Delivering our promise
Better health, for life

Annual Report

2017/18

NHS
Imperial College Healthcare
NHS Trust

Contents

Published July 2018

Welcome

Sir Richard Sykes, Chairman

Imperial College Healthcare is one of the largest NHS trusts in the country, offering a wide range of acute and specialist care for our local communities as well as for patients nationally and internationally. We also play a lead role in healthcare research and education, as part of one of the UK's 11 academic health science centres and 20 National Institute of Health Research biomedical research centres.

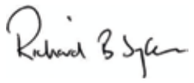
Despite significant operational and financial pressures in 2017/18, we have continued to improve and to innovate. Our research highlights (on page 26) show how new technology is being used and adapted to improve diagnosis and treatment and, importantly, to enable patients to have more control over their health and care. In particular, as a global digital exemplar site, we are embedding advanced approaches to how we gather and use data to drive learning and improvement.

As well as clinical innovation, our staff are making real progress with the development of new models of care and better ways of working. This is having a broad impact, from building stronger partnerships with GPs jointly to improve care for people with long term conditions to adopting new team coaching approaches that are producing tangible increases in safety and quality.

This annual report provides a snapshot of many more developments at the Trust over the past year as well as, we hope, a clear and balanced account of our achievements and challenges.

It also represents my last full year as chairman. I am proud than ever of Imperial, of our 11,000 staff and of the value their expertise, care and commitment brings to hundreds of thousands of people each year.
I am very grateful to Professor Julian Redhead for stepping up so ably as interim chief executive for much of last year and delighted that we have again, in the appointment of Professor Tim Orchard as chief executive from June 2018, one of our own, renowned clinicians to lead the organisation forward and to help us realise our full potential.

I hope you find our report of 2017/18 interesting and helpful – and I would really encourage you to find out more through our website and social media channels, especially on how you can get more involved in shaping and guiding our work this year and for the years to come.



Richard Sykes
Chairman

Performance report

Performance report: 2017/18 overview

Professor Julian Redhead, Interim chief executive officer (to June 2018)

It has become something of a mantra that the NHS – along with all other public services – has to do more, for less.

Our 2017/18 annual report shows that while we achieved that again this year, the scale of the continuing challenge demonstrates more clearly than ever the need to quicken the pace of more transformational change too.

We are impacted by many of the same issues affecting NHS trusts across England – growing and changing care needs, especially of older people and those with long-term conditions; developing and making the most of advances in care and treatment; difficulties in recruiting and retaining enough staff with the right skills; and all in the context of a continuing squeeze on public finances.

We also have to respond to some more local challenges. We are facing a growing struggle with the poor state of our estate and the lack of space in which to expand our capacity and we are still establishing robust processes to make the most of our electronic patient record system in terms of ensuring accurate, real-time data to inform and drive everything we do. The past year has also been defined for us by a series of senior leadership changes.

This all contributed to a very pressurised operational environment, especially over the winter months but even continuing into the so-called quiet summer months of 2018. While we maintained our strong performance against the national cancer care waiting time standards – consistently in the top quartile of trusts nationally – we were not able to meet the four-hour A&E access standard or the 18-week referral-to-treatment waiting time target.

Given that picture, it's especially important to recognise and build on our achievements. That was one of the reasons we took part again this year in BBC2's Hospital series, allowing cameras in to share the challenges and the pressures but also some of the potential solutions and our successes.

This report details a whole range of ways in which we have done more for our patients, local communities and, importantly, our staff, while progressing on the path to long-term sustainability.

Improvements and advances

The year has seen us improve and expand outpatient areas at Hammersmith and Charing Cross hospitals; complete or begin major facility improvements for A&E, elderly care and children's intensive care at St Mary's; and upgrade fire safety and emergency lighting at Western Eye. We have also installed two new, state-of-the-art SPECT CT scanners at Hammersmith. Looking to the longer-term, we secured planning permission for phase one redevelopment of St Mary's, a new, eight-storey building to house ophthalmology services and the majority of the hospital's outpatient services.

As one of 16 global digital exemplar NHS trusts, we continued our ambitious digital roll-out. Last year, that included expanding bedside monitoring directly into our Trust-wide electronic patient record system; introducing a system to enable real-time, central monitoring of babies' heart rates during labour; and piloting an early alert to clinicians of patients at risk of developing sepsis. Around one third of outpatient clinic interactions are now paper free and we expect to complete this aspect of our digital roll-out in 2018/19.

Our work on sepsis alerts is also part of a much wider programme to develop our safety culture. It is underpinned by awareness-raising, training and new processes and policies to ensure staff feel confident to raise safety concerns and know to address potential issues in the workplace. Consequently, we have seen our incident reporting rates increase while maintaining low levels of harm and some of the lowest mortality rates in the country.

In terms of advancing care and treatment, we ran over 650 active research projects across 29 different disease areas. Breakthroughs last year included introducing a new hip resurfacing implant, running the first human trials to treat twin-twin transfusion, establishing a new global standard in assessing the narrowing of the heart's arteries and developing a new tool to detect the earliest signs of glaucoma.

Other nationally recognised developments included our innovative prostate cancer pathway, now being rolled out across the NHS, and we were one of the first three partners selected from across the UK to be a 'flow coaching academy', rolling out a high-impact team coaching and improvement approach developed by Sheffield Teaching Hospitals. We were commended by NHS Improvement for our contribution to reducing hospital-onset E coli bloodstream infections.

There were prestigious national awards for our PREPARE for surgery programme that has reduced post-operative complications and average length-of-stay, and for our dementia nursing team's approach to ensuring good nutrition for dementia patients in hospital.

Looking to the longer-term again, we made real progress as part of the Hammersmith and Fulham Integrated Care Partnership – primary, community, mental health and acute care providers coming together with the support of commissioners, lay partners and other stakeholders to think about, plan and deliver care differently. We are working on new approaches and care pathways to help local people stay healthy and get access to the right care when and where they do need it.

Benefitting more people

Overall, we increased the number of 'contacts' we had with patients last year, compared with the previous one. There was a small, one per cent increase in urgent and emergency attendances – through our A&E departments and ambulatory emergency care units – but a much larger increase of seven per cent in emergency admissions, reflecting our sense that we are seeing patients with greater health needs.

We carried out more operations last year, with the main growth in day cases rather than inpatient procedures, which reflects advances in surgical techniques but also the constraints of our inpatient capacity.

Reducing cost

We achieved our financial plan, delivering a £3m surplus, taking into account additional central support including sustainability and transformation funding. We also met our agency pay cap and capital expenditure plan and remained within our cash limits. Importantly, we have also taken around £10m off our underlying deficit and are finalising a plan that does the same again for the coming year.

This financial outturn was a result of just over £43m recurrent cost improvements and maintaining a strong financial grip on our day-to-day finances. Our systematic and data-driven approach to reviewing each of our clinical specialties generated high levels of staff engagement and also helped to identify shorter-term efficiencies. Given our operational pressures, this is a big achievement and testament to a huge amount of hard work from staff at all levels across the organisation.

Looking ahead

Despite our very significant challenges, we are progressing. We were disappointed that our CQC inspections last year did not result in our overall rating moving up from its current 'requires improvement' but we did see a net improvement across the quality domain and service level ratings that inform that single rating. We're clear that we have to increase our pace and get to 'good' and beyond as soon as possible.

That means keeping our focus on continuous improvement, further embedding our organisation-wide improvement approach. It also requires us to establish a comprehensive strategic development programme to drive larger-scale change which calls for even more collaborative working and alignment across the north west London sector. These developments will also inform and be informed by refreshes of a number of key strategies in the coming year, including of our clinical, redevelopment and quality strategies.

All of that, in turn, means a bigger emphasis on understanding and responding to the needs and preferences of our patients and local communities. In particular, we need to involve more people in developing and shaping our plans and services directly. The expansion last year of our lay partner programme and the work of our strategic lay forum is helping to create tangible improvements in the way we think about involvement and we need to build on that to make it a key aspect of 'business as usual'.

We also have to continue the difficult task of clearing our underlying financial deficit. We have agreed a 'control total' for the coming year with our regulator of £20.6m, including a further £48m in cost efficiencies, which makes us eligible for just over £34m of sustainability and transformation funding. As such, we have been able to confirm that we expect to continue to operate as a 'going concern'.

Above all, we have to make an on-going investment in our staff. We have an amazing workforce – the 70th anniversary of the NHS in 2018 is sparking a wave of inspirational stories about our people, past and present. It's so important that we recognise and celebrate their achievements, and give them the space and support to shape change for themselves.

We have a lot to do to create the health and care system that our population needs and deserves – I am optimistic that if we can harness the combined expertise and commitment of our staff, patients, partners and communities, we can get there.

Professor Julian Redhead
Interim chief executive officer

Professor Timothy Orchard became Chief executive on 7 June 2018

About the Trust

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

Our five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing clinical practice nationally and worldwide. We also have a growing number of community services and provide private healthcare in dedicated facilities on all of our sites, including at the Lindo Wing at St Mary's.

With our partners, Imperial College London, The Royal Marsden NHS Foundation Trust and Royal Brompton & Harefield NHS Foundation Trust, we form Imperial College Academic Health Science Centre. This is one of 11 academic health science centres in the UK, working to ensure the rapid translation of research for better patient care and excellence in education.

Our vision and objectives

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

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

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

Our ethos and values

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

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

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

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

Our values are:

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

Our hospitals

We provide care from five hospitals on four sites:

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

- **Western Eye Hospital, Marylebone** – a specialist eye hospital with a 24/7 A&E department.

Increasingly, we provide our services in community facilities and in partnership with GPs and community, mental health and social care organisations.

Imperial Private Healthcare is our private care division, offering a range of services across all of our sites. This includes the Lindo Wing at St Mary's Hospital, the Thames View at Charing Cross Hospital and the Robert and Lisa Sainsbury Wing at Hammersmith Hospital. The income from our private care is invested back into supporting all of our services.

Research, education and innovation

As well as being part of Imperial College Academic Health Science Centre, the Trust, with Imperial College, hosts one of 20 National Institute for Health Research (NIHR) biomedical research centres (BRCs). This designation is given to the most outstanding NHS and university research partnerships in the country, leaders in scientific translation, and early adopters of new insights in technologies, techniques and treatments for improving health.

The NIHR Imperial BRC currently supports over 650 active research projects across 29 different disease areas. We also lead one of NHS England's 13 genomic medicine centres – the West London Genomic Medicine Centre – with our partners Chelsea and Westminster Hospital NHS Foundation Trust, Royal Brompton & Harefield NHS Foundation Trust and The Royal Marsden NHS Foundation Trust, helping to lead innovation in genomics.

The Trust is also part of the NIHR Health Informatics Collaborative (NIHR HIC) together with Oxford University Hospitals, Cambridge University Hospitals, University College London Hospitals and Guy's and St Thomas' NHS foundation trusts. This collaboration enables NHS clinical data to be linked and shared to allow new insights into care and treatment through research.

In 2017, we were recognised as a leader in the adoption of digital technologies to improve patient care by being selected by NHS England as one of 16 global exemplars of acute care. With our partner, Chelsea and Westminster Hospital NHS Foundation Trust, we received funding and support to drive the use of digital technology to innovate for better patient care and to create products and approaches that can be used by other organisations.

We are a major provider of education and training for doctors, nurses, midwives and allied health professionals including therapists, pharmacists, radiographers and healthcare scientists. In 2017/18, 900 Imperial College London medical undergraduates trained with us. We had over 450 student nurses and midwives in training in the year, many of whom gained their first job or qualification with us.

Our charities

We work closely with Imperial Health Charity who support a wide range of initiatives for patients and staff. In 2017/18, the charity invested £6.9m.

This enabled major improvements to our facilities and equipment, including renovations to the A&E department, children's intensive care unit and Thistlewayte ward at St Mary's Hospital; outpatients clinics and the Riverside theatres at Charing Cross Hospital; and outpatients clinics at Hammersmith Hospital.

Imperial Health Charity also manages the volunteering programme for the Trust, a number of grants programmes, including for research fellowships, and an extensive art collection and programme for patients and staff.

During 2017/18, the Trust also received generous support from COSMIC (Children of St Mary's Intensive Care), the Winnicott Foundation, which raises funds to improve care for premature and sick babies at St Mary's Hospital, and each of the Friends of St Mary's, Charing Cross, and Hammersmith hospitals.

Our lay partners

We are committed to increasing and improving the involvement of patients and the public in every aspect of our work. An important element of our involvement approach is our pool of lay partners – individuals from our local communities with experience or interest in the Trust who form part of our project and programme governance. We now have over 40 roles for lay partners as well as a 12-strong strategic lay forum that helps develop and oversee the implementation of our patient and public involvement strategy.

Our commissioners

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

The CCGs in north west London have formed two groupings:

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

North west London sustainability and transformation partnership (STP)

Over 30 NHS, local authority and voluntary sector partners, including our Trust, are working together to improve health and care across north west London. Our sustainability and transformation plan, one of 44 such plans across England, was published in October 2016.
Its five delivery areas are:

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

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

Our regulators

NHS Improvement is responsible for overseeing both NHS trusts and foundation trusts.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The Trust is currently rated overall as 'requires improvement'; made up of 'good' for the domains of caring and effective and 'requires improvement' for the domains of safe, responsive and well-led. This follows a comprehensive inspection in 2014, a number of core service inspections in November 2016 and in March and November 2017, and our first well-led inspection in December 2017. Our more recent inspection reports show that we are on an improvement trajectory.

The Trust in numbers 2017/18 (all rounded)

1,125,000
Patient contacts
(including inpatients, outpatients and day cases)

299,000
Emergency attendees
(including A&E and AEC)

10,000
Babies born

39,000
Operations
(including day and inpatients)

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

Our staff

11,800
Staff, including:

2,600
Doctors

4,700
Nurses & midwives

720
Allied health professionals

1,200
Scientists & technicians

130
Pharmacists

900
Medical students

470
Nurses in education, pre-registration

Our finances

£3m
Control total surplus

£1,160m
Turnover

£43m
Cost improvements

£57m
Invested in buildings and infrastructure, including IT

Performance analysis: introduction

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

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

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

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

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

Assessing performance against our operational objectives

Assessing progress against our objectives is an important aspect of performance analysis. As we set out in last year's annual report, guided by our long-term strategic objectives, we agreed five operational objectives that underpinned our detailed 2017 - 2019 business plan:

- to improve the way we run our hospitals
- to develop more person centred approaches to care
- to make our care safer
- to make the Trust a great place to work
- to build sustainability.

Assessing performance against the five domains of quality

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

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

This performance report draws out the annual performance against key indicators under each domain, see pages 35 to 46. A more detailed assessment of performance against all of our quality targets for 2017/18 can be found in our 2017/18 quality account.

Many of our major initiatives in 2017/18 were intended to support more than one of our objectives. However, for ease of reporting, we have set them out in this report under the primary objective to which they relate.

Performance against corporate objectives

Objective: to improve the way we run our hospitals

Improving urgent and emergency care pathways

There are a number of important initiatives underway across the Trust to ensure patients move through our urgent and emergency pathways as quickly and as safely as possible.

We are responding to a continuing increase in the number of people attending for urgent and emergency care and in unplanned hospital admissions. In 2017/18, we saw almost a one per cent year-on-year rise in attendances and a seven per cent rise in admissions. In particular, we are seeing more frail, older patients and more with complex health problems.

We did not meet the national standard to achieve that for 95 per cent of patients. Our average performance was 83 per cent.

Our urgent and emergency care improvement programme has six work streams, each led jointly by a clinician and manager:

- streaming and offering better alternatives to hospital admission
- improving emergency department processes
- improving specialist decisions and pathways
- improving bed management
- improving ward processes
- improving discharge processes.

Key achievements through the improvement programme last year include:

Ambulatory emergency care

Our ambulatory emergency care units provide same-day consultant review and treatment for patients with a wide range of more serious urgent or emergency health problems without the need to be seen in A&E or, in most cases, to be admitted to hospital. By moving to longer hours and seven-day working and encouraging direct GP referral, our two ambulatory emergency care units saw a 37 per cent increase in attendances, up to just over 17,500 patients in 2017/18. We believe this has helped to reduce the rate of increase in A&E attendances and enabled many patients to get faster diagnosis and treatment.

St Mary's A&E expansion

We expanded and refurbished the A&E, supported by funding of £3.2m from Imperial Health Charity. The development has increased the number of resuscitation bays from two to four and added a new, four-bed paediatric assessment unit within the children's A&E department. Work continues on further improvements to the department including a sensory room and mental health support area.

We are developing plans for an expansion and refurbishment of Charing Cross A&E in 2018/19.

Rolling out best practice

As part of a national focus on improving urgent and emergency care pathways, NHS Improvement issued guidance to all acute trusts on best practice that helps reduce delays for patients in adult inpatient wards, which it calls the 'SAFER' patient flow bundle. 'SAFER' was piloted on two wards at St Mary's Hospital and one ward at Charing Cross Hospital. By April 2018, the average time of discharge was an hour earlier than the previous year and the proportion of patients discharged before noon had nearly doubled on the wards that piloted the initiative. The best practice is now being rolled out across all of our wards.

Meeting winter pressures

As anticipated, winter 2017/18 was a challenging time for NHS organisations nationally, with a flu outbreak and cold and icy weather adding further to rising demand.

However, good planning, new developments and, above all, the huge hard work and commitment of our staff meant we continued to provide safe care for all our patients.

On top of our ongoing urgent patient pathway improvements, we invested over £1m in a range of measures to boost urgent and emergency care capacity throughout the winter. This included:

- 42 additional winter beds
- community care home beds
- staff flu vaccination campaign
- expanded hospital frailty teams and weekend 'acute take' team
- additional transport and porter resource
- a 'Get winter ready' campaign – for staff, local GPs and the public.

