a review of MDT working, reviews of cancer pathways, introduction of Macmillan Values Based Standards and quarterly internal versions of the National Cancer Patient Experience Survey.

### **Significant issues 2013/14:**

#### **a. Cerner implementation**

The Trust Board has had regular updates on the progress with the implementation of the Cerner Electronic Patient Record which is being delivered to the Trust through the National Programme for IT. The initial phase providing electronic ordering and reporting for pathology and radiology has bedded in well. Implementation of the next phase includes replacement of the Patient Administration System and Maternity module. Implementation of any new Patient Administration System always presents organisations with significant challenges. The Trust has in place a rigorous approach to provide assurance that the system is ready to be taken into live operation. This has identified a number of issues that are now being managed to resolution before the go live date is set.

#### **b. Final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry**

The findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry (published in February 2013) cover a variety of themes which are relevant to acute trusts. The Trust had already tackled a number of issues relevant to the themes of the report, the recommendations will help strengthen existing work and enable the Trust to develop robust plans and to accurately measure them. Actions already undertaken include:

- ▶ A comprehensive self-assessment against the recommendations to determine which ones are relevant to the Trust and creating an action plan
- ▶ Reviewing our standardised hospital mortality rate which shows we are classified as 'lower than expected'
- ▶ Discussions at the Trust board seminar (27 February 2013); governance committee (13 February 2013); and the management board (11 February 2013)
- ▶ Engaging with staff at various forums such as:
  - The chairman's patient experience walkabouts talking to staff about raising concerns
  - Chief executive officer 'Open Hour' discussions
  - Inclusion of information in the Nursing and Midwifery Matters newsletter to staff
  - Team meetings
  - Back to the floor Friday

Looking ahead further work will include:

- ▶ Incorporating the government and NHS England's response to the inquiry, into the Trust's action plan
- ▶ Overseeing the progress of the action plan and gaining assurance about its delivery at the Trust's management board and governance committee
- ▶ Creating a quality governance strategy incorporating the key aspects of the inquiry
- ▶ The Foundation Trust fitness test; this includes the board governance assurance framework, and performing a self-assessment against the quality assurance framework which will relate to the inquiry action plan where relevant
- ▶ An annual report outlining progress against the work plan will be produced and published
- ▶ The Trust's quality accounts for 2013/14 will reflect the work being carried out

### **c. Engaging with new commissioners**

The commissioning environment has completely changed across the NHS for 2013/14, with a number of new organisations given statutory authority for commissioning NHS care. It is important that the Trust develops good working relationships with the key organisations to ensure any changes to activity levels are fully engaged on and understood by both parties. The Trust has appointed a GP liaison manager and is developing forums where senior clinicians from the local CCGs and Trust can engage in partnership working. The Trust has also suggested a similar approach with NHS England on the specialised services contract.

### **d. Cost improvement programme (CIP)**

The Trust delivered a significant CIP in 2012/13, overachieving the value required and creating a good start for 2013/14 due to the full year effect of schemes from the previous year. However, another significant value of £48million is required for 2013/14 before any additional demand issues are dealt with through the commissioning arrangements. This will be delivered through similar but enhanced arrangements from 2012/13. The CIP board has developed its agenda to review transformational schemes as well as ensuring the latest quality assurance processes are adhered to following the recommendations from the Francis report. The Trust will also need to assure its commissioners about the quality impact of CIPs through national metrics. As in 2012/13, the staff of the Trust will ensure this is appropriately delivered to assist in the pathway to Foundation Trust status.

With the exception of the internal control issues outlined in this statement, my review confirms that Imperial College Healthcare NHS Trust has a generally sound system of internal control which supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

**Accountable officer: Mark Davies – Chief Executive Officer**

**Organisation: Imperial College Healthcare NHS Trust**

**Signature:**

**Date: 6<sup>th</sup> June 2013**

A handwritten signature in black ink, appearing to read 'Mark Davies', is written over a light grey rectangular background.

# //Financial accounts

## Details of directors and board members

### Board members

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

The board met a total of six times in public in 2012/13: May 2012, July 2012, September 2012, November 2012, January 2013 and March 2013.

- ▶ **Chairman** Sir Richard Sykes
- ▶ **Non-executive director and vice-chairman** Sir Thomas Legg
- ▶ **Non-executive director** The Honourable Angad Paul (until 30 September 2012)
- ▶ **Non-executive director** Sir Gerald Acher (appointed 1 April 2012)
- ▶ **Non-executive director** Dr Rodney Eastwood (appointed 1 April 2012)
- ▶ **Non-executive director** Jeremy Isaacs
- ▶ **Non-executive director** Dr Martin Knight (1 April 2012 - 1 March 2013)
- ▶ **Non-executive director** Professor Sir Anthony Newman Taylor (appointed 1 October 2012)
- ▶ **Non-executive director** Sarika Patel (appointed 1 January 2013)
- ▶ **Non-executive director** Ellen Schroder (until 30 April 2012)
- ▶ **Chief executive officer** Mark Davies
- ▶ **Chief financial officer** Bill Shields
- ▶ **Chief operating officer** Steve McManus (appointed 20 August 2012)
- ▶ **Medical director** Professor David Taube (resigned 31 August 2012)
- ▶ **Interim medical director** Dr David Mitchell (1 September 2012 - 30 November 2012)
- ▶ **Medical director** Professor Nick Cheshire (appointed 1 December 2012)
- ▶ **Director of nursing** Janice Sigsworth

### Audit and risk committee membership

The audit committee is responsible for all aspects of internal control, including a key focus on financial standing, reporting, management, financial risk and value for money. The audit committee has delegated the review of all aspects of non-financial risk to the governance committee.

The audit and risk committee met five times in 2012/13: April 2012, June 2012, September 2012, December 2012 and March 2013.

The following non-executive directors were members of the audit committee during this period.

- ▶ **Non-executive director and chair** Sir Gerry Acher
- ▶ **Non-executive director and vice-chairman** Sir Thomas Legg
- ▶ **Non-executive director** The Honourable Angad Paul (until 30 September 2012)
- ▶ **Non-executive director** Dr Martin Knight (until 1 March 2013)
- ▶ **Non-executive director** Ellen Schroder (chair until 30 April 2012)
- ▶ **Non-executive director** Sir Anthony Newman Taylor (from 1 October 2012)

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

## Remuneration committee

The remuneration committee determines whether the criteria for performance payment have been met. The remuneration committee met once on 27 June 2012. The following non-executive directors have acted as members of the remuneration committee.