We were the most improved acute trust in England in terms of staff uptake of flu vaccinations this year. Over 60 per cent of frontline staff got their flu jab, up 40 per cent on the previous year.

Better planned care

We are completely re-building our approach to overseeing planned care, especially in terms of how we manage waiting lists and match demand and capacity. This is in response to significant challenges that arose over a year ago with the reliability of our waiting list data and with a growing

backlog of patients waiting for planned procedures. Last year, we were not able to meet the national standard for at least 92 per cent of patients to wait 18 weeks or less from 'referral to treatment', and more than 200 patients have had to wait over 52 weeks.

We have invested in a major waiting list improvement programme, made up of seven workstreams:

- waiting list recovery – ensuring patients with long waits are treated as quickly as possible and finding better ways to predict and match capacity and demand
- elective care operating framework – establishing better monitoring, staff recruitment and training, waiting list management processes and improvement approaches
- digital optimisation – using digital technology to support and automate our processes and monitoring wherever possible
- clinical harm reviews – systematic processes to ensure and review safety of patients who are waiting longer than they should
- oversight and governance – enhanced reporting to the executive and Trust board, commissioners, and NHS Improvement and NHS England
- audit framework – establishing improved audit and assurance checks for our waiting list management
- data clean up – a thorough check and cleanse of our various waiting lists

We are working to have no patients waiting over 52 weeks as quickly as possible but, while we continue to reduce our waiting list backlog, we estimate we will not achieve the national standard until next year. Planned surgery is currently subject to extensive cancellations due to an increasing number of urgent and emergency patients. External improvement consultancy Four Eyes Insight is working with our surgical teams to improve efficiency across the whole of our planned care pathways, from pre-assessment, through to scheduling and operating theatre utilisation.

Improving outpatient services

Completing a £3m redesign and refurbishment of clinics at Charing Cross and Hammersmith hospitals, funded by Imperial Health Charity, was a large part of our outpatient improvement work last year.

Gathering and using patient feedback to drive change was another key focus for the year - the 'Experience lab' initiative brought together 10 multi-disciplinary outpatient teams to build their improvement skills and put them directly to use in practical change projects. Across all ten projects, patient satisfaction scores increased by 15 per cent.

Particular successes included cutting waiting times at the Charing Cross phlebotomy service by flexing staffing at busy times. Staff at the Western Eye Hospital introduced patient navigators to ensure glaucoma patients get appointments when they need them. And all the clinics have improved the quality of information patients receive before their appointments.

We continued to roll out digital technology to improve our outpatient processes and communications:

- many of our services are now available for GPs to book patients in electronically, and all services will be available by 1 August – the national deadline for all GP referrals to be made electronically.
- we introduced a new system to enable clinicians to review GP referrals easily and quickly in order to decide the best course of action for patients
- around one third of clinic interactions are now paper free and we expect to complete the digital roll out in 2018/19.

Our patient services centre, based at Charing Cross Hospital, is bringing together outpatient bookings, planned admissions and patient queries to be managed by one team. It was created in 2016/17 with Imperial Health Charity funding. By the end of 2017/18, around two-thirds of first outpatient appointments and one third of planned admissions were being managed by the patient services centre.

Rescheduling appointments at short notice and long waits in clinic have proved harder to change. Both continue to be the subject of focused attention to achieve improvement.

Children's intensive care expansion gets underway

After a great deal of planning and fundraising, scaffolding went up at St Mary's Hospital to begin the expansion of our children's intensive care unit. It will nearly double the size of the unit from eight beds to 15, allowing many more critically ill children who need specialist care to be treated.

Half of the funding for the expansion has come from the fundraising efforts of Cosmic Charity and Imperial Health Charity through their joint More Smiles Appeal – the rest is from the Trust's capital budget. The expanded unit is due to open in early 2019.

Thistlethwayte transformed for better older people's care

A £1m project to refurbish one of the oldest wards at St Mary's Hospital last year transformed the care environment for older patients with complex conditions.

The 20-bed Thistlethwayte ward was redesigned to create extra space for beds and bathrooms, with special lighting and artwork to help frail patients feel more comfortable during their time in hospital. Dementia-friendly signs, clocks, toilet hand rails and name boards were installed.

A planned refurbishment was brought forward and expanded when part of the ceiling in one section of the ward collapsed last summer. A third of the funding was provided by Imperial Health Charity.

Improvement though digital

Implementing new digital technology plays an important part in improving the way we work.

Last year saw the launch of one of our most ambitious initiatives – to share our electronic patient records system, Cerner, with neighbouring Chelsea and Westminster Hospital NHS Foundation Trust. By 2019, patients' health records will be available to clinicians caring for them across the seven hospitals in the two trusts. Over time, all patient information and test results will be available in real-time wherever and whenever they are needed to inform clinical decision-making.

We are also linking the devices we use to measure vital signs like blood pressure, heart rate and oxygen saturation to our electronic patient record system. This increases patient safety, generating alerts that can identify patients who are at risk of deteriorating, and saves nursing time as we no longer need manual input of data to the system. By the end of 2017/18, we were using connected devices in 63 adult wards across the Trust, releasing an estimated 20,000 hours of nursing time a year for patient care. While we work to exploit digital technology to deliver even better patient care, we also continue to invest to protect our systems from cyber-security attack.

Objective: to develop more person-centred approaches to care

Working with partners to integrate care in Hammersmith and Fulham

Integrated care is a different way of thinking about, planning and delivering care – based on people, not buildings or organisations; outcomes, not procedures or activity. It focuses on the needs of individuals, helping them to stay as healthy as possible and making it simpler for them to get the care they need when it's needed.

In January 2018, we were one of five organisations working in Hammersmith and Fulham that signed a formal partnership agreement to work towards an integrated care model. We set up a 'committees in common' governance mechanism, with each partner remaining independent but delegating oversight of key aspects of the partnership to the committee. Our partners are Hammersmith and Fulham GP Federation, Chelsea and Westminster Hospital NHS Foundation Trust, West London Mental Health NHS Trust and Central London Community Healthcare NHS Trust.

Representatives from the London Borough of Hammersmith and Fulham and Hammersmith and Fulham Clinical Commissioning Group, as well as lay partners, also form part of the partnership's governance structure.

The aim is to agree an 'alliance contract' with Hammersmith and Fulham CCG that supports the delivery of an integrated care approach during 2018/19 for some services for the population of the borough. The areas that are being explored are services for children, adults with long-term conditions and frail, older people.

The partnership is beginning to look at designing new care pathways. All partners are committed to involving patients, carers, voluntary sector partners and local residents as well as wider staff and other stakeholders in this design work through 'co-production' events and activities throughout 2018/19.

Thinking differently about outpatients

When a GP thinks a patient needs the input of a specialist hospital doctor, they generally refer people for an outpatient appointment. Under the sustainability and transformation partnership (STP) for north west London, we are part of a programme looking afresh at how specialist support is made available in order to move towards more integrated care. Our clinicians and managers worked closely with colleagues in general practice and with other trusts and commissioners, as well as patient representatives across north west London, to explore how care pathways that involve outpatients might evolve. The focus is initially in four specialties – renal, chronic kidney disease, lung disease and heart failure.

Feedback so far has shown that where hospital clinicians and GPs work closely and proactively together, many patients can get the care and support they need without having to wait for a hospital outpatient appointment.

Encouraging and supporting patients to take more control of their own health is another key aspect of the programme, especially for those with long term conditions. Self-help tools, digital technologies and early education and support are all being investigated.

Connecting care for adults

A new partnership project with GP practices in north west London is helping to improve care for many patients with long term conditions.

Launched in September 2017, Connecting care for adults is initially focusing on patients with chronic kidney disease, lung disease (chronic obstructive pulmonary disease and asthma) and heart failure. It involves specialist clinicians from the Trust working with local GP practices to provide practical support in three key areas:

- case reviews
- patient self-management
- education and training.

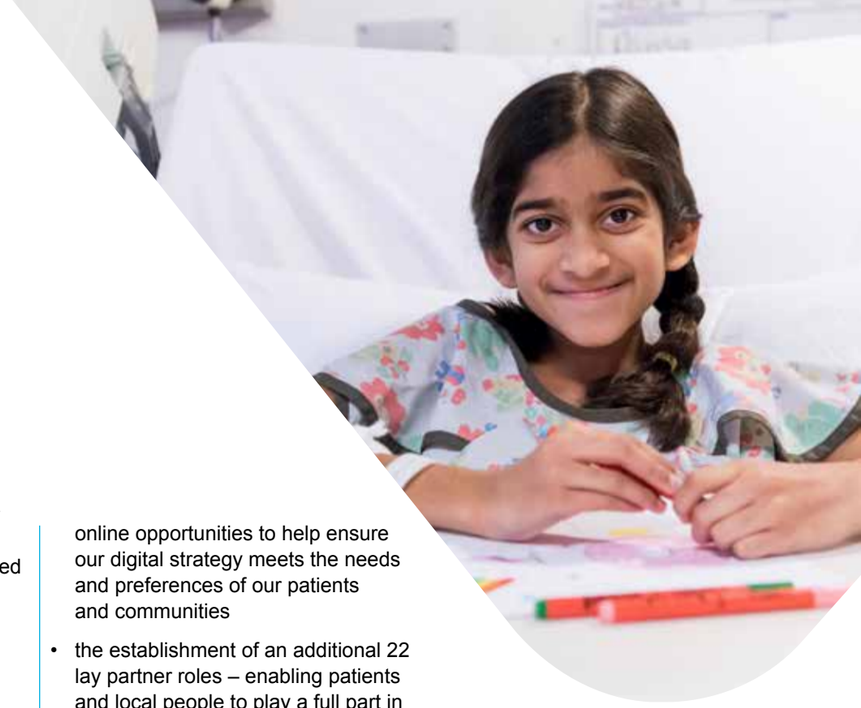
By the end of 2017/18, more than 600 patient records had been reviewed. In more than half of the cases of patients with lung problems, strong steroid medication could be reduced or stopped altogether. For patients with chronic kidney disease, it was possible to reduce the amount of different medication each patient was taking.

Eighty-seven per cent of GPs involved in the project said that it had improved their overall knowledge of the specialist conditions.

The project is funded by Health Education England.

Empowering patients with access to data

Involving patients fully in their own health and care is a key aspect of integrated care. The Care Information Exchange, developed by the Trust and funded by Imperial Health Charity, provides patients with secure, online access to their health records to support self-management. Patients can also share this record with their health and care professionals, family and carers. By the end of 2017/18, the Care Information Exchange had 4,200 registered users across 20 services and six organisations.



Genomics

As lead partner for the West London Genomics Medicine Centre, we continued to expand the number of patients with rare diseases, and their families, as well as patients with common cancers, who have consented to have their genetic make-up sequenced as part of the national 100,000 genomes project.

By 31 March 2018, the West London Genomics Medicine Centre had recruited nearly 1,220 cancer patients and 800 patients with a rare disease, plus their families.

Last year, with funding support from Imperial Health Charity, the Western Eye Hospital appointed an ophthalmic genetics consultant. This allowed the service to start recruiting eligible patients with rare genetic eye conditions to the 100,000 genomes project.

Along with wider genomics research and development, the 100,000 genomes project is intended to enable more precise and earlier diagnosis, faster clinical trials, new drugs and treatments and potentially, in time, cures for conditions that currently have no cure at all.

Patient and public involvement

We are committed to increasing and improving patient and public involvement in every aspect of our work. Our strategy sets out ambitious goals for achieving meaningful involvement in strategic developments, service improvements, service delivery and improving individual health and wellbeing.

Progress in 2017/18 has included:

- a new digital patient reference group – providing input and feedback on the development of apps, the use of digital patient records and other online opportunities to help ensure our digital strategy meets the needs and preferences of our patients and communities
- the establishment of an additional 22 lay partner roles – enabling patients and local people to play a full part in the Trust's key projects and programmes, bringing the total to 44 and influencing major developments such as waiting list improvements, estates redevelopment and a new patient transport tender
- the creation of a new volunteer role to support improvement projects – focusing on gathering feedback from patients, carers, family and friends in clinical environments
- publishing our first involvement toolkit for staff – offering advice and practical support to involve patients and the public in services and improvement work.

Implementation of our patient and public strategy is overseen by our strategic lay forum, a group of 12 lay partners plus senior staff from the Trust, Imperial Health Charity and Imperial College. The full forum meets bi-monthly and is actively engaged in the Trust's work and plans as well as contributing to formal business planning for the first time in 2017/18.

Living with and beyond cancer

Three years in to our partnership with Macmillan Cancer Support, we are continuing to see an improvement in the experience of patients in active treatment, including through additional specialist nurses and the new Macmillan Cancer Navigator Service. In 2017/18, we focused on 'beyond the hospital walls', with research into the impact on quality of life for the increasing number of people living with and beyond cancer following treatment.

The research has included interviews with our patients as well as a worldwide literature review of over 70 studies that looked at people's experience of living with and beyond cancer. It will be published in 2018/19 with the aim of informing the development of support for the many people whose treatment is over, but whose life may be changed.

Our challenges

Achieving big advances in developing more person-centred approaches to care will require more strategic change across the whole of our health sector. This will require us to establish a comprehensive strategic development programme which calls for even more collaborative working and alignment across the north west London sector. Those developments will also inform and be informed by refreshes of a number of key strategies in the coming year, including of our clinical, redevelopment and quality strategies.

All of that, in turn, means a bigger emphasis on understanding and responding to the needs and preferences of our patients and local communities. In particular, we need to involve more people in developing and shaping our plans and services directly.

Objective: to make our care safer

Improving safety

In 2016/17, we shared our commitment to embedding a culture where staff felt confident in raising safety concerns and knew how to address these issues in the workplace. This programme of work continued in 2017/18 with three key outcomes:

- introduction of anonymous incident reporting
- implementation of a monthly safety briefing, providing a new way of communicating with staff about safety issues and updates on our nine safety streams, which had been identified as areas of clinical risk
- improvements to the quality of our serious incident investigations, including changes to the management of our Duty of Candour training and processes; report templates; and the introduction of new training for those involved in investigating serious incidents.

This year, we increased our incident reporting rate – a high reporting rate is viewed as a positive reporting culture, as staff feel able to report incidents that occur. By March 2018, we had increased our reporting rate to 49 per 1,000 bed days, against a national target of 41.7 per 1,000 bed days, which puts us in the top 25 per cent of reporters nationally.

We also expanded our 'freedom to speak up' guardian programme, with a clearly identified guardian at each of our hospitals to encourage and allow staff to report any concerns confidentially, outside of the line management structure.

Safety through technology

Making patient information available to clinical staff when they need it to care for patients is critical to patient safety and is at the heart of our work on electronic patient records. During 2017/18 we successfully piloted a new approach to alert clinicians early to patients at risk of developing sepsis. Acting early to give patients the right treatment plan has been proven to increase patient safety.

Similarly, we are connecting the devices that monitor foetal heart rate to our Cerner electronic patient record system. This allows the clinician to more easily monitor mother and baby's heart rate. Funding through the global digital exemplar programme, see page 71, has helped us to progress further and faster with introducing these innovations.

New scanners improve detection of disease

Trust patients were among the first in the world to benefit from two new state-of-the-art SPECT CT scanners installed at Hammersmith Hospital last year. The new scanner is more sensitive, enabling it to localise disease and detect lesions more accurately. The new technology means patients need fewer diagnostic investigations. It is also more comfortable for patients as images are generated more quickly and appointments are shorter.

The scanners are based in a new look department at Hammersmith Hospital which has been refurbished as part of the wider re-development of Trust outpatient areas.

Our challenges

We were disappointed that our CQC inspections last year did not result in our overall rating moving up from its current 'requires improvement'. We're clear that we have to increase our pace and get to 'good' and beyond as soon as possible. For more on our CQC 'safe' domain, see page 36.

Objective: to make the Trust a great place to work

Advances in training and development for clinicians

Last year, we expanded our range of simulation courses, including in vascular surgery and interventional radiology. We also opened the only obstetrics simulation lab in the country at Queen Charlotte's & Chelsea Hospital.

We established a network of advanced clinical practitioners – experienced, registered healthcare practitioners such as nurses, paramedics, pharmacists and physiotherapists who have completed further training and education at a master's level. With this network in place, we launched our advanced clinical practice committee and held our first advanced clinical practice conference.

We introduced our first cohort of 13 nursing associate trainees across a number of specialties, with 30 more trainees due to start in 2018. The nursing associate role is designed to bridge the gap between healthcare assistants and registered nurses.

Our apprenticeship programme was rolled out further, with administrative opportunities now in place in clinical and corporate departments across the organisation. During the year, 13 apprentices gained full-time, substantive employment with the Trust having successfully completed their programme. We recruited 39 new apprentices to the programme.

We received funding for a practice facilitator in radiology who will contribute to training staff across the Trust in line with the new sector-wide radiographer career framework. This will significantly improve the learning experience and career development for this key group of staff.

We successfully introduced the new contract for junior doctors and have sustained our performance in the national training survey, with many specialties gaining positive feedback for the training experience. We are working with Imperial College School of Medicine to develop the new undergraduate curriculum which will be introduced in 2019.

Imperial College Academic Health Science Centre's Clinical Academic Training Office has overseen significant developments in academic opportunities particularly for non-medical academic programmes. Academic educational collaboration continues to expand at the Trust with the appointment of Professor Mary Wells, lead nurse for research, and Dr Caroline Alexander, lead clinical academic for therapies.

Coaching and leading for improvement

We were one of the first three partners selected from across the UK to be a 'flow coaching academy', rolling out an approach developed by Sheffield Teaching Hospitals, supported by The Health Foundation.

Based within the Trust's improvement team, Flow Coaching Academy Imperial exists to build team coaching and improvement science skills and support their application in developing better clinical pathways.

At the heart of the approach is a one-year programme with two components:

- Coaching pairs – leading on the improvement of a defined clinical pathway. Made up of a clinician working within the pathway plus another individual from outside of the pathway. The pairs have 18 days of face-to-face training across 11 sessions.
- Big rooms – a weekly, face-to-face session bringing together a range of staff and patients involved in the pathway to discuss, plan and review improvements. The pairs put their learning into practice by coaching the big room, focusing on making it as easy as possible for patients to 'flow' through the pathway and reducing unwarranted variation in processes and care.

Three pathways were trialled in 2017: sepsis, diabetic foot and paediatric asthma. The programme is now being rolled out to nine Trust clinical pathways for Flow Coaching Academy Imperial's first official programme. The first group of 18 coaches began their training in March 2018.

An offer full of opportunity

In 2017/18, we launched our 'full of opportunity' campaign to promote all that the Trust has to offer its staff and to encourage others to join us. A recruitment campaign helped us keep our nurse vacancy rate at 14 per cent – slightly lower than the London NHS trust average. The campaign emphasised the Trust's outstanding learning and development pathways, mentoring by senior nurses and great team working. Individual nurses were featured who personify the depth and breadth of opportunity the Trust has to offer. In the most hard to recruit areas, successful candidates were offered a £5,000 premium, in line with many other NHS Trusts, which helped us bring skilled nurses into post and reduce agency costs.

In September 2017, we held our first 'Great place to work' week, with a range of activities across our hospitals, including a health and wellbeing marketplace with healthy food, massage and advice, talks and tours,

and promotions of staff benefits and development opportunities.

We launched our internal transfer career clinics – so that nurses can find the next new role they want right here rather than leave the Trust for promotion. A new training course, 'Springboard', was developed to support nurses moving to more senior roles. Managers were also supported to encourage their staff to develop with a new retention toolkit and a team-building programme, In your shoes.

An 'open door' staff event was held at Charing Cross Hospital in October to reassure staff about the future of the hospital and celebrate recent investments and achievements there. It included a special Schwartz round – where staff are supported to discuss the sometimes challenging emotional realities of their jobs. There were tours of the recently renovated outpatients department and patient service centre, as well as the A&E department to talk about future expansion plans.

In response to the growing challenge of staff shortages nationally, especially in nursing, the Trust is expanding its proactive approach to making sure we have enough people with the right skills. This includes developing new types of roles – nursing associate, advanced clinical practitioners and return-to-practice nurses. We are also undertaking more work to understand what is important to nurses at different points in their career so that we can be more flexible. And, as with many other NHS Trusts, there will be a drive to recruit nurses internationally and build on our diverse workforce.

Best ever staff engagement score

Our staff engagement score increased for the third year in a row in the 2017/18 national NHS survey, reaching a score of 3.84 out of five. We not only achieved our highest engagement score to date, we also moved up to above the national average.

New staff orchestra and choir

In 2017, staff from the Trust and Imperial Health Charity launched our first organisational choir and orchestra. The aim was to encourage staff from all over the Trust to come together to play and sing in a fun, relaxed environment. In December, the Medico Orchestra and the Trust choir held their inaugural concert at St James Church in Paddington. The choir has over 25 members and the orchestra, 40.

Our challenges

Recruiting and retaining staff remains one of our biggest challenges. We are addressing this NHS-wide issue by increasing our own focus on training and development, including through apprenticeship routes, as well as investing more in recruitment in the nearer term. We also recognise we need to do more to ensure and promote equality and diversity. A particular focus for 2017/18 is improving workforce representation of black and minority ethnic staff on band 7 and above and to reduce the disproportionate representation of black and minority ethnic staff receiving a lower rating in their appraisal. An equality and diversity steering committee was established last year, with senior level leadership and broad representation from all divisions with the Trust, to help take this work forward.

Objective: to build sustainability

Specialty review programme

The specialty review programme is our clinically-led process to help develop a refreshed clinical strategy, built upwards from specialty level plans. The programme has three interrelated work streams – clinical services, sustainability and workforce.

By the end of the year, nearly all specialties had begun the process by participating in a clinical strategy workshop. Sixteen specialties had been through all three workshops and have developed – or are developing – specialty specific plans.

As an example, one of the outputs of the review of vascular surgery is to develop plans to reduce the length of stay for an endovascular aneurysm repair (EVAR) to less than one day.

Green light for first phase of St Mary's redevelopment

Planning permission for a new building at St Mary's Hospital was approved by Westminster City Council last year as the first phase of the site's overall redevelopment.

The proposed plan replaces the existing Salton House, Dumbell and Victoria and Albert buildings between Praed Street and South Wharf Road on the eastern side of the hospital estate with an eight-storey building. The new facility will house Western Eye ophthalmology theatres and outpatient services as well as many St Mary's outpatient services.

The urgency of this new build reflects the aging nature of the estate at both St Mary's and Western Eye hospitals. The modern facility will allow us to take advantage of new technologies and practices as well as ensuring the best possible experience for everyone using and visiting the hospital. In 2018/19, we are working on securing the approvals for the capital investment that will be required.

Imperial Private Healthcare

In 2017/18 Imperial Private Healthcare, the private arm of the Trust, generated just under £51m of revenue – a 10 per cent increase on 2016/17. All profits from Imperial Private Healthcare are reinvested back into the Trust, helping to support and improve NHS services as well as our dedicated private facilities. Last year saw Imperial Private Healthcare care for over 18,000 patients, from London, the UK and overseas who either have private healthcare insurance, are embassy sponsored or paid for their own treatment.

We care for patients with a wide range of need. In particular, our private maternity services at The Lindo Wing at St Mary's Hospital and at Queen Charlotte's & Chelsea Hospital delivered over 1,000 babies.

As well as generating revenue for NHS provision, our private patient units enable the Trust to care for very poorly people from around the world. This includes supporting major trauma casualties from war zones and patients requiring live kidney transplants.

Cost improvements

The Trust delivered another challenging programme of cost improvements last year, worth £43.1m recurrently, while continuing to improve our care, caring for more patients. The target for cost improvements had been higher but significant winter pressures, waiting list challenges and our ailing estate meant some of the cost improvements schemes have slipped into 2018/19.

The Trust implemented a number of central initiatives generated by Lord Carter's review of NHS efficiencies that contributed to our cost improvement programme including:

- a pay cap on agency staff resulting in a reduction in agency costs
- efficiency savings from changing the way we deliver services
- tightening procurement, drugs, contracts, estates and facilities spending including looking at comparative data from across different NHS trusts.

Our cost improvements in 2017/18 helped us to achieve our financial plan. We delivered a £3m surplus, taking into account additional central support including sustainability and transformation funding. We also met our agency pay cap and capital expenditure plan and remained within our cash limits. Importantly, we have also taken around £10m off our underlying deficit and are finalising a plan that does the same again for the coming year.

Our challenges

We have an ongoing struggle to deal with the poor state of our estate across all of our sites as well as the lack of space in which to expand our capacity. While we continued to make progress on reducing our underlying financial deficit, the scale of our challenge to achieve a fully balanced budget and long-term financial sustainability is significant.

Highlights 2017/18

BBC2 Hospital

Last year we partnered with production company Label1 for the second time to bring series two of the documentary Hospital, to BBC2. The series, which showed the daily life of a major acute NHS trust, won the Royal Television Society award for best documentary series and was shortlisted in the 'factual series' category at the 2018 BAFTAs. There were over two million viewers per episode. The series generated over 500 news articles and thousands of views of our blog posts offering background on issues explored in the programmes.

Award from the Ministry of Defence

The Trust received the ERS Bronze Award from the Ministry of Defence for supporting its staff to be part of the UK's reserve forces and helping people leaving the military to secure jobs at the Trust through the Step into Health programme. The Trust's major trauma unit in particular has a special link to the military, with trauma doctors experiencing field work in war zones, helping them develop the specialist skills for trauma medicine.

The Trust at 10

In October 2017, we celebrated 10 years of the Trust and our decade long partnership with Imperial College London. We cut the ribbon bringing together our five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's, and the Western Eye – and have been able to develop more integrated care for local people as well as a range of nationally and internationally renowned specialist services.

Hosting our own 'Old People's Home for 4-Year-Olds'

Some of our oldest patients enjoyed a very special Christmas party in 2017. After being inspired by Channel 4's 'Old People's Home for 4 Year Olds', departments from around the Trust teamed up to host our very own intergenerational Christmas party. The party saw 10 children aged six and seven years old from Laurel Lane primary school come to visit the Albert Ward at St Mary's Hospital. Together the older patients and school children played games, enjoyed some festive snacks, decorated Christmas trees and wrapped presents together.

Innovating for improvement

Trust and Imperial College teams were selected by the Health Foundation, an independent health and health care charity, to be part of its £1.5m innovation programme Innovating for Improvement. The project will develop IT software to process all anonymised patient feedback and group it into themes in order to better identify and prioritise areas of improvement. As a result, our efforts can be further focused on finding solutions to common problems.

Smallest ever UK nappy to help premature babies

New nappies specifically designed to meet the needs of premature babies were piloted on two neonatal intensive care units at the Trust in April 2017. The range of new nappies, developed by Pampers in partnership with charity Bliss, includes the size P3 nappy which is three sizes smaller than a regular newborn nappy and suitable for babies weighing as little as 1.8lb. The new nappies are designed to minimise disruption to help with premature babies sleep, positioning and medical care.

Stream of live operation to educate surgeons

A surgeon at St Mary's performed an operation which was streamed live at the 22nd World Congress for the International Federation for the Surgery of Obesity and Metabolic Disorders, held in London. Mr Ahmed Ahmed performed a laparoscopic insertion of a LINX device which is implanted to treat acid reflux. The LINX procedure implants a ring of magnetic beads around the lower part of the oesophagus to strengthen it and help keep it closed when not swallowing.

Research highlights 2017/18

New heart procedure set to become global standard

A new tool for assessing the narrowing of the heart's arteries, developed by Trust clinicians, is set to be adopted internationally as the new global standard in evaluating patients' suitability for a stent. Narrowing of the coronary arteries can affect how the heart functions, potentially leading to chest pain, heart attacks and heart failure.

Instantaneous wave-free ratio (iFR) allows clinicians to measure the pressure loss caused by the narrowing in these blood vessels to see whether the patient is suitable for a stent – a type of mesh tube used to hold open clogged arteries and increase blood flow. The new technique is more comfortable for patients, takes less time and is more cost effective.

Pioneering prostate treatments

Charing Cross Hospital is trialling a new world-leading 'one-stop-shop' approach to diagnosing prostate cancer which is helping to reduce diagnosis times from six weeks to just one week. A new scanning and diagnosis method called RAPID means men having an MRI scan can get their results on the same day. For those with a suspicious MRI, a biopsy is done the same day, using new FUSION technology, rather than multiple outpatient visits over four to six weeks.

In addition, Rezum Water Vapour – a new treatment which could improve the lives of thousands of men who are living with the effects of an enlarged prostate – was performed for the first time in London at Charing Cross. The new technique injects small amounts of steam into the prostate which permeates throughout the tissue and allows the gland to shrink as it repairs itself, relieving men of symptoms. It aims to replace a procedure which takes over an hour and includes two to three days of hospital stay with a 10-15 minute procedure under sedation/local anaesthetic, with patients able to go home that same day.

Promising new treatment for rare pregnancy cancer

A research trial at Charing Cross Hospital was the first to show how an immunotherapy drug could be used to cure women of a rare type of cancer arising from pregnancy when existing treatments have failed.

The researchers wanted to test whether the drug, pembrolizumab, could be used to treat patients with the cancerous forms of gestational trophoblastic disease (GTD) who had become resistant to long-term chemotherapy.

Three out of the four patients in the trial went into remission after receiving the immunotherapy.

Pioneering parent-delivered care for premature babies

Parents of premature babies are being given a much greater role in the care of their babies in neonatal care introduced at the Trust. In a UK first, parents of premature babies become the main caregiver while in hospital, with the support and supervision of neonatal doctors and nurses.

Putting parents at the forefront of their premature baby's care reduces anxiety in parents and their baby and benefits the baby's medical progress and development.

It is linked to improvements in weight gain, higher breastfeeding rates, and reductions in infections and length of hospital stay. The approach was funded by a £180,000 grant from Imperial Health Charity.

£2.2 million funding for twin pregnancy research

Clinicians at the Trust were awarded a £2.2m grant by the Medical Research Council to carry out the first human trials to treat twin-twin transfusion (TTTS), a potentially fatal complication in 10-15 per cent of pregnancies where identical twins share a placenta.

If the blood doesn't flow evenly between the twins, the uneven blood flow results in one of the twins growing too big and the other growing too slowly. High Energy Focused Ultrasound will be trialled to selectively target and destroy placental blood vessels – potentially enabling it to split the placenta in two without the need for an invasive procedure.

New hip resurfacing implant

Surgeons at Charing Cross Hospital are treating patients with a new type of hip implant that could lead to better outcomes for younger, more active people requiring surgery. The collaboration with Imperial College is the first investigation in the world to resurface patients' hips without using metal implants.

Fifteen patients have so far been treated with a novel ceramic hip resurfacing implant and early results suggest patients can return to physical activities such as swimming and cycling within six weeks of their operation. The clinical trial is designed to show that the ceramic implant is suitable for both men and women, as conventional hip resurfacing techniques are currently unsuitable for female patients.

New eye test detects the earliest signs of glaucoma

Researchers at the Western Eye Hospital and University College London have developed a new diagnostic tool to detect signs of glaucoma up to a decade earlier than current approaches, when treatment is much more successful. The technique, called DARC (detection of apoptosing retinal cells), uses a fluorescent marker that shows sick cells as white fluorescent spots during an eye examination, using routine hospital eye examination equipment.

The researchers hope that eventually it may be possible for opticians to carry out the tests, enabling even earlier detection of the disease. The test also has potential for early diagnosis of other degenerative neurological conditions, including Parkinson's, Alzheimer's and multiple sclerosis. The research is funded by the Wellcome Trust, with equipment funded by Imperial Health Charity.

New technique could bring benefit to Alzheimer's patients

Patients with suspected Alzheimer's have benefited from a study on the use of PET (positron emission tomography) scans to help diagnose the disease at Charing Cross Hospital. The study found patients were able to receive more tailored care and needed fewer investigations after having the scan. In a number of cases a diagnosis became possible for individuals whose clinical features were not typical of the disease.

PET scans have long been used to image tumours, clots and blood flow in the brain. However, their use in patients with Alzheimer's has been limited to date. The scan can show the build-up of misshapen proteins, called beta-amyloid, which are characteristic of Alzheimer's disease – the most common form of dementia.

Using CGI in reconstructive surgery

Surgeons at St Mary's Hospital and researchers at Imperial College have shown for the first time how surgeons can use computer-generated augmented reality imaging (CGI) while operating on patients undergoing reconstructive lower limb surgery. It is hoped that the approach will improve outcomes for patients.

The Microsoft HoloLens headset is a self-contained computer headset that enables the wearer to interact with 'holograms' – computer-generated objects made visible through the headset. The technology overlays images of CT scans – including the position of bones and key blood vessels – onto the patient's leg, in effect enabling the surgeon to 'see through' the limb during surgery.

Recognition of our staff 2017/18

Gemma Clunie

Gemma Clunie, clinical specialist speech and language therapist, and Rebecca Smith, physiotherapist at Imperial College, were awarded the NIHR (National Institute of Health Research) Clinical Doctoral Research Fellowship to carry out studies about a rare airway disorder and balance problems following a head injury.

Professor Graham Cooke

Professor Graham Cooke was awarded a prestigious research professorship for work to help accelerate the elimination of hepatitis C in the UK by the NIHR. Professor Cooke will work with patients at St Mary's Hospital to develop new ways of diagnosing and managing people infected with hepatitis C.

Dr Nichola Cooper

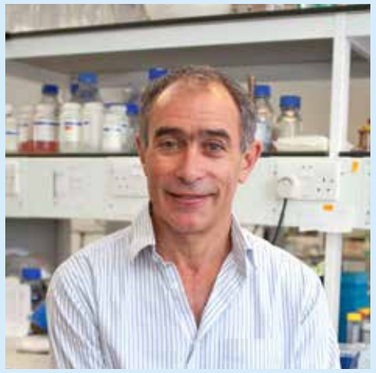
Dr Nichola Cooper, consultant haematologist, was awarded the John Moulton grant by the BMA Foundation at its award ceremony. Dr Cooper was awarded the grant to assist her research into idiopathic thrombocytopenic purpura (ITP) to understand clonality in T cells in ITP.

Professor Alison Holmes

Professor Alison Holmes, director of infection prevention and control at the Trust, was appointed senior investigator by the NIHR. Senior investigators are among the most prominent and prestigious researchers funded by the NIHR. The appointment was for her research work in infectious diseases and epidemiology.

Mr Shehan Hettiaratchy

Mr Shehan Hettiaratchy, trauma lead and major trauma director, was recognised for his work in treating people injured in terrorist attacks in London during 2017. Mr Hettiaratchy was one of 12 individuals collectively named 'the most influential Londoners' in this year's Progress 1000 list by the Evening Standard. He was also presented an award by Prime Minister Theresa May at the Daily Mail's Health Hero of the Year awards.



Professor Michael Levin

Professor Michael Levin, consultant paediatrician based at St Mary's Hospital, was awarded an MBE by Her Majesty the Queen, recognised for his 'services to infectious diseases, critical care and research in paediatrics' in the New Year's Honours List.