- ▶ **Non-executive director** Jeremy Isaacs (chair)
- ▶ **Non-executive director** Sir Thomas Legg
- ▶ **Non-executive director** The Hon. Angad Paul (until June 2012)
- ▶ **Chairman** Sir Richard Sykes (from June 2012)
- ▶ **Non-executive director** Ellen Schroder (until April 2012)

## Executive and CPG directors

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

- ▶ Chief executive officer - Mark Davies
- ▶ Chief financial officer - Bill Shields
- ▶ Chief information officer - Kevin Jarrold
- ▶ Chief operating officer - Steve McManus (appointed 20 August 2012)
- ▶ Director of communications - Rebekah Fitzgerald
- ▶ Director of education - Dr Jeremy Levy
- ▶ Acting director of estates and facilities - John Cryer
- ▶ Director of governance and corporate affairs - vacant
- ▶ Director of infection control and prevention - Professor Alison Holmes
- ▶ Director of nursing - Janice Sigsworth
- ▶ Director of operational finance - Marcus Thorman
- ▶ Director of people and organisational development - Jayne Mee (appointed 18 March 2013)
- ▶ Director of research - Professor Jonathan Weber
- ▶ Director of strategy - Brendan Farmer
- ▶ Director of public health and primary care - Dr Josip Car
- ▶ Medical director - Professor Nick Cheshire (appointed 1 December 2012)
  
- ▶ Medicine CPG1 - Dr Julian Redhead, director
- ▶ Surgery and cancer CPG2 – Mr Justin Vale, director
- ▶ Specialist services CPG3 - Dr Mark Palazzo, director
- ▶ Circulation sciences and renal medicine CPG4 - Dr Jamil Mayet, interim director (appointed 1 December 2012)
- ▶ Women's and children's CPG5 – Mr Keith Edmonds, director
- ▶ Clinical and investigative sciences CPG6 - Professor Martin Wilkins, director
  
- ▶ Lead clinician, Imperial Private Healthcare - Dr Jonathan Ramsay

## Register of interests - March 2013

### **Sir Richard Sykes**, chairman

- ▶ Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- ▶ Chairman, UK Stem Cell Foundation since 2004
- ▶ Member, Bristol Advisory Council since 2006
- ▶ President, British Medical and Dental Students' Trust since 2009
- ▶ President, Institute for Employment Studies since 2008
- ▶ Chairman, Careers Research Advisory Centre since 2008
- ▶ Non-executive chairman of NetScientific
- ▶ Non-executive director of ContraFect since 2012
- ▶ Chairman of Royal Institution of Great Britain

### **Mark Davies**, chief executive

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

### **Sir Thomas Legg**, non-exec director

- ▶ Trustee, Imperial College Healthcare Trust Charity

### **The Hon. Angad Paul**, formerly non-exec director

- ▶ Nothing to declare

### **Professor Anthony Newman-Taylor**, non-executive director

- ▶ Chairman, Colt Foundation
- ▶ Trustee, Rayne Foundation
- ▶ Chairman, Independent Medical Expert Group, Armed Forces Compensation Scheme, MoD
- ▶ Member, Bevan Commission, advisory group to minister of health, Wales
- ▶ Trustee, CORDA, Preventing Heart Disease and Stroke

### **Jeremy M Isaacs**, non-exec director

- ▶ Director, JRJ Group Limited
- ▶ Director, JRJ Jersey Limited
- ▶ Director, JRJ Investments Limited
- ▶ Director, JRJ Team General Partner Limited
- ▶ Partner, JRJ Ventures LLP
- ▶ Partner, JRJ Partner 1 LP
- ▶ Limited Partner, JRJ Partner 2 LP
- ▶ Partner, JRJ Carry LP
- ▶ Director/non-executive director chairman, Marex Spectron Group Limited
- ▶ Member, Bridges Ventures Advisory Board (privately owned venture capital company with a social mission)
- ▶ Director, Kytos Limited
- ▶ Trustee, Noah's Ark Children's Hospice

### **Dr Rodney Eastwood**, non-executive director

- ▶ Rector's envoy, Imperial College
- ▶ Governor, Chelsea Academy (secondary school)
- ▶ Consultant, Mazars

**Sir Gerry Acher**, non-executive director

- ▶ Deputy chairman, Camelot Group PLC
- ▶ Vice chairman, Motability
- ▶ Trustee, Motability 10 Anniversary Trust
- ▶ Vice chairman, RSA Academy

**Sarika Patel**, non-executive director

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

**Dr Martin Knight**, formerly non-executive director

- ▶ Chairman, Merrycroft Ltd
- ▶ Chairman, Imperial Innovations Group PLC
- ▶ Chairman, Cambridge Mechatronics Ltd
- ▶ Director, Chrysalis VCT
- ▶ Director, Toumaz Holdings Ltd
- ▶ Trustee, Royal Institution of Great Britain
- ▶ Director, LMS Capital PLC

**Professor David Taube**, AHSC director; formerly medical director - clinical services

- ▶ Non-executive director, North West London Hospital NHS Trust
- ▶ Advisor, National Kidney Foundation
- ▶ Trustee, St Mary's Hospital Kidney Patients Association
- ▶ Advisory board member, Sandoz Pharmaceuticals (Sandoz is owned by Novartis with whom the Trust will have many drug contracts)

**Professor Janice Sigsworth**, director of nursing

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

**Professor Nick Cheshire**, medical director - clinical services; formerly director of CPG 4

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

Cook, Medtronic and Gore are endovascular equipment suppliers to the Trust.

Hansen Medical manufactures the only commercially available endovascular robot and supplies hardware and disposable robotic equipment to the Trust.

**Bill Shields**, chief financial officer

- ▶ Honorary Colonel 243 (Wessex) TA Field Hospital
- ▶ Member, Group Board, CIPFA
- ▶ Vice chairman, Audit Committee, CIPFA
- ▶ Member, NHS Supply Chain Board Customer Board
- ▶ Board member, NHS Shared Business Services
- ▶ Member, NHS Confederation Hospitals Forum
- ▶ Advisor, Hunter Healthcare (involves remuneration)

**Dr David Mitchell**, medical director - professional development

- ▶ PACES examiner for Royal College of Physicians MRCP

**Anne Mottram**, formerly director of corporate affairs and governance

- ▶ Nothing to declare

**Jayne Mee**, director of people and organisational development

- ▶ Board director, Kick Out

**Mike Griffin**, formerly director of people and organisational development

- ▶ Nothing to declare

**John Cryer**, acting director of estates and facilities

- ▶ Nothing to declare

**Phil Hudson**, formerly director of estates

- ▶ Nothing to declare

**Cymbeline Moore**, formerly director of communications

- ▶ Nothing to declare

**Rebekah Fitzgerald**, director of communications

- ▶ Nothing to declare

**Kevin Jarrold**, chief information officer

- ▶ Nothing to declare

**Dr Jeremy Levy**, director of education

- ▶ Nothing to declare

**Professor Jonathan Weber**, director of research

- ▶ ERANDA Foundation
- ▶ Elton John AIDS Foundation
- ▶ Medical Research Council (MRC) – Stratified Medicine Group
- ▶ MRC – Developmental Pathway Funding Scheme
- ▶ Council – Academy of Medical Sciences
- ▶ Research Excellence Framework 2014 – Sub panel 1: Clinical Medicine

- ▶ MRC/National Institute of Health Research - Efficacy & Mechanism Evaluation Board
- ▶ Crick Executive Committee
- ▶ Global Medical Excellence Cluster (GMEC) Committee
- ▶ Imanova Board
- ▶ Research grants from: The Wellcome, Medical Research Council and European Commission – EDCTP

**Professor Alison Holmes**, director of infection and prevention control

- ▶ Nothing to declare

**Steve McManus**, chief operating officer

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

**Brendan Farmer**, director of strategy

- ▶ Nothing to declare

**Dr Julian Redhead**, director CPG1

- ▶ Secretary to the British Association Immediate Care (BASICS) London
- ▶ Doctor, Chelsea Football Club