Dr Matt Williams

Dr Williams, a consultant clinical oncologist at the Trust, helped advise producers at Coronation Street on their latest storyline after it was revealed that soap icon Rita Tanner had a brain tumour. Dr Williams worked closely with producers at ITV and the charity Brain Tumour Research to ensure that Rita's storyline was portrayed as accurately as possible.

PREPARE for surgery team

The Trust's PREPARE for surgery team was named Patient Partnership and Surgical Team of the Year, at the BMJ Awards 2017.The PREPARE for Surgery programme 'trains' patients for surgery based on their individual needs, covering physical activity, diet, psychological wellbeing and medication management. The programme has led to improvements in post-operative complications, with post-operative pneumonia falling from 60 per cent to 30 per cent. Patients are also recovering quicker, with the average length of stay in hospital reducing from 12 days to nine.

Nursing Times Awards 2017

We were one of 11 NHS Trusts acknowledged for their nurses' response to the London and Manchester terror attacks in 2017 with special recognition Awards. Our nurses were recognised for outstanding contribution during the Westminster and London Bridge terrorist attacks.

Dementia care team

The dementia care team were recognised for their tailor-made eating and drinking plans for patients, Dementia Nutritional Support in Hospital Pathway (NoSH), at the HSJ awards where they received the acute sector innovation prize.

NoSH, which helps patients with dementia manage their food and drink, was recognised after making a big impact at St Mary's Hospital, speeding up recovery rates and helping patients return home faster.

Sustainability report

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. At the Trust, we aim to continually:

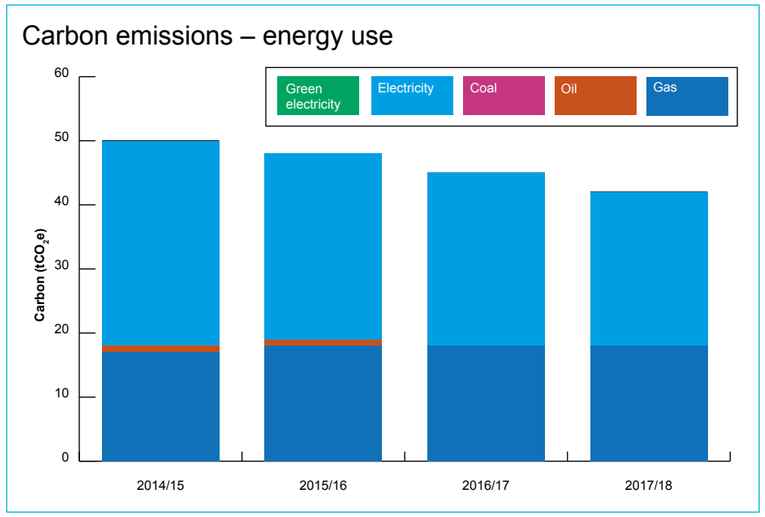
- minimise our carbon footprint
- reduce our energy usage and increase our proportion of green energy
- ensure water efficiency
- encourage sustainable transport
- ensure procurement that is sustainable both environmentally and socially
- improve our preparations for adverse climate impacts.

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

While we have not yet delivered a comprehensive sustainability plan, the following report demonstrates our successes and challenges in moving forward with our sustainability agenda during 2017/18. The schemes being introduced to minimise the Trust's carbon footprint are set out below.

Minimising our carbon footprint

The Trust acknowledges its responsibility to its patients, local communities and the environment by working hard to minimise our carbon footprint. As an NHS Trust it is our duty to contribute towards the national aim of reducing the carbon footprint of the NHS, public health and social care system by the equivalent of 28 per cent by 2020 (from the footprint set out in 2013). It is our aim to go beyond this target and emissions in 2017/18 are down over 2.2 per cent compared with 2016/17.



Every action counts, and we are a lean organisation trying to realise efficiencies across the board to achieve both cost and carbon (CO_2e) reductions.

During 2017/18 the Trust implemented three projects:

- condensing flue gas recovery at Hammersmith Hospital
- boiler house upgrades at Charing Cross Hospital
- GEM steam traps at St Mary's Hospital.

These projects further reduced our carbon emissions by 2,092 tonnes. Following the success of the flue gas recovery project at Hammersmith Hospital (found to be delivering 120 per cent of target savings), a similar project has just been completed at Charing Cross Hospital which will decrease Trust's emissions by another 1,683 tonnes in 2018/19.

As noted in last year's report, two of the Trust's hospitals – Hammersmith and Charing Cross – are no longer required to be in the carbon reduction commitment energy efficiency scheme; providing a net reduction in our carbon tax liability of almost £2m over the next five years.

We recognise that there is more to be done to reduce the impact of our activities on the environment. During 2017/18, we aimed to reinvigorate and revive our plans in line with the NHS Sustainability Development Unit guidance, but this has been carried forward to 2018/19. A key part of this will be the introduction of combined heating and power (CHP) reconfiguration at Hammersmith Hospital which will lessen our emissions by 2,616 tonnes, and also secure financial savings of circa £250,000 per annum from 2019/20.

Starting in 2009/10, the Trust has invested in over 34 energy efficiency projects, all funded by Salix interest-free loans (total loan value of £9.4m), which together are delivering savings of £2.4m per annum against the business-as-usual energy spend.

The Trust has benefitted from most of the easier to implement energy efficiency options and in 2018/19 will be exploring the possibility of an energy performance contract. This will enable achievement of medium to long term heat and power aims, as well as identify and implement a full range of commercially viable energy efficiency options.

The Trust has undertaken risk assessment and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Reducing our energy usage and increasing our proportion of green energy

We spent £9,242,000 on energy in 2017/18, a 3.4 per cent increase on that in 2016/17. This increased spend has been due primarily to the particularly adverse weather conditions over the winter period, with nearly five per cent more total degree days below 18.5C than the previous year. Additionally, the age of much of the Trust's estate, particularly on the St Mary's, Hammersmith and Western Eye hospital sites, makes it very difficult to reduce energy consumption.

The Trust has yet to procure green energy, as demonstrated in the table opposite, as it is prohibitively expensive.

Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	82,453	86,702	86,716	84,814
	tCO_2e	17	18	18	18
Oil	Use (kWh)	2,834	2,843	658	1,096
	tCO_2e	1	1	0	0
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	54,034	53,444	54,757	57,534
	tCO_2e	32	29	27	24
Green electricity	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Total energy CO_2e		50	48	45	43
Total energy spend		£ 8,916,631	£ 9,012,756	£ 8,940,086	£ 9,242,247

Work continues to review the mechanical and electrical infrastructure across all sites to assess both current and future needs. This work focuses on the development and implementation of an automated meter reading system, and improved integration with the building management system and energy monitoring, as well as targeting and reporting systems.

This will provide improved 'real time data', and an improved speed and quality of plant performance and energy consumption data. The data will be visible to staff, patients and visitors and this will assist in engaging them in supporting our future energy reduction plans. When the systems integration is complete, the reporting interface will display costs, consumption and emissions data at main entrances and employee workstations.

We have installed LED lighting and, through a continuous review of the building management system, adjusted temperature set points and system operating times to ensure energy is used as efficiently as is possible given the infrastructure issues outlined.

Water		2014/15	2015/16	2016/17	2017/18
Mains water	m^3	408,319	428,001	447,780	409,818
	tCO_2e	372	390	408	373
Water and sewage spend		£ 40,411	£ 746,213	£ 874,505	£ 874,505

Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient and visitor own travel	miles	1,801,377	1,741,784	1,608,420	2,021,121
	tCO_2e	661.88	629.89	581.30	720.18

Ensuring water efficiency

The Trust has been working on water efficiency measures for the past five years. Significant progress has been made on reducing water consumption waste through a variety of initiatives and 2017/18 has seen a further decrease in consumption, by 37,962m^3 from 2016/17.

The Trust is working with Advanced Demand Side Management (ADSM), a utility management consultancy that provides water management services. Their services include invoice validation, including water consumption reports, which has helped achieve saving of circa £170,000 from 2016/17. Their service also includes a water leak detection system that includes underground water leak detection. This identified a large water leak of 20 m^3 per hour, which would not otherwise have been detected until the invoice was received.

Encouraging sustainable transport

We seek to improve local air quality and improve the health of our community by promoting active travel that avoids car use to our staff and to the patients and public that use our services. Air pollution, accidents and noise – all caused by cars and other vehicles – all cause health problems for our local population, patients, staff and visitors.

The Trust's non-emergency patient transport service undertakes in excess of two million journeys each year. Recent changes to the vehicle fleet have introduced smaller and more appropriate vehicles to improve service quality and also deliver lower vehicle emissions.

Ensuring procurement that is sustainable both environmentally and socially

The Trust uses the approved Department of Health and Social Care terms and conditions for procurement which contain sustainability clauses, and regularly reviews its compliance against these.

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

The Trust was not able to move forward with its plans for implementation of the good corporate citizenship (GCC) tool to help promote social sustainability awareness, but this remains part of our broader sustainability planning.

Improving our preparations for adverse climate impacts

Events such as heat waves, cold snaps and flooding are expected to increase as a result of climate change, and the Trust has ensured that both current and projected environmental conditions are addressed in the estates redevelopment programme approved by the Trust board. The Trust continues to review, develop and implement policies and protocols in partnership with our site partners and other local agencies to mitigate the impact of these changes including handling extreme cold and heat, which were both experienced in 2017/18.

Performance against the five domains of quality

Our 2015 – 2018 quality strategy is delivered through the achievement of our quality goals which ensure quality is our number one priority. Our goals are:

Safe

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

Effective

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

Caring

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

Responsive

To consistently meet all national access standards.

Well-led

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

Our quality improvement priorities for 2017/18 were defined in our quality account last year following consultation with our clinical and management teams and with our external stakeholders, through the quality steering group.

Progress with these goals and the targets which support them is described here under each quality domain. Areas where we are proud of the improvements we have made or sustained are outlined overleaf as well as areas where we have not performed as well as we would wish. We also developed measurable and structured improvement projects which were assessed for their potential to positively impact on the goals and targets we set. For full details, please see our quality account, which is published on our website.

Safe

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

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

Safe quality highlights and challenges

We had fewer incidents which cause the most harm to patients compared to other acute trusts again this year, and so continue to be below average for incidents causing severe or extreme harm to patients.

We increased our incident reporting rate: An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety, to learn from them and deliver improved care. A high reporting rate is viewed as evidence of a positive reporting culture, as staff feel able to report incidents that occur. By the end of the year, we had increased our reporting rate to almost 48 per 1,000 bed days, which puts us in the top 25 per cent of reporters nationally.

We reduced our never events, reporting one never events this year, compared to four in 2016/17. Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

We maintained safe staffing levels: Although our vacancy rates remain higher than our targets, we have ensured staffing meets planned safe levels this year. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses.

We have achieved a 37 per cent reduction in the number of grade 3 and 4 pressure ulcers: We are proud that we have exceeded our target of a ten per cent reduction in pressure ulcers compared to 2016/17.

We have met our venous thromboembolism (VTE) assessment target since November 2017: The risk of hospital acquired VTE – blood clots in the vein – can be reduced by assessing patients on admission. The Trust moved to assessment for VTE at drug prescription on admission rather than at discharge at the end of March 2017 in response to limited assurance on accuracy of data from auditing. There was an initial drop in performance across the Trust which we had anticipated and a Trust-wide action plan that included sharing performance data locally was implemented.

We reported ten avoidable infections: Although we did not meet our stretch target to have none we have seen a decrease in avoidable infections in 2017/8, reporting 10 compared to 12 last year. We have also seen a reduction in total cases of both infections when compared to last year.

In March 2018, the Trust also received a letter from NHS Improvement commending our contribution to reducing Escherichia coli bloodstream infections. The Trust was one of 59 who achieved a 10 per cent or greater reduction in hospital onset infection.

We have not fully met our targets for compliance with Duty of Candour although we are making sustained improvements: This involves giving patients accurate, truthful and prompt information when mistakes are made and treatment does not go to plan as well as providing an apology. As well as being a requirement under the Duty of Candour legislation, the Trust recognises the importance of being open with patients if they have suffered harm related to care or treatment.

Effective

Goal: To show continuous improvement in national clinical audits.

The goal and targets in our Effective domain are designed to drive improvements to support good practice in our services and ensure the outcomes for our patients are as good as they can be using best available evidence to continuously improve care and treatment. We are delighted that the CQC increased our overall rating in this domain to 'good' following their inspections in 2017 which reflects the progress we have made over the last few years.

Effective quality highlights and challenges

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

We have participated in 40 out of 41 relevant national clinical audits, and action plans have been implemented where required: Clinical audit is a key improvement tool through which we can monitor and improve the quality of care that we provide. By taking part in national clinical audit programmes, we are able to benchmark our performance and measure improvements on a year-by-year basis.

We are reviewing all cardiac arrests that occur outside of our intensive care units, emergency departments and coronary care units for harm: When cardiac arrests occur outside of these areas it can be because patients are not being monitored properly, or staff have failed to recognise and act on deterioration in their condition. The Trust now has an increasingly robust process in place to review each of these cardiac arrests for care or service delivery issues. Two cases have been found to have resulted in harm this year, compared to one the previous year.

We did not meet our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days however we are improving due to focussed work and action: Since quarter two 2016/17, our results have consistently fallen below the 90 per cent target reflecting process and data changes introduced by the Department of Health that year. Performance has also declined nationally. A new consultation by NHS England is currently proposing to establish a single set of national clinical trials metrics which are more robust and which are resistant to different interpretations by Trusts as is currently the case. We continue to review procedures for the timely initiation and delivery of clinical trials.

Caring

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

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

Caring quality highlights and challenges

We have exceeded our target for the percentage of our inpatients and A&E patients who would recommend us to friends and family: For patients reporting a positive experience, interaction with staff continues to be the most significant factor. This relationship between staff and patient experience is well recognised; our patients report this as having the most positive impact on their experience. We are continuing to build upon this relationship by actively encouraging staff to understand and act upon patient feedback.

We have maintained the percentage of outpatients who would recommend our Trust since last year: Although we are disappointed that our outpatient Friends and Family Test (FFT) score has not improved since last year, we are confident that the changes we are making as part of our outpatient improvement programme will significantly improve outpatient experience in the long run.

We did not quite maintain our performance in the national inpatient survey relating to responsiveness to patient's needs: We scored 6.72 out of 10 in the 2016 survey, compared to 6.74 in the 2015 survey.

We did not improve further on our national cancer patient experience survey results: In 2016/17 year we saw the best set of results in the five years that the survey has been running. Unfortunately we did not manage to improve on our results again in 2017/18, scoring 8.5/10 compared to 8.6/10 the previous year. However, the Trust did score above the expected ranges on questions about whether taking part in cancer research was discussed with the patient, and if the patient was given the name of the clinical nurse specialist who would support them through their treatment.

We have exceeded our target to respond to 95 per cent of complaints within the timeframe agreed with the patient: We maintained a high level of performance in relation to responding to complaints within the timeframe agreed with the patient. The process for complaints handling is fully embedded and effective. With a strong commitment to resolving concerns as promptly and effectively as possible and with better access to complaints investigators, we have also seen a reduction in the numbers of complainants taking their complaint onto the Parliamentary and Health Service Ombudsman (PHSO). Overall, the volume of formal complaints received by the Trust continues to fall year-on-year which suggests that people's concerns are being dealt with nearer the point at which they occur. Clinical care and issues with appointments continue to be the most frequent categories of complaints received. In the latest inspection reports for the Trust, the CQC concluded that overall the management of complaints was "good".

Responsive

Goal: To consistently meet all national access standards.

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment, which can cause harm to our patients. Our goal is to consistently meet the national targets.

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

Responsive quality highlights and challenges

We have not consistently met all eight cancer standards: Although we did not consistently meet all eight cancer standards across the year, improvements have been seen. These improvements have been the result of a number of actions across each of the targets, including increasing MRI capacity to deliver same day scanning and reporting for prostate cancer referrals and increasing CTC scanning and reporting capacity to support the colorectal straight to test pathway. In September the Trust signed a memorandum of understanding with RMP Vanguard to deliver the £943k investment over the next two years to fully establish the prostate RAPID diagnostic pathway.

We have not met the national four hour A&E standard: Like many NHS trusts, we continue to struggle to meet the 95 per cent standard for A&E patients to be treated and discharged or admitted within four hours, reporting 83 per cent against this target in 2017/18.

Pressures on A&E are complex and include pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery.

We have not met the national performance targets for referral to treatment (RTT): We reported 83 per cent of people treated within 18 weeks between April 2017 and March 2018 compared to the national standard of 92 per cent.

We also reported 267 patients who waited over 52 weeks for treatment throughout the year, compared to the national standard of zero. As part of the Trust's waiting list improvement programme we introduced a clinical review process for patients waiting over 52 weeks for treatment and three cases of clinical harm have been confirmed since the process began in August 2016.

In 2017/18 we also included an 'on admission' clinical harm review for patients waiting 52 weeks and over for treatment within specialties that are included within the 'high risk' category. To date there have been no incidents of clinical harm. Also, a dedicated email address was set up for GP colleagues to alert us to any patients that they are concerned about having increased risk of harm to support us to escalate patients for earlier care where appropriate. No patients have been found to suffer harm through this route.

We continue to deliver our outpatient improvement programme and are seeing improvements as a result: Although we have not met our targets, we have increased the number of appointments made within five working days of receipt of referral from 77 per cent in 2016/17 to almost 84 per cent in 2017/18.

We have improved our PLACE (patient led assessment of the care environment) scores in all categories: This year's results showed an improved position in all six areas measured by PLACE (cleanliness; food and hydration; privacy, dignity and wellbeing; condition, appearance and maintenance; dementia; disability). These improvements were the result of a detailed action plan led by the PLACE steering group, as well as progress with our wayfinding, clinical and estate strategies.