**Mr Justin Vale**, director CPG2

- ▶ Director, Opus Health

**Dr Mark Palazzo**, director CPG3

- ▶ Director (unpaid) and 50 per cent shareholder of AcuBase Ltd (a software company) since 2001

**Mr Keith Edmonds**, director CPG5

- ▶ Nothing to declare

**Professor Martin Wilkins**, director CPG6

- ▶ Chair, allocation of British Heart Foundation grants, British Heart Foundation
- ▶ Principal investigator iron homeostasis and pulmonary hypertension, British Heart Foundation
- ▶ Principal investigator, Clinical Research Facility and Translational Medicine Training Fellowships, Wellcome Trust
- ▶ Principal Investigator, dichloroacetate in pulmonary hypertension and stem cell unit pump-priming funding, MRC
- ▶ Board panel member, Translational Stem Cell Medicine, MRC
- ▶ Novartis Database registry for detection of side effects with Gleevec
- ▶ Consultant, Bayer Clinical Trial Steering Committee
- ▶ Chair, Bayer Scientific Advisory Board for Pulmonary Hypertension research project grants
- ▶ President, Pulmonary Vascular Research Institute
- ▶ MHRA Member

**Dr Josip Car**, director of public health and primary care

- ▶ Director, eHealth Unit, School of Public Health, Imperial College London

**Marcus Thorman**, director of operational finance

- ▶ Nothing to declare

## Remuneration report for the Trust – 2012/13

	Salary	Other remuneration	Benefits in kind	Real increase in pension at age 60	Real increase in lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31st March 2013	Total accrued lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent 31 March 2013	Cash Equivalent 31 March 2012	Real increase in cash equivalent transfer value
	(bands of £5,000)	(bands of £5,000)	(Rounded to nearest £00)	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Name	£000	£000	£00	£000	£000	£000	£000	£000	£000	£000
Sir Richard Sykes, Chairman	20-25	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas S Legg, Non-executive Director	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Isaacs, Non-executive Director	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ellen Schroder, Non-executive Director <sup>1</sup>	0-5	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
The Honorable Angad Paul, Non-executive Director <sup>2</sup>	0-5	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Gerald Archer, Non-executive Director <sup>3</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Rodney Eastwood, Non-executive Director <sup>4</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Martin Knight, Non-executive Director <sup>5</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Prof. Sir Anthony Newman Taylor <sup>6</sup>	0-5	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarika Patel, Non-executive Director <sup>7</sup>	0-5	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Davies, Chief Executive	255-260	0	0	Not Available	Not Available	85-90	265-270	1,812	Not Available	Not Available
Bill Shields, Chief Financial Officer	215-220	0	70	(2.5-5)	(12.5-15)	55-60	165-170	939	985	(46)
Steve McManus, Chief Operating Officer <sup>8</sup>	95-100	0	104	New Board Member	New Board Member	45-50	135-140	743	New Board Member	New Board Member
Prof. David Taube, Medical Director <sup>9</sup>	35-40	40-45	0	Left	Left	Left	Left	Left	Left	Left
Dr David Mitchell, Medical Director <sup>10</sup>	20-25	40-45	0	Left	Left	Left	Left	Left	Left	Left

	Salary	Other remuneration	Benefits in kind	Real increase in pension at age 60	Real increase in lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31st March 2013	Total accrued lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent 31 March 2013	Cash Equivalent 31 March 2012	Real increase in cash equivalent transfer value
	(bands of £5,000)	(bands of £5,000)	(Rounded to nearest £00)	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Name	£000	£000	£00	£000	£000	£000	£000	£000	£000	£000
Prof. Nick Cheshire, Medical Director <sup>11</sup>	25-30	50-55	0	New Board Member	New Board Member	45-50	145-150	919	New Board Member	New Board Member
Prof Janice Sigsworth, Director of Nursing	155-160	0	0	0-2.5	5-7.5	65-70	195-200	1182	1114	68

#### Notes

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

## Remuneration report for the Trust – 2011/12

	Salary	Other remuneration	Benefits in kind	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 2012	Total accrued lump sum at age 60 related to accrued pension at 31 March 2012	Cash equivalent transfer value at 31 March 2012	Cash equivalent transfer value at 31 March 2011	Real increase in cash equivalent transfer value
	(bands of £5,000)	(bands of £5,000)	(Rounded to nearest £00)	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Name	£000	£000	£00	£000	£000	£000	£000	£000	£000	£000
Lord Christopher Tugendhat, Chairman <sup>1</sup>	15-20	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Richard Sykes, Chairman <sup>2</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sir Thomas S Legg, Non-executive Director	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeremy Isaacs, Non-executive Director <sup>3</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ellen Schroder, Non-executive Director	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
The Honorable Angad Paul, Non-executive Director	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Crispin Simon, Non-executive Director <sup>4</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Maggie Dallman, Non-executive Director <sup>5</sup>	5-10	0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Davies, Chief Executive <sup>6</sup>	20-25	315-320	0	0	0	0	0	0	0	0
Prof Stephen Smith, Chief Executive <sup>7</sup>	30-35	0	0	Left	Left	Left	Left	Left	Left	Left
Bill Shields, Chief Financial Officer <sup>8</sup>	100-105	0	71	New Board Member	New Board Member	60 - 65	180 - 185	985	New Board Member	New Board Member
Steve Morris, Director of Finance <sup>9</sup>	85-90	0	0	Left	Left	Left	Left	Left	Left	Left
Claire Perry, Managing Director <sup>10</sup>	100-105	0	0	Left	Left	Left	Left	Left	Left	Left
Prof David Taube, Medical Director	85-90	100-105	0	0	0	0	0	0	0	0
Prof Janice Sigsworth, Director of Nursing	155-160	0	0	0 - 2.5	5 - 7.5	60 - 65	190 - 195	1114	962	152

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Notes

1 Lord Christopher Tugendhat left the Board on 31st December 2011

2 Sir Richard Sykes joined the Board on 1st January 2012

3 Mr J Isaacs' salary is donated to the J Isaacs' Charitable Trust

4 Crispin Simon left the Board on 31st March 2012

5 Maggie Dallman left the Board on 31st January 2012

6 Mark Davies joined the Board on 16th May 2011

7 Prof Stephen Smith left the Board on 15th May 2011

8 Bill Shields joined the Board on 1st October 2011

9 Steve Morris left the Board on 30th September 2011

10 25% of Claire Perry's salary was recharged to Imperial College London from 1st April to 31st August 2011. The salary shown above relates to NHS remuneration only. She left the Board on 30th September 2011

## 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 2012-13 was £257,500 (2011-12 - £385,150\*). This was 6.72 times (2011-12 – 10.22\*) the median remuneration of the workforce which was £38,320 (2011-12 - £37,670).

In 2012-13, one (2011-12 – none) employee received remuneration in excess of the highest paid director. Remuneration was £260,765 (2011-12 – nil)

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

\* In 2011-12 the highest paid director was only paid through payroll for one month and prior to this was remunerated through a third party company. Based on the annualised salary through payroll, the 2011-12 ratio of the median salary to the highest paid director was 6.91.