We have not achieved our target to discharge at least 35 per cent of our patients on relevant pathways before noon: The Trust is supporting wards to implement the SAFER flow bundle which combines five elements of best practice to improve patient flow and prevent unnecessary waiting for patients. This includes early discharge to make beds available on the wards to admit new patients from A&E. This year 11.7 per cent of our patients were discharged before noon from across the Trust, compared to 17.5 per cent last year.

Well-led

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

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

Well-led quality highlights and challenges

We have achieved our goal and increased the percentage of staff who would recommend our Trust as a place to work and as a place for treatment. We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice, Our Trust' which was run between May and June 2017. We were very pleased to see that our scores for both of these increased again this year; they are our best results for these two questions since the staff survey was introduced in 2013.

We have met our voluntary turnover rate target: A key aspect of reducing the voluntary turnover rate (the number of staff who choose to leave and work elsewhere) is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. We are pleased that we have seen a decrease in staff voluntarily leaving the Trust this year from 10.2 per cent to 9.1 per cent.

Our sickness absence rate remains low: Low sickness absence is an indicator of effective leadership and good people management. We are continuing our focus on supporting the health and wellbeing of our staff along with supportive management interventions for those who are absent due to sickness. There are a range of activities and services available within the Trust including occupational health, staff counselling, stress management, yoga and meditation classes, and smoking cessation clinics. In September 2017 we also ran our 'Great place to work week' which included events designed to get staff fit, active and having fun.

We have maintained our performance overall in the General Medical Council's National Training Survey of junior doctors and our performance for placement satisfaction as measured by SOLE (Student Online Evaluation): As one of London's largest teaching hospitals, we want to provide the best training for our doctors, as we believe this is a key element of being a 'well-led' organisation. Two important elements we use to monitor the satisfaction of our trainee doctors and medical students are:

- Student Online Evaluation (SOLE): In 2016/17, we achieved this target for 76 per cent of our programmes. We are pleased that we have succeeded in slightly improving still further, with 79 per cent of students agreeing that 'overall (they are) satisfied with their placement' in 2017/18.
- General Medical Council's national training survey (GMC NTS): The results of the GMC NTS were published in July 2017. Whilst the 2016 survey demonstrated significant improvement on previous results, the 2017 results indicate that we have maintained our performance overall. Ongoing supportive improvement plans are in place for specialties of concern through education specialty reviews. Two specialties (ophthalmology and neurosurgery) have been removed from enhanced monitoring by the GMC due to their sustained improved performance. Critical care at Charing Cross Hospital remains under enhanced monitoring with a formal action plan in place.

We re-ran our ward accreditation programme and saw improvements in 38 wards: Our programme of ward inspection carries out regular checks and instigates immediate improvement where necessary. Overall, out of 90 areas reviewed across the Trust, 38 had improved since 2016/17.

We have increased the percentage of staff who have had a performance development review (PDR): Our appraisal scheme for staff is aimed at driving a new performance culture across the Trust. Although we are below target we have improved on last year's result at 88.5 per cent compared to 86.2 per cent in 2016/17.

We have not achieved our target of 90 per cent of staff being compliant with core skills training, with 87 per cent of our staff fully trained by the end of March 2018: Our core skills training programme ensures the safety and well-being of all our staff and patients. We have an ongoing work programme to maximise compliance rates which includes the introduction of pre-assessment modules, a review of target groups, better communication and improving access to training.

We have not met our percentage target

for the number of doctors who have had an appraisal, however we had positive feedback from our ‘higher level responsible officer quality review visit’: In February 2017 the Trust was visited by the London revalidation team to assess against the Core Standards Framework for the supervision, support and management of medical staff by the organisation and the responsible officer. The visit highlighted a number of areas of good practice including appraisers having refresher training that was well evaluated by participants, the production of electronic revalidation monthly newsletters, and good working relationships between the medical staff team and the revalidation team. An action plan has been developed for areas highlighted for improvement.

We have not achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 60 per cent of clinical wards, clinical departments and corporate departments: Targeted work has been underway to increase the numbers of trained staff, however high demand on our clinical areas has restricted the availability of our staff to attend the training sessions. In response, a more concise training package for fire wardens has been developed this year and a new e-learning course is being considered for department safety co-ordinator training.

Accountability report

NHS bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health and Social Care. The accountability report takes account of the Department of Health guidance for NHS trusts in the manual for accounts, as follows:

- The corporate governance report explains how the composition and organisation of the Trust’s governance structures, developed in line with good governance standards, support the Trust’s objectives, and provide assurance that the Trust’s risks are appropriately identified and managed.
- The remuneration and staff report sets out the Trust’s remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce.
- The Trust’s external auditor also provides a report of its audit of the annual accounts, remuneration and staff report and annual report.

Corporate governance report
Governance statement

Directors' report

The Trust board and its committees

The Trust board is accountable, through the chairman, to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board at 31 March 2018 consisted of the chairman, six non-executive directors, interim chief executive officer, medical director, director of nursing, and chief financial officer, as outlined below.

The membership of the Trust board is balanced and appropriate; biographies for each of the Trust's board directors are available on the website at: https://www.imperial.nhs.uk/about-us/who-we-are/our-board.

The members of the Trust board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector. The Trust board is confident that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability. Both the selection process (led by NHS Improvement) and the board seminar programme in place, ensure that the non-executive directors have appropriate skills and level of understanding to undertake their role.

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

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust board directors have been assessed as being fit and proper persons to be directors of the Trust; this process was reviewed by the Care Quality Commission during the well-led inspection in December 2017.

The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for executive directors, by the chief executive; for non-executive directors and the chief executive by the chairman; and for the chairman, by self-assessment with sign-off by NHS Improvement.

The Trust board, and each of the committees, undertook a self-assessment of performance and effectiveness, using a detailed questionnaire developed for this purpose. The questionnaire was sent to all committee members and standing attendees for completion. The findings were reported back to, and discussed at, the relevant committee, and also to the Trust board in May 2018 to seek continuous improvement in performance. Overall, the results showed similar or slightly improved reported scores for both non-executive and executive members and attendees, and, as for 2016/17, a reasonably homogenous view across responders. An area of particularly positive behaviour was seen in 'right people being invited to attend and present at committee meetings', with continued high scores reported in relation to 'impact at board level' and 'reaction to bad news' and good processes existing in 'sufficient number and timing of meetings'. Improved scores were received for the question relating to 'timeliness of information', but again, whilst showing some improvement, still further work is required on the 'length and relevance of papers'.

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

- Following her resignation, Dr Tracey Batten was replaced as chief executive officer by Ian Dalton from 31 July 2017.
- Following his appointment as chief executive officer at NHS Improvement, Ian Dalton was replaced by Professor Julian Redhead, acting as the interim chief executive officer, from 4 December 2017.
- Victoria Russell was appointed as a non-executive director from 1 July 2017.

The Trust board at 31 March 2018 was as follows:

Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy chairman
Professor Andrew Bush	Non-executive director
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Victoria Russell	Non-executive director
Professor Julian Redhead	Interim chief executive officer (CEO)
Professor Tim Orchard	Interim medical director
Dr William Oldfield	Interim medical director
Professor Janice Sigsworth	Director of nursing
Richard Alexander	Chief financial officer

There was one vacant non-executive position and one vacant executive position on the board as at 31 March 2018.

Attendance at Trust board meetings: 1 April 2017 – 31 March 2018

The Trust board met six times in regular session in the reporting period, and there were also two extraordinary private sessions. Attendance at the Trust board and attendance at and role of the board committees is described below:

Member*	Attendance (actual/possible)
Non-executive directors*	
Sir Richard Sykes, Chairman	7/8
Sir Gerald Acher, Deputy chairman	6/8
Dr Rodney Eastwood (to 30 June 2017)	1/1
Dr Andreas Raffel	6/8
Sarika Patel	7/8
Peter Goldsbrough	5/6
Professor Andrew Bush	6/8
Victoria Russell (from 1 July 2017)	4/6
Executive directors	
Dr Tracey Batten, Chief executive (to 30 July 2017)	3/3
Ian Dalton, Chief executive officer (31 July – 3 December 2017)	3/3
Professor Julian Redhead, as Interim CEO (from 4 December 2017)	2/2
Richard Alexander, Chief financial officer	8/8
Professor Janice Sigsworth, Director of nursing	7/8
Professor Julian Redhead, as Medical director (to 3 December 2017)	4/6
Professor Tim Orchard, Interim medical director (from 4 December 2017)	2/2
Dr William Oldfield, Interim medical director (from 4 December 2017)	2/2

* Changes to the board membership are outlined above

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

Audit, risk and governance committee

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

In its broader, non-mandatory role, the committee oversees and seeks assurance that risk management and corporate governance arrangements are in place and working effectively, and undertakes reviews of areas of activity which may expose the Trust to particular risk and seeks assurance that appropriate management action is being taken. In such matters, it is cognisant of the work of other committees. The terms of reference of the audit, risk and governance committee are available upon request.

The committee met five times in regular session during the reporting period, and also held two extra-ordinary meetings to discuss accounts and year-end issues.

Member*	Attendance (actual/possible)
Sir Gerald Acher, Non-executive director (chair)	7/7
Professor Andrew Bush, Non-executive director	2/7
Sarika Patel, Non-executive director	6/7
Dr Rodney Eastwood, Non-executive director (to 30 June 2017)	1/1
Dr Andreas Raffel, Non-executive director	7/7
Dr Tracey Batten, Chief executive (to 30 July 2018)	4/4
Ian Dalton, Chief executive officer (31 July to 3 December 2017)	1/1
Professor Julian Redhead, as Interim CEO (from 4 December 2017)	2/2
Richard Alexander, Chief financial officer	6/7
Professor Janice Sigsworth, Director of nursing	3/5
Professor Julian Redhead, as Medical director (to 3 December 2017)	1/3
Dr William Oldfield, as Interim medical director (from 4 December 2017)	2/2

During 2017/18, the committee has remained observant of the key financial, operational and strategic risks facing the Trust through review of the board assurance framework (to gain on-going assurance of risk and internal control processes), and through internal sources of validation and by way of triangulation with the quality committee.

The committee has reviewed and approved the annual internal and external audit plans, and has reviewed

and evaluated internal audit reports on key systems of internal audit control, including finance, governance, risk management, policy scrutiny, human resources and payroll. A full list of internal audits provided by TIAA (the Trust's internal auditor in 2017/18) is attached as appendix one. Particular areas identified as requiring management attention were: securing income from overseas visitors (identified gaps in process are being addressed); management of accounts payable (where an increasing number of disputed invoices were identified, and also further reconciliation between Trust and contractor recommended); oversight of strategic procurement (where the plan needed further development to embrace partnership working); completion of consultant job planning (where various operational issues meant that deadlines had not be achieved); recording of patient request in relation to resuscitation (not all records reviewed had been appropriately completed); referral to treatment and diagnostic imaging (where, in both audits, not all procedures would appear to have been fully complied with); and income data quality in various specialties (where gaps and errors in the underlying data were observed).

The phasing of the 2017/18 internal audit plan resulted in some of the highest areas of risk being reviewed in the later part of the year, the timing driven by the development of a new audit approach with which to assess the Trust's new data quality governance framework in place for waiting times and income data sets. As often the case with a new framework, it had been anticipated by management that these reviews were likely to result in a number of control weaknesses being identified, as indeed they were; the committee will receive management action plans to address each of these audits where limited assurance has been given, to demonstrate the delivery of improvement.

The corporate risk register is also reviewed regularly, and during 2017/18, the committee engaged in a welcome discussion as to the development of a formal risk appetite framework and statement to support improved decision making and prioritising across the Trust. Presented for adoption in March 2018, Deloitte LLP and Pricewaterhouse Coopers LLP (PwC) commented on the maturity of risk management approach inherent in such a development. The risk appetite framework and statement would be subject to further committee review during 2018/19. Further details are outlined in the governance statement.

The committee has undertaken a number of in-depth reviews where specific risks were identified. These included cyber security, where the committee commended the arrangements put in place to minimise the potential threat of cyber attack and the particularly successful response to the Wannacry attack by the chief information officer and his team; the main impact on the Trust had been providing operational and systems support to other trusts in a less fortunate position. Following the Grenfell Tower fire, the Trust's fire safety arrangements and plans came under close review, and were found to be, in most areas, of a robust nature. Concerns as to accuracy and completeness of data relating to patients awaiting elective surgery once more came under close review when previous issues, considered addressed, became apparent. The divisional leadership team took swift action to comprehensively review and improve processes and training programmes; this is now being supported by external review and recommendations.

At the committee's request, following a number of terrorist attacks in London, and the resulting major incidents, the committee considered a terrorism threat security report. A further area subject to scrutiny has been the Trust's programme to address recruitment and retention issues, particularly amongst nursing, midwifery and some other clinical areas; the Trust issues and actions in this regard are outlined in the governance statement. The committee also considered the Trust's preparations for general data protection regulations (GDPR) compliance, and as a result, all board members were provided with an overview briefing on the subject. The committee welcomed attendance at the committee by senior national management from the Trust's soft facilities management contractor, where commitment was given to an improvement in cleaning standards; unfortunately, improvement was not consistent, and the committee supported the Trust in seeking further redress.

The committee also liaises with other committees within the Trust whose work can provide relevant assurance to the audit risk and governance committee's own scope of work. The committee received regular reports on losses and compensation payments, the waiver of tendering process and competitive quotations, and any allegation of suspected fraud notified to the Trust. The Trust places strong emphasis on countering fraud and corruption and follows the Secretary of State's directions to ensure that public funds are protected. The Trust has an annual counter-fraud work plan which is agreed with the local counter-fraud specialist (LCFS) to ensure that appropriate coverage is provided and maintained. Firm counter-fraud policies are in place, which are promoted widely to staff and patients through awareness sessions and at the Trust's corporate induction. Relevant Trust policies are reviewed on a regular basis by the LCFS and the Trust. In 2017/18, Deloitte LLP acted as the Trust's external auditors, having been appointed from April 2017 for a three year period. During 2017/18, the committee appointed Pricewaterhouse Coopers LLP (PwC) as their internal auditors for a period of three years from April 2018, with the option to extend for two periods of one year.

The committee provided robust challenge to preparation of the year-end accounts, both in formal meetings and in additional briefings; this included oversight of the working papers and the audit of the accounts.

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

Quality committee

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

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

Member*	Attendance (actual/possible)
Professor Andrew Bush, Non-executive director (chair)	5/7
Sir Gerald Acher, Deputy chairman	6/7
Dr Rodney Eastwood, Non-executive director (to 30 June 2017)	1/1
Victoria Russell, Non-executive director (committee member from August 2018)	4/6
Dr Tracey Batten, Chief executive (to 30 July 2017)	2/2
Ian Dalton, Chief executive officer (31 July to 3 December 2017)	3/3
Professor Julian Redhead, as Interim CEO (from 4 December 2017)	2/2
Professor Janice Sigsworth, Director of nursing	5/7
Professor Julian Redhead as Medical director (to 3 December 2017)	5/5
Dr William Oldfield, Interim medical director (from 4 December 2017)	1/2
Professor Tim Orchard, Interim medical director (from 4 December 2017)	1/2

Regular discussions included review of divisional risks, the Trust's comprehensive quality report, the infection prevention and control report (where the real reduction in antibiotic usage, and success in minimising both MRSA and C difficile infections were applauded). The Trust's management of the growing risk of Carbapenemase-producing Enterobacteriaceae (CPE) infection), serious incident monitoring report, claims and complaint data, health and safety report (where a sustained reduction in slips, trips and falls was noted following a series of actions with the cleaning contractor), and the progress of the outpatient improvement programme were also commended. The committee also received regular reports on actions and processes relating to Care Quality Commission compliance, which reviewed the Trust's status, the ratings and findings of inspections and actions to address, and the results of the Trust self-assessment process which seeks to support continual improvement.

A number of in-depth reviews were also undertaken in areas of potential quality concern such as: progress in implementing the requirements of the Duty of Candour, where significant improvement was demonstrated during the year; the on-going challenges in recruitment of nursing, midwifery and some other clinical staff, and the real progress being achieved; and patient care in the Vocare urgent care centre and its impact on the emergency department (while issues remained it was recognised that the risk of patient harm had reduced). The committee reviewed closely the introduction of the 'learning from deaths' requirements, and was pleased to note the training of clinicians and completion of reviews as appropriate. Close attention was also paid to the progress in ensuring the minimal use of non-safe sharps and improving the staff influenza immunisation rates (the Trust was the most improved trust nationally).

Finance and investment committee

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

The committee met six times in regular session during the reporting period, and also held two extra-ordinary meetings.

Member*	Attendance (actual/possible)
Dr Andreas Raffel, Non-executive director (chair)	8/8
Dr Rodney Eastwood, Non-executive director (to 30 June 2017)	2/2
Peter Goldsbrough, Non-executive director	5/8
Victoria Russell, Non-executive director (committee member to August 2018)	3/3
Dr Tracey Batten, Chief executive (to 30 July 2017)	3/3
Ian Dalton, Chief executive officer (31 July to 3 December 2017)	3/3
Professor Julian Redhead, as Interim CEO (from 4 December 2017)	2/2
Richard Alexander, Chief financial officer	7/8

During the summer and autumn of 2017, the committee supported the executive in discussions with NHS Improvement in agreeing a control total which was considered to be achievable; and the move from annual to a two year budget agreement was welcomed by the committee.

Regular reports were considered in relation to the Trust's financial position against agreed budgets and against cost improvement plans, providing both support and challenge. The committee also sought a greater focus on potential savings from reducing duplication across the health economy, and noted the move towards nationally contracted procurement, away from locally contracted purchasing. In-month budgets were achieved in most months, although a concerted effort to return to this position was needed after a couple of particularly challenging months in early winter. The committee welcomed the return to a balanced position by year-end. Preparations for development and submission of annual plans for 2018/19 were also considered, as was oversight of spend against the capital plan, where the committee requested a move away from a high 'back-end' spend towards a smoother pipeline approach. Following work to understand the scale of, and prioritise, the backlog maintenance requirements undertaken in 2016/17, the committee supported the commitment of a significant proportion of the 2017/18 capital budget in addressing high risk items of backlog maintenance (described further in the governance statement). Recognising that the Trust's need for capital (given the parlous state of the estate) by far exceeds the level of allocated funding, the committee supported submission of a request for additional capital funding (again, described in the governance statement), in part to address the high level of backlog maintenance requirements.

The committee reviewed and commented on development by the executive of a transformation plan, which focused on larger-scale and longer-term change programmes to deliver our strategic goals, including financial sustainability. It considered progress reports on the specialty review programme, welcoming the level of clinical engagement and noting expected outputs and timeframes, recognising this to be a key part of clinical transformation and sustainability.

The committee undertook regular review of a number of key areas of activity: annual financial review of the redevelopment programme, where assurance was taken from arrangements in place to ensure robust oversight of contractors' costs; and annual review of the performance of Imperial Private Healthcare noting that, despite a reduction in some areas of activity, the unit was delivering a strong financial performance. During 2017/18, the committee commenced regular review of the financial position of North West London Pathology (NWLP), given its newness in acting as a semi-autonomous business. NWLP, faced with a number of operational and financial issues in year, was not able to achieve its plan; the committee discussed effective strategies for attracting new business.

A number of business cases were reviewed and supported for Trust board approval, including the global digital exemplar case (noting the benefits that would be realised both in terms of improvements in quality and cash releasing savings), and the refurbishment of the emergency department at Charing Cross Hospital (noting the higher than expected cost of moving roof-mounted plant to accommodate the expansion). The committee also received summaries of smaller business cases approved by the executive during the year.

Redevelopment committee

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

The committee met nine times in the reporting period.

Member*	Attendance (actual/possible)
Sir Richard Sykes, Chairman (chair)	9/9
Dr Andreas Raffel, Non-executive director	9/9
Peter Goldsbrough, Non-executive director	6/9
Victoria Russell, Non-executive director (from 1 July 2017)	4/4
Dr Tracey Batten, Chief executive (to 30 July 2017)	3/3
Ian Dalton, Chief executive officer (31 July to 3 December 2017)	3/3
Professor Julian Redhead, as Interim CEO (from 4 December 2017)	4/4
Richard Alexander, Chief financial officer	8/9
Professor Julian Redhead, as Medical director	5/5
Dr William Oldfield, Interim medical director (from 4 December 2017)	4/4

Discussions focused on the redevelopment programme at St Mary's Hospital, with the Trust being pleased to obtain full planning permission for phase one, which would accommodate many of the Trust's outpatient and diagnostic services alongside services from the Western Eye Hospital; focus now turns to continuing broad engagement and identifying potential sources of funding. An outline approach for the full redevelopment of St Mary's Hospital has been developed and is being shared with key stakeholders, including NHS Improvement.

Safety concerns, especially for 'blue-light' ambulances, regarding the proposed new road access to St Mary's Hospital as part of the Paddington Quarter development continued into 2017/18, with the Trust submitting court papers for a judicial review, which was disappointingly refused.

Remuneration and appointments committee

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

Member*	Attendance (actual/possible)
Sarika Patel, Non-executive director (chair)	4/4
Sir Richard Sykes, Chairman	2/4
Peter Goldsbrough, Non-executive director	3/4
Dr Tracey Batten, Chief executive (to 30 July 2017)	1/1
Ian Dalton, Chief executive officer (31 July to 3 December 2017)	1/1
Professor Julian Redhead, Interim CEO (from 4 December 2017)	2/2

The committee met four times during the reporting period, where discussions included: the appointment of Ian Dalton as chief executive officer (who subsequently moved to NHS Improvement as the chief executive officer), the interim appointment of Professor Julian Redhead (following Ian Dalton's departure), the review of executive performance and executive succession planning, the noting of the appointment of Victoria Russell as a non-executive director, and the making permanent of the chief information officer's joint appointment with Chelsea and Westminster Hospital NHS Foundation Trust.

The committee also considered the Trust's gender pay gap report prior to publication, and the plans in place to improve the gender pay balance across the workforce; the terms of reference of the committee were amended to include review of the Trust's broader diversity agenda. The committee has also focused on talent management for senior clinical positions to ensure that employees can both access, and move on from, these opportunities.

Hammersmith & Fulham integrated care partnership board

In January 2018 five formal partners in Hammersmith and Fulham signed a partnership agreement to work towards an integrated care model, which included setting up a 'committees in common' governance mechanism. This means that each partner remains an independent organisation, accountable to its own board, but oversees key aspects of the partnership's work through delegation to the committee, which is a formal Trust board committee.

Member*	Attendance (actual/possible)
Professor Julian Redhead, Interim CEO	0/3
Professor Tim Orchard, Interim medical director	3/3
Anna Bokobza, Associate director of integrated care	3/3

The committee has been seeking to agree an alliance contract with Hammersmith and Fulham clinical commissioning group (CCG) that would support the delivery of an integrated care approach for some services for the population of the borough, particularly in relation to services for children, adults with long term conditions and frail, older people.

Directors' interests

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

The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust board directors which may conflict with their management responsibilities. This register is updated on the change of any directors' interests, and is reported formally twice yearly to the Trust board; the register as at 31 March 2018 is attached at appendix two, and is available to the public on the website at www.imperial.nhs.uk. The Trust board considers that all its non-executive directors are independent in character and judgement, although it notes that Professor Andrew Bush, as an appointee of Imperial College London, brings its views to the Trust board.

Early in 2017/18, NHS England issued guidance which aimed to: introduce common principles and rules for

managing conflicts of interest; provide simple advice to staff and organisations about what to do in common situations; and support good judgement about how interests should be approached and managed. The Trust's policy and procedures were reviewed to ensure that the Trust remains compliant with the new requirements, and strengthened where considered appropriate. The Trust seeks annual declarations from all staff graded band 8a and above; returns for 1483 staff, approaching 85 per cent, had been returned at the end of May 2018. The Trust publishes on its website a list of those staff considered to hold clear decision-making roles; of these 122 staff, 95 per cent had declared at the end of May 2018.

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

Statement of the Chief executive officer's responsibilities as the Accountable officer of the Trust

The Chief executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief executive officer should be the Accountable officer of the Trust. The relevant responsibilities of Accountable officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

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

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

Professor Julian Redhead
Interim chief executive officer

25 May 2018

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Trust board

Professor Julian Redhead
Interim chief executive officer

25 May 2018

Richard Alexander
Chief financial officer

25 May 2018

Governance statement

Scope of responsibility

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

The structure for the Trust's annual governance statement for 2017/18 follows the format required by NHS Improvement.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Imperial College Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Imperial College Healthcare NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

The following have been identified as the significant issues facing the Trust as it enters 2018/19. Further detail on each is provided later in the report:

- ability to recruit and retain clinical staff, particularly in relation to ward-based nurses, midwives and radiographers
- ability to achieve and maintain financial stability
- ability to achieve required performance targets in the emergency department and for elective surgery
- risk of delayed treatment to patients awaiting planned procedures due to data quality problems which can also result in breach of contractual and regulatory requirements
- ability to secure broader health economy (sustainability and transformation partners – STP) commitment to the Trust's clinical and financial transformation plans
- risk of failure of estates critical equipment and facilities that jeopardises Trust operations and increases clinical and safety risks.

Capacity to handle risk

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

The Trust board approved framework, consists of the:

- risk management policy, which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk within the Trust
- risk registers, which document risks at each level of the Trust, alongside actions to control, mitigate or resolve each risk
- board assurance framework, with its focus on assurance
- newly developed risk appetite (described below).

Together, these support the development of an organisational culture whereby effective risk management is an integral part of providing healthcare and day to day decision-making.

The board assurance framework provides a high level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level. The assurance framework has most recently been reviewed at the May 2018 meeting, with the Trust board noting that it formed a key part of providing their assurance on the Trust's activities. Responsibility for maintaining the framework rests with the Trust company secretary. The framework is described later in the governance statement.

In determining its risk appetite, a new focus for 2017/18, the Trust board recognised the need to take into account the expectations of its stakeholders when determining the amount of risk considered desired (opportunistic risk – normally relating to strategic risks) or tolerated (hazard risk – normally relating to operational risks).

Key stakeholders in this context are: patients, commissioners, regulators, staff, strategic partners, and the public. There will always be a number of risks that the organisation will be exposed to, in spite of its inclination not to tolerate them; these are external risks that are outside the organisational power to control (e.g. risk of malicious attack).

Risk appetite is not a single, static concept; there are a range of appetites for different risks which influence each other and need to align, these are reflected in the Trust risk management policy. A risk appetite framework has been developed, interlinking with the existing risk registers and board assurance framework, forming an illustration of the Trust's current risk exposure, by taking into account; the length of time a risk has existed on the register, the score it has held for that period, and the target score. Initial review demonstrates that our existing risk profile focuses on hazard and compliance risk, which is not surprising, in a highly regulated public organisation.

The risk appetite statement developed over a number of Trust board, board committee, and executive committee discussions is recognised as a working document, and one which will be amended as implementation across the Trust is achieved. The Trust board approved the following statement in March 2018:

It is recognised that the Trust is currently operating within a challenging financial and operational environment and is not comprehensively achieving national standards and targets. Rather than through choice, it is considered that a higher level of risk appetite is inherent in the scale of challenge faced in these areas. The Trust is cognisant of the need to actively manage the financial and operational risks whilst ensuring that patient safety is not compromised. In view of this:

- *the Trust will not take any unnecessary risk that has a direct impact on patient safety; however, it will be open in accepting risks that emerge while developing intra and inter-provider pathways which do not impact on any individual patient negatively*
- *the Trust will minimise any risk posed to patients or staff as a result of staff competence, conduct, health and behaviour*
- *recognising the challenging recruitment environment, the Trust will be open to taking opportunistic risk in improving staff recruitment and retention*
- *the Trust will tolerate a higher reputational risk associated with ensuring the implementation of its redevelopment plan. This will ensure sustainable mitigation to the estates risk*
- *in view of this, the Trust is open to the risks associated with the implementation of emerging technology; however, it will minimise exposure to cyber risk*
- *the Trust has a significant appetite to exploit opportunistic risks where positive gains can be anticipated, particularly in relation to promoting and delivering excellent research and education.*

The Trust's internal and external auditors considered that the Trust demonstrated a mature approach to risk management in having achieved a position where it felt able to articulate its attitude to risk appetite.

The Trust's continues to develop its leadership development programme. Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients, lowering the risk to which they are exposed. The Trust has implemented a number of improvements to increase staff engagement throughout the organisation, and during 2017/18, committed to further developing training programmes as well as piloting management and leadership apprenticeship programmes. The Trust runs a suite of leadership and management development programmes for staff across the organisation. Linked to the Trust's talent and succession plan, these programmes equip our leaders with the skills to be highly effective in their roles. The 'Horizons' and 'Aspire' leadership programmes bring together senior leaders and develop their ability to lead across teams and systems in an authentic and engaging way, and the 'Headstart' and 'Foundations' programmes are highly practical and participative management development programmes for those who are new to management or looking to broaden their existing skill set.

The offer is continually evolving with two new programmes added in 2017/18; 'Springboard' for band 5-6 nurses in support of the Trust's retention strategy (outlined overleaf) and 'Engage' to further improve our employee's experience of working at the Trust. In August 2017, following progress in the 2016 NHS staff survey and the development of the local

‘Engage’ workshop and toolkit for managers, the Trust was featured as a best practice case study published by NHS Employers.

The Trust also organised a two-day leadership course aimed at senior leaders in the Trust and College to enhance collaborative learning on leadership for safer care, which inherently reduces risk to patients.

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

The Trust put in place in 2017/18 a recruitment and retention action plan to address recruitment and retention challenges. In addition, there have been a series of campaigns run for the hard to recruit staff groups and areas. The action plan was made up of a series of initiatives outlined as follows; the action plan has been refreshed for 2018/19.

Recruitment: The Trust created a new recruitment brand and the concept focuses on the strapline ‘Full of opportunity’. The careers microsite which was stand-alone has been updated and aligned to the new brand and moved onto the main website; rolling adverts have been rewritten to complement the brand. New marketing materials have been created; and a style guide has been developed for all advertising including social media. The Trust ran a ‘Great place to work’ week in September to promote its employment offer to our internal staff. The staff pages on the intranet pages have been redrafted to complement the employment offer and Pulse, the Trust magazine, includes feature articles to promote the employment offer. An automatic offer is in place for student nurses and this has seen the retention rate increase to 60 per cent. In addition, a student attraction strategy has been developed which includes attending student fairs, placing adverts on student job boards and running a series of adverts specifically for students. The Trust runs monthly recruitment open days for all staff groups, attends recruitment fairs for nurses, midwives and radiographers and has quarterly advertising campaigns in place for nurses and midwives. A ‘preferred supplier list’ has been introduced for all staff groups and the proposal is to build on this list and work with agencies to recruit staff in hard to recruit areas. A team of resourcing business partners have been recruited and are aligned to the divisions to run bespoke campaigns for different staff groups and directorates. Recruitment and retention premiums have been put in place for a number of staff groups including sonographers, cardiologists and band 5 nurses. Finally an internal transfer scheme has been piloted and the plan for 2018/19 is to extend this and to further develop the careers clinics. The latter are proving very successful in other trusts.

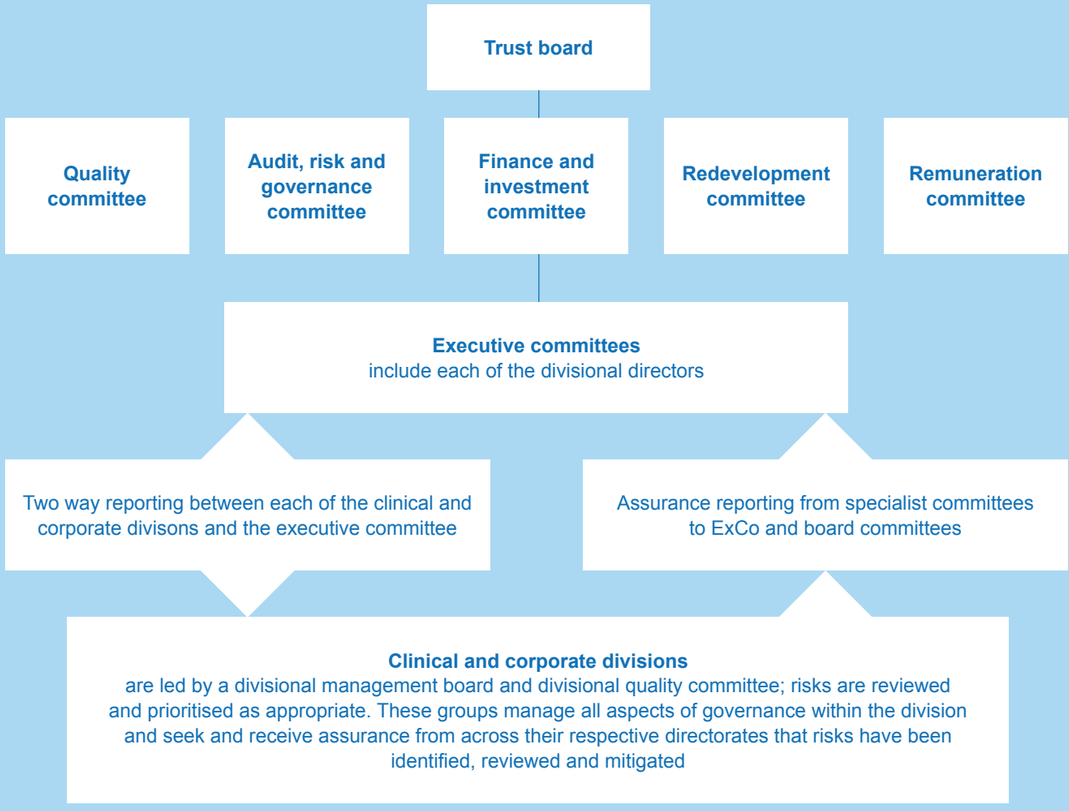
Grow our own: The Trust has been part of the nursing associate pilot in 2017/18 and has a cohort of 13 nursing associates training with the Trust; with a plan to train/recruit another 30 in 2018/19. The ‘strategic supply of nursing’ business case launches the introduction of the graduate nurse apprentice to complement the health care support worker apprentice. There is a training programme in place for sonographers and the numbers for this scheme will be increased in 2018/19.

Retention: As part of the recruitment and retention action plan a whole range of retention initiatives have been introduced. The length of the Preceptorship programme was redesigned to last for one year to better support newly qualified band 5 nurses. A new leadership programme for band 5/6 nursing and midwife staff was introduced to fast track high potential nurses into leadership roles and support those who have secured promotion to be the best leaders they can be. A retention toolkit and master class was developed to support the staff survey and to help all leaders and managers consider how to create a ‘Great place to work’ and improve retention. In addition, more than 800 ‘In your shoes’ workshops have been run involving all staff to support engagement and retention. Our action plan was showcased by NHS Improvement as part of their master class series in November 2017.