## Financial summary

### Summary financial performance

The Trust has achieved an adjusted surplus of £9.0m a favourable variance against the plan of £8.5m. This demonstrates the continued improvement the Trust has made and needs to sustain into 2013/14 in order to deliver the financial plan. The Trust delivered cost improvements of £54.1m, which was £2m more than the plan. The improvement in the cash position, predominantly due to an improved I&E position and a reduction in capital expenditure, resulted in the repayment of a Department of Health capital loan of £20.4m.

### Key financial achievements

	Annual Plan	Actual	Variance
	£m	£m	£m
Total Income	950.1	971.3	21.2
Operating Expenses Adjusted for Impairments*	(926.1)	(939.7)	(13.6)
Finance costs (inc. Public Dividend Capital)	(23.5)	(22.6)	0.9
Retained Surplus Adjusted for Impairments*	0.5	9.0	8.5
Cost Improvement Plan (CIP)	52.1	54.1	2.0
Cash Balance	24.4	55.3	30.9
Capital Programme	25.2	25.0	(0.2)

\*Excluding an impairment of £48.4m which is a non-cash, non-operational charge mainly relating to the downward valuation of the Trust's building assets and an accounting adjustment of £0.6m for the treatment of donated assets. The total deficit for the year was, therefore, £40.0m.

### Income, expenditure and activity

Income from patient activities increased by £21.4m (2.9 per cent) when compared to the previous year. North West London (NWL) income reflects the block contract of £500m agreed with the NWL Commissioners. Other operating income increased by £8.2m, which can be attributed to additional research income linked to an equivalent level of expenditure to ensure a net zero impact for research projects, and the sale of Acton Hospital.

Expenditure increased by £2.8m (0.3 per cent) after excluding the impairment charge for the change in the value of the Trust's property portfolio.

### Capital investment, cash and liquidity

The Trust invested £25m in its estate financed, mainly, by internally generated funds. Completed projects this year include relocation and improvement of facilities for clinical chemistry, refurbishment of the Lindo Wing, creation of a paediatric clinical haematology day unit and enhancing power backup capacity with a new standby generator at St Mary's Hospital.

The improved cash position, predominantly due to an improved I&E position and a reduction in capital expenditure, allowed the Trust to make early repayment of a Department of Health capital loan of £20.4m.

The Trust ended the year with a financial liquidity risk rating of four, which meets the Foundation Trust (FT) requirement for good financial governance and is one of the key financial targets to achieve FT status.

## Challenging environment

The Trust delivered a significant CIP in 2012/13, over achieving the value required and creating a good start for 2013/14 due to the full year effect of schemes from 2012/13. Another significant value of £48m is, however, required for 2013/14, before any additional demand issues are dealt with through commissioning arrangements. This will be delivered through similar but enhanced arrangements to those operating in 2012/13. The Transformation Board (previously CIP Board) has developed its agenda to review transformational schemes as well as ensuring the latest quality assurance processes, following the recommendations from the Francis Report, are adhered to.

The commissioning environment has completely changed across the NHS for 2013/14, with a number of new organisations given statutory authority for commissioning NHS care. The Trust has agreed to move away from a block contract and back to a full PbR contract. This has inherent risks for all parties and it is, therefore, important that the Trust develops good working relationships with the key organisations to ensure any changes to activity levels are fully engaged on and understood by both parties. To this end, the Trust has appointed a GP liaison manager and is developing forums where senior clinicians from the local Clinical Commissioning Groups and Trust can engage in partnership working.

## Non-NHS income disclosure

The Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

## Going concern

The going concern assessment for 2012/13 was presented to the Audit Committee in June and provided assurance to the Trust's directors that it has adequate resources to continue in operational existence for the foreseeable future and, consequently, to continue to adopt the 'going-concern' basis in preparing its accounts.

## Accounting policies

NHS accounting rules require trusts to revalue their assets periodically and the impact of this was an impairment charge of £47.5m to the accounts for 2012/13. This is a non-cash, non-operational charge relating to the downward valuation of the Trust's property portfolio. There were no other material changes to accounting arrangements during the year.

## Countering fraud and corruption

The Trust is committed to promoting and maintaining an absolute standard of honesty and integrity and to eliminating fraud and illegal acts committed within the Trust. We undertake rigorous investigation and disciplinary action where appropriate and seek recovery of any losses where possible. The Trust has adopted best practice, as recommended by the NHS Counter Fraud and Security Management Service (CFSMS), and is also involved in the National Fraud Initiative, which is led by the Audit Commission. We have widely publicised our procedure for staff to report any concern about potential fraud and corruption. Any concerns raised are investigated by our local counter-fraud specialists or the CFSMS as appropriate and all investigations are reported to the audit committee.

## Financial accountability

Deloitte LLP is the appointed external auditor to the Trust. During 2012/13, the fees payable to Deloitte for its external audit were £231,000. Deloitte also provided advice to the Trust on estates matters and other sundry issues for £8,000.

The better payment practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Total value of undisputed invoices paid within 30 days was 95.7 per cent. Details of compliance with the code can be found as note 10.1 of the full financial accounts.

The 2012/13 annual report includes the summary financial statements for Imperial College Healthcare NHS Trust. If you require further understanding of the Trust's financial position and performance, please phone 020 3313 3864 for a copy of the full accounts or refer to the Trust's website: [www.imperial.nhs.uk](http://www.imperial.nhs.uk).

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

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and related notes 1 to 8.

This report is made solely to the Board of Directors of Imperial College Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to the Trust 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 accept or assume responsibility to anyone other than the company and the company's members as a body, for our audit work, for this report, for our audit report, or for the opinions we have formed.

### **Respective responsibilities of directors and auditors**

The directors are responsible for preparing the annual report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the annual report with the statutory 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 statement.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the company's statutory financial statements describes the basis of our opinion on those financial statements.

### **Opinion**

In our opinion, the summary financial statement is consistent with the statutory financial statements of Imperial College Healthcare NHS Trust for the year ended 31 March 2013.

Heather Bygrave FCA (Engagement Lead)  
for and on behalf of Deloitte LLP  
Appointed Auditor  
St Albans, United Kingdom  
4<sup>th</sup> June 2013

## Statements of accounts

### Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Gross employee benefits	3	(522,485)	(534,821)
Other costs	3	(466,159)	(403,467)
Revenue from patient care activities	1	752,725	731,345
Other operating revenue	2	218,549	210,345
<b>Operating surplus/(deficit)</b>		<b>(17,370)</b>	3,402
Investment revenue		287	188
Other gains and (losses)		(13)	54
Finance costs		(1,791)	(1,939)
<b>Surplus/(deficit) for the financial year</b>		<b>(18,887)</b>	1,705
Public dividend capital dividends payable		(21,068)	(22,184)
<b>Deficit for the year</b>		<b>(39,955)</b>	(20,479)
<b>Other Comprehensive Income</b>		<b>2012-13 £000</b>	<b>2011-12 £000</b>
Impairments and reversals		0	0
Net gain/(loss) on revaluation of property, plant & equipment		31,423	9
Net gain/(loss) on revaluation of intangibles		0	0
<b>Total comprehensive income for the year</b>		<b>(8,532)</b>	(20,470)
<b>Financial performance for the year</b>			
Retained surplus/(deficit) for the year		(39,955)	
Impairments		48,379	
Adjustments in respect of donated / government grant asset reserve elimination		(601)	
<b>Adjusted retained surplus/(deficit)</b>		<b>9,025</b>	
PDC dividend: balance receivable at 31 March 2013		585	

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 2013

		31 March 2013	31 March 2012
	NOTE	£000	£000
<b>Non-current assets:</b>			
Property, plant and equipment	8	715,616	744,023
Intangible assets		1,681	579
Trade and other receivables		0	0
<b>Total non-current assets</b>		<b>717,297</b>	<b>744,602</b>
<b>Current assets:</b>			
Inventories		17,652	17,141
Trade and other receivables		65,462	54,752
Cash and cash equivalents		55,326	22,974
<b>Total current assets</b>		<b>138,440</b>	<b>94,867</b>
Non-current assets held for sale		0	0
<b>Total current assets</b>		<b>138,440</b>	<b>94,867</b>
<b>Total assets</b>		<b>855,737</b>	<b>839,469</b>
<b>Current liabilities</b>			
Trade and other payables		(127,930)	(106,373)
Provisions		(37,353)	(12,891)
Borrowings		(1,833)	(1,338)
Capital loan from Department		(1,226)	(2,426)
<b>Total current liabilities</b>		<b>(168,342)</b>	<b>(123,028)</b>
<b>Non-current assets plus/less net current assets/liabilities</b>		<b>687,395</b>	<b>716,441</b>
<b>Non-current liabilities</b>			
Trade and other payables		0	0
Provisions		0	0
Borrowings		(2,540)	(2,598)
Capital loan from Department		(20,822)	(42,448)
<b>Total non-current liabilities</b>		<b>(23,362)</b>	<b>(45,046)</b>
<b>Total Assets Employed:</b>		<b>664,033</b>	<b>671,395</b>
<b>FINANCED BY:</b>			
<b>TAXPAYERS' EQUITY</b>			
Public Dividend Capital		696,088	694,918
Retained earnings		(72,899)	(32,944)
Revaluation reserve		40,844	9,421
<b>Total Taxpayers' Equity:</b>		<b>664,033</b>	<b>671,395</b>

## Statement of Changes in Taxpayers' Equity For the year ended 31 March 2013

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
<b>Balance at 1 April 2012</b>	<b>694,918</b>	<b>(32,944)</b>	<b>9,421</b>	<b>671,395</b>
<b>Changes in taxpayers' equity for 2012-13</b>				
Retained surplus/(deficit) for the year	0	(39,955)	0	(39,955)
Net gain on revaluation of property, plant, equipment	0	0	31,423	31,423
New PDC received	1,170	0	0	1,170
Net recognised revenue/(expense) for the year	1,170	(39,955)	31,423	(7,362)
<b>Balance at 31 March 2013</b>	<b>696,088</b>	<b>(72,899)</b>	<b>40,844</b>	<b>664,033</b>
<b>Changes in taxpayers' equity for the year ended 31 March 2012</b>				
<b>Balance at 1 April 2011</b>	694,918	(12,465)	9,412	691,865
Retained surplus/(deficit) for the year	0	(20,479)	0	(20,479)
Net gain on revaluation of property, plant, equipment	0	0	9	9
Net recognised revenue/(expense) for the year	0	(20,479)	9	(20,470)
<b>Balance at 31 March 2012</b>	<b>694,918</b>	<b>(32,944)</b>	<b>9,421</b>	<b>671,395</b>

## Statement of Cash Flows for the Year Ended 31 March 2013

	2012-13 £000	2011-12 £000
<b>Cash Flows from Operating Activities</b>		
Operating Surplus/Deficit	(17,370)	3,402
Depreciation and Amortisation	37,053	37,136
Impairments and Reversals	48,379	12,060
Donated Assets received credited to revenue but non-cash	(80)	0
Government Granted Assets received credited to revenue but non-cash	0	0
Interest paid	(1,835)	(1,943)
Dividend paid	(21,472)	(22,672)
(Increase)/Decrease in Inventories	(1,385)	4,356
(Increase)/Decrease in Trade and Other Receivables	(10,125)	(6,148)
Increase/(Decrease) in Trade and Other Payables	17,854	9,690
Provisions Utilised	(1,223)	(113)
Increase/(Decrease) in Provisions	25,685	12,869
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<b>75,481</b>	<b>48,637</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Interest Received	285	188
(Payments) for Property, Plant and Equipment	(20,705)	(42,522)
(Payments) for Intangible Assets	(1,494)	(33)
Proceeds of disposal of assets held for sale (PPE)	3	62
Proceeds of disposal of assets held for sale (Intangible)	0	0
Rental Revenue	0	0
<b>Net Cash Inflow/(Outflow) from Investing Activities</b>	<b>(21,911)</b>	<b>(42,305)</b>
<b>NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING</b>	<b>53,570</b>	<b>6,332</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Public Dividend Capital Received	1,170	0
Other Loans Received	1,979	2,613
Loans repaid to DH - Capital Investment Loans Repayment of Principal	(22,826)	(2,426)
Other Loans Repaid	(1,541)	(1,043)
Capital grants and other capital receipts	0	0
<b>Net Cash Inflow/(Outflow) from Financing Activities</b>	<b>(21,218)</b>	<b>(856)</b>
<b>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS</b>	<b>32,352</b>	<b>5,476</b>
<b>Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period</b>	<b>22,974</b>	<b>17,498</b>
<b>Cash and Cash Equivalents (and Bank Overdraft) at year end</b>	<b>55,326</b>	<b>22,974</b>

## Notes to the summarised financial statements

<b>1. Revenue from patient care activities</b>	<b>2012-13</b>	2011-12
	<b>£000</b>	£000
Strategic health authorities	<b>5,746</b>	5,162
NHS trusts	<b>723</b>	984
Primary care trusts - tariff	<b>348,034</b>	316,438
Primary care trusts - non-tariff	<b>267,672</b>	295,372
Primary care trusts - market forces factor	<b>84,496</b>	76,491
Foundation trusts	<b>4,097</b>	230
Department of Health	<b>4,529</b>	2,115
NHS other	<b>0</b>	0
Non-NHS:		
Private patients	<b>30,477</b>	28,582
Overseas patients (non-reciprocal)	<b>1,802</b>	2,018
Injury costs recovery	<b>1,361</b>	1,344
Other	<b>3,788</b>	2,609
	<b><u>752,725</u></b>	<u>731,345</u>

Injury costs recovery income reflects actual rates of collection.