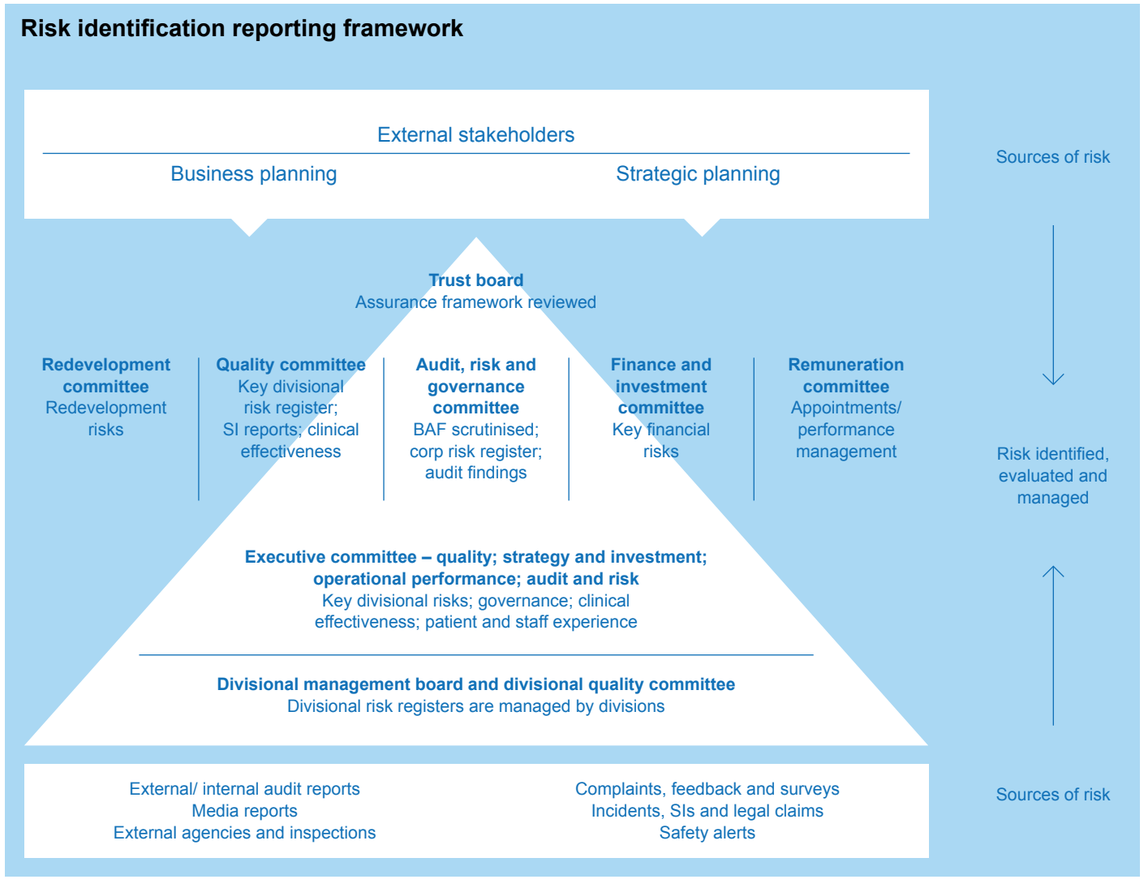
In 2018/19 the Trust will be a part of cohort three of the NHS Improvement retention programme. A business case has been put together to secure a ‘supply of nurses’ for the next five years. This includes funding for recruiting international nurses at scale and pace, money to ramp up retention activity initiatives and funding to make our pipeline much more sustainable going forward by expanding our nursing associate and graduate student cohorts and launching the graduate nurse apprenticeship.

The risk and control framework

The Trust has a systematised framework for ensuring effective reporting mechanisms, not only from the divisional management and divisional quality groups, but also from the specialist committees (for example the health and safety committee and infection prevention and control committee).



Risk identification reporting framework



The risk management policy describes the approach that the Trust will take to identifying, managing and mitigating risk. Each directorate and division maintain a risk register containing clinical and non-clinical risks. The divisional boards ensure that operational staff identify and mitigate risk appropriately; each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be satisfactorily resolved or managed at a local level, they are considered for inclusion in the divisional or functional registers, with risks on these registers in turn reviewed for inclusion in the corporate risk register where they score 15 or above. The corporate risk register contains risks which might prevent the Trust from achieving its corporate objectives.

Corporate committees provide internal assurance to the Trust board that the mitigations are effective and the risks are adequately controlled. Risk is monitored and communicated via these committees reporting to the Trust board. Clinical audits, internal audit programme and external reviews of the organisation are all sources used to provide assurance that these processes are effective and risk monitoring is fully embedded.

Risks are identified through feedback from many sources such as proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, whistleblowing, stakeholder/partnership feedback and internal and external assurance assessments. External stakeholders include the Care Quality Commission, NHS Improvement, the Health and Safety Executive (HSE), NHS Resolution, the Medicines and Healthcare Products Regulatory Agency, the Information Commissioner's Office and health analytics company Dr Foster Intelligence.

There are clear examples of risks being identified 'bottom to top' and 'top to bottom'. The Datix system provides a tool for ensuring that risks are reviewed and action taken in a timely manner.

Risk management is embedded within the organisation through the corporate, divisional and directorate structures and the reporting and feedback mechanisms are in place as outlined on the previous page.

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

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

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

Within the Trust, the overall role of an assurance mechanism is to bring to the attention of the Trust board information that may have an impact on the ability of the Trust to achieve its strategic objectives and assure the Trust board that the appropriate accountability is being taken for those areas of responsibility held by a group or individual. An internal audit of the board assurance framework in 2017/18, rated it as providing substantial assurance.

Risks to the Trust's strategic objectives are identified and tracked in the board assurance framework. The framework includes details of mitigations and controls already in place, before and after risk scores, future actions required and identification of the sources of assurance for each risk element.

As the Trust moved into 2018/19, the following were considered to be its current key risks as detailed on the corporate risk register, see overleaf.

Risk description	Risk mitigation and control
Failure of estates critical equipment and facilities that prejudices Trust operations and increases clinical and safety risks	• Clear focus on addressing estates backlog maintenance high risk areas (more than £14m spent in year on improvement of estate) • Compliance with statutory and mandatory undertakings a priority • Estates and facilities issues a key part of all site management meetings and arrangements • PLACE team reviews contribute to works prioritisation
Failure to meet required or recommended band 2-6 vacancy rate for nursing and midwifery staff	• Safe staffing monitored at all times; staff flexed across clinical areas when appropriate • All graduating student nurses offered permanent roles • Comprehensive recruitment and retention programmes in place
Failure to maintain financial sustainability	• Fortnightly finance-focused meetings to support delivery of budgets and savings plan • Focus on improving efficiency using national good practice examples • Specialty review programme undertaken to identify future service development and efficiency opportunities
Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	• Regular engagement with stakeholders as to Trust's plans for estate and patient care configurations • Focus on clinically sustainable plans in all site planning proposals • Development of integrated care pathway plans with partners
Failure to maintain key operational performance standards	• Emergency department • Increase capacity at St Mary's and Charing Cross emergency departments • Extend operational hours for ambulatory emergency care services at St Mary's and Charing Cross • Comprehensive escalation and full capacity protocols in place • Elective procedures • Improvement to patient pathway planning to remove bottlenecks in flow • Outsourcing of elective pathways to manage demand • Improvements to IT system management
Risk of delayed treatment to patients due to data quality problems, which can also result in breach of contractual and regulatory requirements	• Comprehensive validation undertaken to ensure accurate record of patients waiting for procedures • Clinical harm review of all patients experiencing long waits • Introduction of more robust revised training and supervision arrangements
Risk of cyber security threats to Trust data and infrastructure	• Access to social networking, webmail and high risk sites minimised • Robust firewalls and anti-virus software in place across all desktops and servers • Effective anti-malware procedures in place, and additional third party security advisors
Failure to comply with CQC regulatory requirements and standards could lead to a poor outcome from a CQC inspection and/or enforcement action being taken	• Clear framework for managing compliance in place • Regular self-assessment identifies areas requiring remedial action • Involvement of senior clinicians in inspections at other trusts ensure continual opportunities for learning
Failure to currently meet some of the CQC core standards and service specifications for high dependence areas of the Trust	• All patients appropriately cared for, with additional ICU support • Outreach available 8-8 Monday to Saturday • Clinical teams meet daily to discuss individual care for patients
Risk of spread of carbapenem-resistant Enterobacteriaceae (CPE) infection across clinical areas	• Improved screening and isolation • Improved hand hygiene arrangements, and environmental cleaning and disinfection • Known carriers are highlighted on electronic patient record

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

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

The audit, risk and governance committee oversees and monitors the performance of the risk management system; internal auditors (TIAA to 31 March 2018, PwC from 1 April 2018) work closely with this committee, undertaking reviews and providing assurance to the committee on the systems of control operating within the Trust.

Care Quality Commission regulatory framework

The Trust is fully compliant with the registration requirements of the Care Quality Commission, the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care that meet fundamental standards.

The CQC has taken enforcement action against Imperial College Healthcare NHS Trust during 2017/18. This was in the form of Requirement Notices, relating to regulatory breaches identified during inspections carried out in 2016/17 and 2017/18, and set during 2017/18. Details of findings and actions being taken in response are outlined below.

CQC Requirement Notice Regulation 12: Safe care and treatment:

- Medicines management policies were not always being adhered to: in maternity at St Mary's Hospital, medical care at St Mary's, Charing Cross and Hammersmith hospitals, and urgent and emergency services at Charing Cross Hospital. Changes were made to the Trust's medicines management quality improvement programme, including a shift to focusing on human factors in why medicines policies/procedures are not followed in practice. Changes were also made in local areas including moving the storage of keys to a controlled drugs cupboard, and introduction of ad-hoc audits/checks on medicines practice.
- Statutory and mandatory training was not always completed as required, with completion rates below the Trust target: in maternity at St Mary's Hospital, in Medical care at St Mary's, Charing Cross and Hammersmith hospitals, and among medical staff in surgery at St Mary's Hospital. Introduction of a core skills group to oversee Trust-wide improvement activities, including: review of core modules required for various staff groups, to remove unnecessary modules; review of data capture to improve data integrity, by more accurately reflecting issues such as staff who have left the Trust, are on leave (e.g. maternity), have honorary contracts, etc; a targeted campaign for junior doctors and roll out of a programme to enable mobility of training, to prevent an unnecessary requirement to repeat training during rotations among organisations; increased capacity for classroom-based training; and development of a Trust-level business case to improve the IT systems used for recording completion of training. Statutory and mandatory training compliance is reported to the Trust board as part of the integrated performance report.
- Airway and emergency trolleys were not always appropriately checked in urgent and emergency services at Charing Cross Hospital. All trolleys now have checklists attached for daily completion; completion of checklists is audited weekly; checklists will now be incorporated to an electronic departmental database.
- Clinical and hazardous waste management guidelines were not always adhered to in surgery at St Mary's Hospital. Training is being delivered to staff to alert them to finding and improve awareness of the guidelines/ requirements.
- Daily cleaning requirements were not always being completed and checks were not being undertaken to identify this in surgery at St Mary's Hospital. Documented cleaning schedules are now in place; weekly cleaning audits will be jointly carried out by the Trust's cleaning team and theatre staff (these had previously been carried out by the cleaning team only); the theatre manager will monitor cleaning checks and audit outcomes; and completion and outcomes of audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor, and will be reported by exception to the Trust's cleaning sub-group.

- Deep cleaning of theatres was not taking place in line with Trust policy in surgery at St Mary's Hospital. A deep cleaning schedule was in place at the time of the inspection; action is being taken to ensure the schedule is communicated to all relevant staff; the theatre manager will monitor completion of deep cleans in line with the agreed schedule. Completion of deep cleans and outcomes of cleaning audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor.
- The poor state of repair of seven theatres resulted in an infection control risk in surgery at St Mary's Hospital. The scope of theatre refurbishment has been agreed and works will be undertaken in 2018, one theatre at a time; meetings are in place to monitor theatre refurbishment at a divisional operations meeting; and theatre refurbishment is on the divisional risk register; mitigation of the risk is monitored monthly at the divisional quality and safety meeting.

Regulation 15: Premises and equipment:

- Portable equipment (medical devices) did not always have safety tests and planned preventative maintenance completed at due dates, in urgent and emergency services at St Mary's and Charing Cross hospitals. The Trust has a planned preventative maintenance programme in place which is overseen by the medical devices and management group, chaired by the associate medical director. Following the CQC's findings the timeframe for the year's programme was accelerated.

Regulation 17: Good governance:

- Performance was not always monitored against agreed standards in urgent and emergency services at St Mary's Hospital. The inspection findings are being taken account of as part of the Trust's annual review of the performance framework and related governance arrangements.

The Trust has not participated in any special reviews or investigations by the CQC during 2017/18. However, all trusts are captured in CQC patient surveys, of which three, carried out during 2016, were published during 2017/18: children's services, A&E departments, and maternity. The Trust's performance in the children's and maternity surveys was similar to previous results, and the Trust was not identified as an outlier in either of these. However, the Trust was identified as an outlier for poor performance in the A&E survey. A detailed action plan has been developed by the operational teams, which was presented to the executive and the Trust board in January 2018; it focuses on delivering improvement in four key areas: patient experience – environment; patient experience – respect and dignity; patient experience – information provided to patients when leaving the department; and early detection (and action) of changes in performance through measuring and monitoring patient experience feedback.

Responses to survey outcomes are managed by the division responsible for the service, with support from the Trust's patient experience team.

During 2017/18, two of the Trust's core services were inspected: urgent and emergency services at St Mary's and Charing Cross hospitals, and surgery at St Mary's, Charing Cross and Hammersmith hospitals. The Trust also had its first inspection of the well-led domain at Trust level, a new type of inspection introduced by the CQC this year. Inspection reports from all inspections carried out during 2017/18 were published by the CQC on 21 February 2018. Actions were set for the Trust to take following the core service inspections.

NHS trusts' overall rating for the well-led domain is based on the findings from the trust level inspection of the well-led domain and performance of core services during inspections in the year preceding the well-led inspection. Following the Trust's first inspection of well-led at Trust level, which took place in December 2017, the domain was rated as Requires improvement.

Following the well-led inspection, CQC updated the site/hospital and Trust overall ratings to reflect all inspections carried out during the year. The Trust's updated ratings reflect: the inspection of outpatient services and diagnostic imaging at St Mary's, Charing Cross and Hammersmith hospital, carried out in November 2016; the March 2017 inspections of maternity at St Mary's Hospital and medical care at St Mary's, Charing Cross and Hammersmith hospitals; the November 2017 inspections of urgent and emergency services at St Mary's and Charing Cross hospital, and surgery at St Mary's, Charing Cross and Hammersmith hospital; and the well-led inspection.

Overall, the Trust no longer has an Inadequate rating for any domain in any service at the Trust; the overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remain Requires improvement; and the Trust's overall ratings for each domain and for the Trust overall, remain the same as they were in 2014.

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

The Trust has a range of processes to ensure resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of monthly finance and performance reports to the finance and investment committee, executive committee and to the Trust board. The Trust has an agreed risk-based annual audit programme with the Trust's internal auditors. These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focused, in part, on reviewing operational arrangements for securing best value and optimum use of resources in respect of the services we provide. The head of internal audit opinion provides reasonable assurance that the Trust has a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Our external auditors are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if, in their opinion, the Trust has not. In their review, they have specifically considered the 'undertakings' letter agreed between NHS Improvement and the Trust in November 2017. The letter records the regulator's statement that it had 'reasonable grounds to suspect that that the Trust [was]… failing to comply with [certain] conditions' required of it. This related mainly to non-compliance with required operational targets (A&E and referral to treatment), but also reflected concerns relating to longer-term financial sustainability and data quality in relation to certain aspects of patient activity; each of these issues, and the Trust's response to dealing with them, are detailed in the relevant significant issues sections of the governance report. The Trust board monitors progress towards achieving the actions agreed in the letter at each public meeting as part of the integrated performance report.

To ensure that any cost improvement schemes, a key part of the Trust's focus on economy, efficiency and effectiveness, do not impact adversely on the quality of patient care, a Trust board approved quality impact process is used to review schemes which are recorded on standard templates in a Trust database. Schemes approved by the responsible director are then reviewed and risk scored by the medical director and director of nursing prior to sign off; schemes scored as high risk require mitigations and controls in place before approval is granted. Post-implementation reviews occur to ensure that low risk scoring schemes did not have a higher quality impact than expected and that the controls enacted for high risk scoring schemes were effective. If a serious quality impact begins to materialise during implementation, schemes are stopped. A quarterly summary is provided to the executive quality committee, the board quality committee and the Trust board, and shared with our commissioners; this also includes information on schemes that were not approved for progression.

Robust review of, and understanding of the drivers for, the financial and operational sustainability of the organisation is key to delivering the economy, efficiency and effectiveness of the Trust; both of these area have been identified as significant issues for the Trust.

Significant issue: Ability to achieve and maintain financial stability

At the beginning of the year the Trust was set a control total of a £6.6m surplus after full sustainability and transformation funding (STF), equivalent to a deficit of £17.6m pre-STF.

After reviewing the position mid-way through 2016/17 the Trust submitted a plan to NHS Improvement in December 2016 for a deficit of £47.8m, which was revised to a deficit of £41.0m when the plan was resubmitted in March 2017, a gap of around £23.0m to our control total. This was driven by a significant increase in cost pressures, the majority of which were outside of the Trust's control. For example, research income had been reduced, the phased withdrawal of education infrastructure support continued, and the Trust was facing additional costs from the introduction of the junior doctors contract and the apprenticeship levy. Further, income was significantly tighter in 2017/18, particularly for north west London (NWL), and therefore the Trust's ability to include income-based cost improvement plans (CIP) within the overall plan was more limited than in 2016/17.