<b>2. Other operating revenue</b>	<b>2012-13</b>	2011-12
	<b>£000</b>	£000
Recoveries in respect of employee benefits	<b>6,439</b>	5,026
Patient transport services	<b>0</b>	0
Education, training and research	<b>122,743</b>	118,606
Charitable and other contributions to revenue expenditure - Non NHS	<b>29</b>	229
Receipt of charity donations for capital acquisitions	<b>747</b>	1,117
Receipt of Government grants for capital acquisitions	<b>42</b>	0
Non-patient care services to other bodies	<b>33,093</b>	34,377
Income generation	<b>6,011</b>	5,133
Rental revenue from operating leases	<b>5,593</b>	5,369
Other revenue	<b>43,852</b>	40,488
	<b><u>218,549</u></b>	<u>210,345</u>
Total operating revenue	<b><u>971,274</u></b>	<u>941,690</u>

## Notes to the Summarised Financial Statements

<b>3. Operating expenses (excluding employee benefits)</b>	<b>2012-13</b>	2011-12
	<b>£000</b>	£000
Services from other NHS trusts	<b>8,601</b>	5,029
Services from PCTs	<b>2,707</b>	1,243
Services from other NHS bodies	<b>872</b>	310
Services from foundation trusts	<b>6,205</b>	4,883
Purchase of healthcare from non NHS bodies	<b>2,980</b>	4,290
Trust chair and non-executive directors	<b>64</b>	62
Supplies and services - clinical	<b>183,421</b>	174,245
Supplies and services - general	<b>37,035</b>	50,864
Consultancy services	<b>16,212</b>	6,354
Establishment	<b>8,042</b>	8,111
Transport	<b>9,628</b>	8,555
Premises	<b>40,193</b>	36,046
Impairments and Reversals of Receivables	<b>553</b>	4,228
Inventories write down	<b>874</b>	0
Depreciation	<b>36,641</b>	36,745
Amortisation	<b>412</b>	391
Impairments and reversals of property, plant and equipment	<b>47,505</b>	12,060
Audit fees	<b>231</b>	445
Other auditor's remuneration	<b>8</b>	59
Clinical negligence	<b>12,827</b>	13,354
Research and development (excluding staff costs)	<b>16,711</b>	13,951
Education and Training	<b>2,439</b>	2,560
Other	<b>31,998</b>	19,682
	<b><u>466,159</u></b>	<u>403,467</u>
<b>Employee benefits</b>		
Employee benefits excluding board members	<b>521,307</b>	533,985
Board members	<b>1,178</b>	836
<b>Total employee benefits</b>	<b><u>522,485</u></b>	<u>534,821</u>
<b>Total operating expenses</b>	<b><u><u>988,644</u></u></b>	<u><u>938,288</u></u>

## 4. Staff Numbers

	2012-13		2011-12	
	Total Number	Permanently employed Number	Other Number	Total Number
<b>Average Staff Numbers</b>				
Medical and dental	1,685.9	1,624.3	61.6	1,718
Ambulance staff	0.0	0.0	0.0	0
Administration and estates	2,243.4	1,934.2	309.2	2,454
Healthcare assistants and other support staff	1,056.8	901.6	155.2	1,032
Nursing, midwifery and health visiting staff	3,439.1	3,161.3	277.8	3,481
Nursing, midwifery and health visiting learners	0.0	0.0	0.0	0
Scientific, therapeutic and technical staff	1,344.3	1,294.7	49.6	1,382
<b>TOTAL</b>	<b>9,769.5</b>	<b>8,916.1</b>	<b>853.4</b>	<b>10,067</b>
Of the above - staff engaged on capital projects	9.7	5	4.7	12

## 5. Staff Sickness absence

	2012-13 Number	2011-12 Number
Total Days Lost	62,691	64,384
Total Staff Years	8,943	9,040
Average working Days Lost	7.01	7.12

## 6. Exit Packages agreed in 2012-13

Exit package cost band (including any special payment element)	2012-13			2011-12		
	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	4	12	16	5	7	12
£10,001-£25,000	8	28	36	5	8	13
£25,001-£50,000	12	24	36	4	5	9
£50,001-£100,000	7	6	13	6	5	11
£100,001 - £150,000	6	1	7	4	1	5
£150,001 - £200,000	1	0	1	0	0	0
>£200,000	1	0	1	1	0	1
<b>Total number of exit packages by type (total cost)</b>	<b>39</b>	<b>71</b>	<b>110</b>	<b>25</b>	<b>26</b>	<b>51</b>
<b>Total resource cost (£000s)</b>	<b>2,235</b>	<b>1,942</b>	<b>4,177</b>	<b>1,505</b>	<b>784</b>	<b>2,289</b>

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). **Exit costs in this note are accounted for in full in the year of departure.** 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 taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

## 7. Better Payment Practice Code - Measure of Compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
<b>Non-NHS Payables</b>				
Total Non-NHS Trade Invoices Paid in the Year	141,159	305,986	170,962	370,357
Total Non-NHS Trade Invoices Paid Within Target	129,754	291,626	159,351	352,926
Percentage of NHS Trade Invoices Paid Within Target	91.92%	95.31%	93.21%	95.29%
<b>NHS Payables</b>				
Total NHS Trade Invoices Paid in the Year	3,745	40,881	5,340	50,622
Total NHS Trade Invoices Paid Within Target	3,408	40,205	5,024	49,703
Percentage of NHS Trade Invoices Paid Within Target	91.00%	98.35%	94.08%	98.18%

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

## 8. Property, plant and equipment

2012-13

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Cost or valuation:</b>	179,707	481,913	1,800	9,478	113,310	23,136	667	<b>810,011</b>
<b>At 1 April 2012</b>	0	0	0	8,120	0	0	0	<b>8,120</b>
Additions of Assets Under Construction	0	5,829	0	0	4,125	5,344	125	<b>15,423</b>
Additions Purchased	0	0	0	0	747	0	0	<b>747</b>
Additions Donated	0	0	0	0	42	0	0	<b>42</b>
Additions Government Granted	0	15,246	0	(15,791)	(57)	602	0	<b>0</b>
Reclassifications	879	(67,639)	(45)	0	(528)	0	0	<b>(67,333)</b>
Disposals other than for sale	26,692	4,286	445	0	0	0	0	<b>31,423</b>
Upward revaluation/positive indexation	<b>207,278</b>	<b>439,635</b>	<b>2,200</b>	<b>1,807</b>	<b>117,639</b>	<b>29,082</b>	<b>792</b>	<b>798,433</b>
<b>At 31 March 2013</b>								
<b>Depreciation</b>	0	0	0	0	52,060	13,807	121	<b>65,988</b>
<b>At 1 April 2012</b>	0	299	0	0	(299)	0	0	<b>0</b>
Reclassifications	0	0	0	0	0	0	0	<b>0</b>
Reclassifications as Held for Sale	879	(67,639)	(45)	0	(512)	0	0	<b>(67,317)</b>
Disposals other than for sale	0	0	0	0	0	0	0	<b>0</b>
Upward revaluation/positive indexation	0	50,161	0	0	0	0	0	<b>50,161</b>
Impairments	(879)	(1,777)	0	0	0	0	0	<b>(2,656)</b>
Reversal of Impairments	0	18,956	45	0	15,094	2,474	72	<b>36,641</b>
Charged During the Year	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>66,343</b>	<b>16,281</b>	<b>193</b>	<b>82,817</b>
<b>At 31 March 2013</b>	<b>207,278</b>	<b>439,635</b>	<b>2,200</b>	<b>1,807</b>	<b>51,296</b>	<b>12,801</b>	<b>599</b>	<b>715,616</b>
<b>Net Book Value at 31 March 2013</b>								
	207,278	414,774	2,200	1,807	48,748	12,801	599	<b>688,207</b>
Purchased	0	23,067	0	0	2,509	0	0	<b>25,576</b>
Donated	0	1,794	0	0	39	0	0	<b>1,833</b>
Government Granted	<b>207,278</b>	<b>439,635</b>	<b>2,200</b>	<b>1,807</b>	<b>51,296</b>	<b>12,801</b>	<b>599</b>	<b>715,616</b>
<b>Total at 31 March 2013</b>								
<b>Asset financing:</b>	207,278	439,635	2,200	1,807	51,296	12,801	599	<b>715,616</b>
Owned	<b>207,278</b>	<b>439,635</b>	<b>2,200</b>	<b>1,807</b>	<b>51,296</b>	<b>12,801</b>	<b>599</b>	<b>715,616</b>
<b>Total at 31 March 2013</b>								

The financial statements were approved by the Board on 5th June and signed on its behalf by Mark Davies, Chief Executive, Imperial College Healthcare NHS Trust on 5th June 2013.



Mark Davies  
Chief Executive Officer  
Imperial College Healthcare NHS Trust

## Review of tax arrangements of public sector appointees

**For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012**

No. In place on 31 January 2012	9
Of which:	
No. that have since come onto the organisation's payroll	1
Of which:	
No. that have since been re-negotiated/re-engaged to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	6
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have come to an end	2
Total	8

**For all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months**

No. of new engagements	0
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total	0

## Glossary of terms

### **Adjusted retained surplus**

This is the surplus excluding impairment charges against which the Trusts 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 licenses

### **Investment Revenue**

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

### **Net current assets/ (liabilities)**

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

### **Operating expenses**

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

### **Other operating costs**

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

### **Payables**

Monies owed by the Trust as at 31 March 2013

### **Provision**

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

### **Property, plant and equipment**

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

### **Public capital dividends payable**

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

**Public dividend capital**

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

**Receivables**

Monies owed to the Trust as at 31 March 2013

**Retained earnings**

The value of the cumulative income and expenditure deficit

**Revenue from patient care activities**

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

**Revaluation reserve**

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

**Statement of cash flows**

The statement of cash flows summarises the sources of cash received and expended by the Trust

**The statements included in this annual report are merely a summary of the information in the full accounts and which are available on demand from:**

The Financial Service Department  
Imperial College Healthcare NHS Trust  
6<sup>th</sup> Floor, Salton House  
St Mary's Hospital  
Paddington  
London W2 1NY  
Telephone: 020 3312 7159

# //Commissioning for Quality and Innovation (CQUIN)

Goal Number	CQUIN scheme	Description of goal	Goal Weighting (% of CQUIN scheme available)	Quality domain (Safety, effectiveness, patient experience or Innovation)
Goal 1	Venous thromboembolism (VTE) prevention	Reduce avoidable death, disability and chronic ill health from VTE	5%	Safety
Goal 2	Patient experience	Composite indicator on responsiveness to personal needs	5%	Patient safety
Goal 3	Dementia (draft)	Improve awareness and diagnosis of dementia using risk assessment	5%	Safety, effectiveness, patient experience , innovation
Goal 4	NHS Patient Thermometer (draft)	Improve collection of data in relation to pressure ulcers, falls, VTE, urinary tract infections (UTIs) in those with catheter	5%	Safety, effectiveness, patient experience , innovation
Goal 5	GP real time information	Locally developed CQUIN on timely exchange of electronic clinical data between primary and secondary care	20%	Safety, effectiveness, patient experience , innovation
Goal 6	Utilisation of north-west London formulary	Reduce cost and increase consistency of prescribing	20%	Safety, effectiveness, patient experience , innovation
Goal 7	Enhanced recovery	Improve patient care by implementation and development of enhanced recovery schemes	13.33%	Safety
Goal 8	Chronic obstructive pulmonary disease (COPD)	Patients admitted with primary diagnosis of COPD or exacerbation being discharged with care bundle	13.33%	Effectiveness, patient experience , innovation
Goal 9	Oral anticoagulation	Improve management and transfer of care of patients in receipt or need of oral anticoagulation	13.33%	Safety, effectiveness, patient experience , innovation
<b>Total</b>			100% (of 2.5% of contract value)	

# // Staff profiles

Staff Profiles ~ 31 March 2013 (month 12 of 2012/13)

## Headcount of employees ~ 31 March 2013

Age group	Headcount
16-19 years	31
20-29 years	1,566
30-39 years	3,017
40-49 years	2,699
50-59 years	1,704
60 years and over	503
<b>Grand total</b>	<b>9,520</b>

Ethnic origin	Headcount
A White - British	2,964
B White - Irish	343
C White - Any other White background	1,082
D Mixed - White & Black Caribbean	43
E Mixed - White & Black African	52
F Mixed - White & Asian	60
G Mixed - Any other mixed background	161
H Asian or Asian British - Indian	638
J Asian or Asian British - Pakistani	112
K Asian or Asian British - Bangladeshi	60
L Asian or Asian British - Any other Asian background	1,104
M Black or Black British - Caribbean	336
N Black or Black British - African	752
P Black or Black British - Any other Black background	521
R Chinese	160
S Any other ethnic group	506
U Undefined	43
Z Not stated	583
<b>Grand total</b>	<b>9,520</b>

## Equality and diversity policy

The Trust values diversity and ensures fairness for our diverse patients, carers and workforce. As we progress during the NHS transition and in particular, the academic health science partnership (AHSP) review, we will continue to strive to deliver fairer and more accessible services for the patients and carers we serve. We successfully met our statutory requirements in April 2012 to publish equality reports covering both workforce and patients, and are on track to meet the next target of 13 October 2013.

We are also successfully implementing the NHS Equality Delivery System framework, which will help us to engage and work in partnership more effectively with local stakeholders, patients, carers and third sector partners, as well as our workforce and NHS trade unions to analyse our performance and identify common equality objectives. The outcomes of our grading and equality objectives for 2013/14 are published on our website. In 2013/14, we will work closely with our clinical divisions to share learning to ensure that they enhance their existing capability to meet these statutory equality requirements.

# Appendix 1

## Sustainability report data

### Expenditure on energy in each of the last five financial years

	2008/09	2009/10	2010/11	2011/12	2012/13	% Reduction	Reduction
Energy Cost	£9,149,625	£7,803,721	£7,382,856	£7,783,098	£8,489,663	-9	£706,565

### NPV of the savings expected as a result of plans to change the Trust to make it more sustainable and time period

NPV	1,259,126
Time period	10

### Weight of generated waste that was recycled, and proportion of total waste

	2012/13	Proportion	Percentage
Total Waste	4913	0.652963566	65
Recycled waste	3208.01		

### Total consumption of energy in each of the last five years (MWh), floor area (in order to calculate energy intensity), proportion of energy from renewable sources, and how much energy is generated on site

	2008/09	2009/10	2010/11	2011/12	2012/13	
Oil						
Gas	92155	92183.6111	94260.863	92404	114850	
Coal						
Renewables						
Other						
Electricity	46769.4444	64633.8889	61827.096	55392	54343	Risen/fallen
<b>TOTAL</b>	<b>295741.944</b>	<b>460701.459</b>	<b>473076.959</b>	<b>316989</b>	<b>169193</b>	fallen

	2011/12	2012/13
Floor Area (m2)	297628.093	296862.093
	1.07	0.57

### Proportion of energy generated on site - we do not generate any energy

The tariff which the Trust pays for electricity is a "green" or "renewable" tariff

## Operating expenditure (per the financial statements) in the last two financial years

2011/12	2012/13
£938,288	£988,644

Energy as a proportion of costs	786.84	787.25
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## Gross scope 1-3 carbon emissions over the last five years

	UNIT		2008/09	2009/10	2010/11	2011/12	2012/13
Emissions as a result of Electricity Consumption	kWh	Electricity	25489	35225	33696	30189	29617
Emissions as a result of Gas Consumption	kWh	Gas	17049	17054	17438	17095	21247
Emissions as a result of Business Travel - Air	km	Air					284307
Emissions as a result of Business Travel - Road	miles	Road					not known
Emissions as a result of Business Travel - Rail	miles	Rail					140031

Change in Emissions increased 0.51109691

The Trust does not currently collect data on our annual Scope 3 emissions

## Water consumption in m3 in the last four financial years

	2008/09	2009/10	2010/11	2011/12	2012/13	Gross reduction		
Water consumption	542,758	337,419	443,233	418,568	456,337	37,769	increased	37,769

Total expenditure on water in the last financial year £576,109

**Gross expenditure on the CRC Energy Efficiency Scheme in 2012/13** £502,932

**Expenditure on official business travel in 2012/13?** £368,408 (data for air, rail and staff taxis only; inclusive of taxes)

## Expenditure on waste disposal in the following categories:

	2011/12	2012/13
Total Waste arising	£1,183,916	£1,031,714
Waste sent to landfill	£46,005	£35,221
Waste recycled/reused	£58,578	£56,330
Waste incinerated/energy from waste	£458,124	£485,313

The Trust board has approved a Sustainable Development Management Plan in the last 12 months

The Trust board has approved plans which address the potential need to adapt the organisation's activities (models of care) as a result of climate change

The Trust board has approved plans which address the potential need to adapt the organisation's buildings or estates as a result of climate change

The Trust board does consider sustainability issues as part of its risk management process

The Trust has not developed policies on sustainable procurement

The Trust has begun to calculate carbon emissions related to procurement of goods and services

Sir Thomas Legg is the board Level lead for sustainability on the Trust board

Sustainability issues, such as carbon reduction, are not included in the job descriptions of all staff

The last staff energy awareness campaign was in 2012 and it is an ongoing process

The Trust has a sustainable transport plan

## Alternative formats for the annual report

### Alternative formats for the annual report

This document is also available in other languages, large print and audio format on request. Please contact the communications directorate on 020 3312 2168 for further details.

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

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

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

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

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

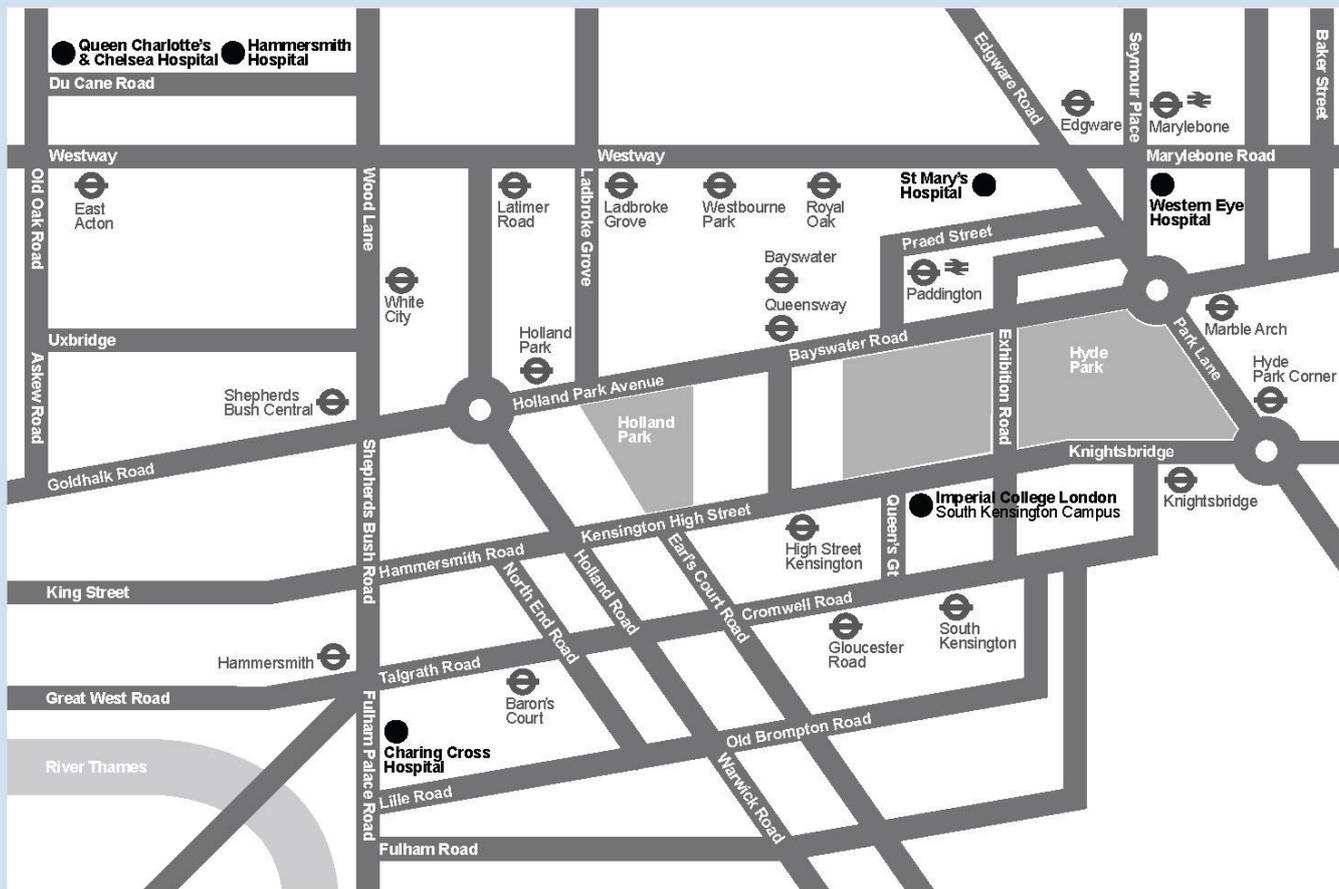
Dokument ten jest na życzenie udostępiany także w innych wersjach językowych, w dużym druku lub w formie audio.

Este documento también está disponible y puede solitarse en otros idiomas, en letra grande y formato de audio.

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

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

# //Contact us and map of Trust sites



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**Respect** our patients and colleagues  
Encourage **innovation** in all that we do  
Provide the highest quality **care**  
Work together for the **achievement** of outstanding results  
Take **pride** in our success