As a result of not signing up to our control total, the Trust was put in the capped expenditure process with other partners across the sector to examine all options to close both the Trust's, and the wider NWL sector's, control total gap. Following that process, and discussions with NHS Improvement, at the end of August 2017, the Trust was able to agree a revised control total of a £25.0m deficit pre STF, underpinned by a £54.0m CIP

programme. This gave the Trust access to up to £20.7m of STF subject to delivering the financial targets and operational trajectory for A&E performance.

Despite the Trust signing up to a £25m control total, its underlying deficit was forecast to be around £37.0m at the end of 2017/18. The Trust recognises it needs to return to financial sustainability and is therefore looking to reduce its underlying deficit by around £10m per year to get back to underlying balance by 2021/22.

Therefore, to ensure delivery of the plan in year, as well as plan for longer term sustainability, the Trust has undertaken work in three key areas during the past year. Firstly, we were successful in our application to be part of the second financial improvement programme (FIP2) focusing support in the women's, children's and clinical services division.

Secondly, the Trust launched its specialty review programme (SRP), which had been postponed from 2016/17 due to the need to focus on short term measures. The programme involves supporting each of the Trust's specialties to develop a clinical strategy that is financially sustainable and that has an associated workforce plan. The outputs of the programme will help inform the development of a five-year clinical strategy for the organisation, and the early efficiencies identified are feeding into CIP plans for 2018/19 with further savings expected in future years.

Thirdly, the Trust began to develop a comprehensive, transformation plan, focusing on large-scale and longer-term change programmes to deliver our strategic objectives, including financial sustainability.

At the end of the year, the Trust delivered its control total, and received £25.5m of STF. CIP savings of £43.1m were delivered, against a target of £54.0m, with a major factor in the under delivery this year being an extended period of significant winter pressures affecting elective activity, alongside capacity constraints and an ailing estate. The undelivered target will be carried over in to 2018/19.

The Trust's control over its cash position and capital programme were very significantly strengthened during the year resulting in the delivery of both our cash and capital targets. The improved cash control and the receipt of the STF (assessed quarterly against financial and operational targets) meant that none of the approved working capital facility was required in 2017/18.

The 2018/19 plan has been submitted with a deficit of £20.6m before STF representing an improvement of over £10m in the underlying deficit but requiring another challenging CIP of £48.0m.

The issue of going concern has been discussed at audit, risk and governance committee with the active engagement of external audit. The Trust still has access to the working capital facility provided by the Department of Health and Social Care if required. If appropriate repayment conditions can be agreed then this short term facility may be converted into a more appropriate funding model during 2018/19. The condition of the majority of the Trust's estate is a cause of continuing concern reported elsewhere, however the financial drain of this on both capital and revenue resources, and significant estate deterioration could also call into account the going concern status of the Trust. Further details are outlined in the chief financial officer's report, and also the notes to the accounts. The Trust has applied for additional capital support to make repairs and has also submitted a document outlining the vision for St Mary's redevelopment which sets out the need for major capital funding.

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

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

Emergency department: The Trust is not currently achieving the national standard to see and admit, or treat and discharge 95 per cent of patients that present to A&E within four hours. The key drivers of this underperformance are rising demand, increasing acuity and high levels of inpatient bed occupancy.

There are a number of important initiatives underway across the Trust that aim to improve our ability to move patients through our urgent and emergency pathways as effectively as possible. The plan is supported by a trajectory for improvement, agreed with our commissioners and approved by NHS Improvement, which will bring performance to 95 per cent by the end of March 2019.

The Trust's 'four-hour A&E access' improvement programme is led by the division of medicine and integrated care and progress is reported to the executive committee. There are six workstreams, each led jointly by a clinician and manager. These are:

- streaming and offering better alternatives to hospital admission
- improving emergency department processes
- improving specialist decisions and pathways
- improving bed management
- improving ward processes
- improving discharge processes.

Each scheme includes a plan of delivery with clear measurement of the impact of the change and its effect on minimising breaches of the four-hour standard.

The biggest risk to delivery of the trajectory remains rising demand. Winter 2018/19 saw unprecedented demand (and indeed capacity continues to be challenged into the summer months) and any further increase above that planned would stretch current resources well beyond capacity.

Planned procedures: Performance relating to patients awaiting planned procedures is contained within the overall Trust referral to treatment (RTT) performance; the time between a patient being referred by a GP to being seen in outpatients. The Trust is not currently achieving the national standard with respect to RTT within 18 weeks, and more than 200 patients have had to wait in excess of 52 weeks. The key drivers for this underperformance include: increasing demand on limited elective capacity (surgical, diagnostic and outpatient – especially impacted by the emergency pressures seen during the Winter of 2017/18), limited training for staff to interact correctly with computer systems and consequently poor data quality.

These key drivers are being addressed across seven workstreams:

1. waiting list recovery – focus on supporting long waiting patients through the system, using national metrics to develop demand and capacity and trajectory mapping
2. elective care operating framework – focus on developing high quality user validation dashboards, supporting training and recruitment programs, link to correct input and performance. Use quality improvement methodology and engagement to ensure adherence to standard operating procedures, 'Getting it right first time' and rapid improvement cycles
3. digital optimisation – on-going work to improve the data extraction and business information reporting suite
4. clinical harm reviews – patient safety and review
5. oversight and governance – reporting to the executive and Trust board, commissioners, and NHS Improvement/ NHS England
6. audit framework – data quality improvement/ external audit/ external assurance check
7. data clean up – focus on validation and cleansing of current inpatient and outpatient waiting list complete.

Each workstream has a lead and reports through the internal to external reporting framework. The agreed trajectories suggest a focused reduction in over 52 week waiting to zero long waiters by July 2018 (with acknowledgement that a small number of patients will be affected for some time). However, the Trust is not expected to meet the 92 per cent RTT performance target (to treat patients within 18 weeks) until late in 2019.

Elective surgery in particular is subject to extensive cancellations from the non-elective emergency surgery pathways. The Trust is currently being supported by Four Eyes Insight (a process improvement consultancy) to try and address the inefficiencies across the elective pathway (from pre-assessment through scheduling to operating theatre utilisation).

Performance management and oversight

The Trust reviews and revises its integrated performance framework each year. The current framework provides oversight of over 70 core indicators at each of the four levels of the organisation (board, division, directorate and where relevant ward/ clinic). The framework is split into the five CQC quality domains, with a further score on use of resources (reflecting the NHS Improvement use of resources assessment). Quality, workforce and financial indicators are all included e.g. patient safety incidents and incident reporting rate, pressure ulcers, staffing fill rates, mortality, sickness absence, bank and agency spend, Friends and Family Test results, national operational standards, in month variance to plan and cost improvement plan delivery.

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

NHS Improvement's Single Overview Framework (SOF) remains NHS Improvement's focus in overseeing both NHS trusts and foundation trusts, and identifying the support they need to

deliver high quality, sustainable healthcare services; its stated aim is to help providers attain and maintain CQC ratings of 'good' or 'outstanding'. The framework is reflected in the integrated performance framework and other performance monitoring processes.

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

1. providers with maximum autonomy, and no potential support needs have been identified
2. providers are offered targeted support, where there are concerns in relation to one or more of the themes
3. providers are receiving mandated support for significant concerns
4. providers are in special measures.

Throughout 2017/18, the Trust has been placed, by NHS Improvement, in segment three of four segments, relating predominantly to financial position and performance on constitutional standards.

As part of enhanced oversight by NHS Improvement, in November 2017, the Trust agreed on a series of undertakings with its regulator. The delivery of the undertakings forms a key element of regulatory requirement, and NHS Improvement requires a robust monitoring mechanism to be in place to review progress, and ultimately delivery, of each element. Much of the undertaking reflects existing commitments monitored as part of the Trust's overall performance, but to ensure all items are addressed, bi-monthly summary monitoring reports are also provided to the Trust board.

Significant issue: Risk of delayed treatment to patients awaiting planned procedures due to data quality problems which can also result in breach of contractual and regulatory requirements.

Significant challenges arose over a year ago with the reliability of the Trust's waiting list data and a growing backlog of patients waiting for planned procedures. Last year the Trust was not able to meet the national standard for at least 92 per cent of patients to wait 18 weeks or less waiting from 'referral to treatment'(RTT), and more than 200 patients have had to wait over 52 weeks for treatment.

The Trust is working to have no patients waiting over 52 weeks as quickly as possible but, while continuing to reduce the overall waiting list backlog, it is estimated we will not achieve the overall national standard until next year.

The poor quality of data is mainly due to incorrect data entry or pathway administration, with a small element attributable to electronic system issues. To address this risk we have invested in a major waiting list improvement programme, with a focus on tracking patients, training our people and using digital technology to support and automate our processes wherever possible; this is described further above.

As part of this programme, a number of clinical review processes have also been established. The purpose of these are to monitor the impact waiting for treatment is having on our patients and to ensure that avoidable harm has not/is not occurring as a result of delays in treatment on the RTT pathway. Three cases of clinical harm have been confirmed for patients waiting over 52 weeks since the process began in August 2016. There have been no cases of clinical harm identified in the 2017/18 business year. In 2017/18 we also included an 'on admission' clinical harm review for patients waiting 52 weeks and over for treatment within specialities that are included within the 'high risk' category. As at May 2018, there had been no incidences of clinical harm.

Sustainability and transformation plan/ partnership, and opportunities for site transformation

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

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

The stakeholders of the plan are now described as the sustainability and transformation partnership and have a series of pan-organisation groups taking forward elements of the plan, overseen by the joint health and social care transformation group, which in turn reports to the boards of each of the partners. The Trust's own strategies are very much in line with the objectives of the STP and a number of key initiatives are being supported by and/or influencing the STP's implementation.

Significant issue: Ability to secure broader health economy (sustainability and transformation partners) commitment to the Trust's clinical and financial transformation plans

There is a growing impetus to align and co-design change and transformation across north west London, building on the sustainability and transformation plan and its implementation over the past year or so. To date, although the Trust has been part of STP projects, including transforming outpatient services, it will need to significantly increase its involvement and external collaboration as it evolves its own strategic development programme to drive longer-term and larger-scale change and help achieve financial sustainability.

The following initiatives, in particular, will need to have the understanding, support and input of our partners:

- Estates redevelopment – the allocation of any central capital funding for major redevelopments will be co-ordinated through the STP and so will require alignment on priorities as well as a shared understanding of how we can make best use of all of the existing NHS estate across the sector. We will be looking for support on the phase one redevelopment of St Mary's, the new eight-storey building to house ophthalmology services and the majority of the hospital's outpatient services, as well as on the wider redevelopment approach for St Mary's and, longer-term, our other sites.
- Integrated care – we already have good, multi-organisational working on the Hammersmith and Fulham Integrated Care Partnership. As well as a formal partnership – including a committees in common structure – with Hammersmith and Fulham GP Federation, Chelsea and Westminster Hospital NHS Foundation Trust, West London Mental Health NHS Trust and Central London Community Health NHS Trust, we have increasingly strong links with our commissioners, the local authority and lay partners. As the sector moves towards formal integrated care models in line with national policy, we will need to have a shared approach to all aspects of delivery in north west London.
- Digital strategy – as a global digital exemplar, we are leading or co-leading a number of important digital developments across this sector, including the roll out of a shared electronic patient administration system across our Trust and Chelsea and Westminster Hospital NHS Foundation Trust, the Care Information Exchange and a range of formal data processing and data sharing arrangements to aid or improve direct patient care. By definition, digital developments are not necessarily restricted to physical organisational boundaries and optimum impact often relies upon good inter-operability and aligned user verification processes.
- Refresh of our clinical strategy – to be informed by our specialty review process and our 'flow coaching' programme of pathway improvements as well as the wider STP and wider involvement and engagement.

The Trust's current redevelopment programme heralds the most significant transformational change to the estate in a generation, and reflects the sustainability and transformation plan.

The Trust is delighted that plans for a comprehensive outpatient and diagnostic facility at St Mary's Hospital have been approved by the Westminster planning committee in June 2017, and is now exploring funding options. The new building will form phase one of the redevelopment of St Mary's Hospital. An outline approach for the full redevelopment of St Mary's Hospital has been developed and is being shared with key stakeholders, including NHS Improvement.

Significant issue: Risk of failure of estates critical equipment and facilities that jeopardises Trust operations and increases clinical and safety risks

The Trust has the largest backlog maintenance liability of all NHS trusts, at £650m, largely due to the age of estate, with St Mary's Hospital dating from 1851 and Hammersmith Hospital from 1904, combined with Charing Cross Hospital dating from 1973, but being of an age where plant, machinery, and the infrastructure would normally have been replaced or refurbished.

In the summer of 2017, part of the first floor structure in the Cambridge wing failed; scaffolding was erected to provide temporary support to ensure patient and staff safety during the repair works. Repaired at a cost of £650,000, this was highly disruptive to the wider hospital, causing the closure of 25 beds for six months and the St Mary's Hospital birthing centre for two months.

Continued investigation has demonstrated that further structural weaknesses exist within Cambridge Wing; this has required that an area, the equivalent of 30 beds, has been

closed, and will require extensive and highly disruptive works before being returned to patient care.

The Trust has also had a major electrical failure within the Patterson wing, which required the building to be closed for two weeks while rectification works were undertaken. There was no risk to patient safety, but again this was disruptive for patients and staff alike, and required significant financial expenditure.

At Charing Cross Hospital, a seventh floor ward required refurbishment, partially attributable to the need to minimise risk of transference of hospital acquired infection. More generally, the age and condition of much of the Trust's estate is adversely impacting on the delivery of healthcare services to our patients.

In addition, the Trust has numerous instances where equipment is now obsolete and this means that on occasion parts have to be specifically manufactured to support this obsolete equipment – this can lead to prolonged downtime, adversely affecting patient experience, service provision, and, at times, create a risk to patient safety.

As a result of agreement at a board seminar in October 2016, the Trust re-profiled the capital programme to create some headroom to fund backlog maintenance, and re-profiled the £130m of high risk backlog maintenance over eight years rather than five years. Recognising the daily impact on patients and staff of unreliable lift availability, this includes an extensive refurbishment programme to ageing lifts and the electrical infrastructure of the buildings, required to support the growing importance of technology to the delivery of healthcare. This has been reflected in the Trust's business case for investing the £10m funding awarded to the Trust as a global digital exemplar.

In addition, the Trust has submitted to NHS Improvement a case for a loan to support its overall capital programme, given the extreme position that the Trust finds itself in respect of its estate, and the growing impact on clinical services. The unpredictable nature of some of these deteriorations highlights the risk that the speed of redevelopment at St Mary's may not be in keeping with the speed at which the estate is deteriorating, to a point where safe care cannot be delivered. The Trust continues to seek and implement interim solutions to ensure the buildings are kept safe, and, as outlined above, seeks to expedite the redevelopment programme.

Data protection and information governance

The Trust has a published data protection structure designed to deliver compliance via the Trust privacy programme with the new legislative framework as set out in the General Data Protection Regulations (GDPR) and the new NHS digital data security and protection toolkit. The Information governance and cyber security committee (IGCS) is responsible for oversight of Trust cyber security and data protection policies and monitoring the mitigation plans identified in the information and computer technology (ICT) risk register and ICT risks listed in the corporate risk register.

The Chief information officer (CIO) acts as the Senior information risk owner (SIRO), a role designed to take ownership of the Trust's information risk policy, and as advocate for information risk on the Trust board, with overall accountability for data protection and cyber security. The Chief clinical information officer (CCIO), as Caldicott Guardian, is the appointed senior clinician with ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key advisory role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information. The data protection officer is a role assigned in compliance with, and duties outlined in GDPR. In summary these are: to inform and advise the organisation and its employees about their obligations to comply with the GDPR and other data protection laws; to monitor compliance with the GDPR and other data protection laws, including managing internal data protection activities, advise on data protection impact assessments; to train staff and conduct internal audits; and to be the first point of contact for the ICO and for individuals (patients/staff) whose data is processed.

In order to meet its contractual obligations the Trust must submit an annual information governance toolkit return that is rated satisfactory and subject to independent audit that returns a minimum of reasonable assurance. In March 2018, the Trust published an overall return of 67 per cent (satisfactory), achieved by a minimum level two assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2014 and again in March 2018. The final audit report gave the Trust a rating of reasonable assurance of the self-assessment.

A new data security and protection toolkit has also been introduced, reflecting additional requirements on the Trust to demonstrate compliance through robust assurance procedures and records of processing. This will be delivered through the implementation of the new Trust privacy programme.

All staff must undertake annual mandatory information governance training; as at the end of March 2018, 96 per cent of staff held a compliant training record.

Information security incidents

There is dual reporting for information governance incidents that involve a data breach or a cyber security incident; firstly, via the Trust's incident system (Datix), and secondly, incidents must also be recorded on the Department of Health and Social Care (DH) information governance toolkit incident system. In 2017/18 the information governance team undertook a matching and reconciliation exercise of incidents recorded on Datix and on the DH information governance system. Incidents are reported to the Caldicott Guardian at the weekly Caldicott review meeting, and upwards in relevant Caldicott reports; they are also used to inform the ICT risk register and/or the informatics audit programme.

Table of information governance serious incidents requiring investigation (SIRI)

Information governance SIRI	Number
Level 2 serious incidents (reported to DH and Information Commissioner's Office). 115 distinct patients' emails were sent to wrong email addresses between 22/11/2018 and 7/12/2018. The emails contained outpatient appointment letters. Patients who received the letter in error were contacted and asked to delete the email correspondence. The patients whose appointment information was sent in error to the wrong recipient were also contacted with a formal apology from the Trust. The root cause analysis revealed that an incorrect update to a database table caused the error. The emailing of patients was suspended until the cause of the incident was corrected. This incident is being subject to an independent audit review and the findings will be reported to the IGCS committee and the Trust audit committee.	1
Level 1 IG SIRIs (internally reported)	31
Level 0 IG SIRIs (near misses)	5

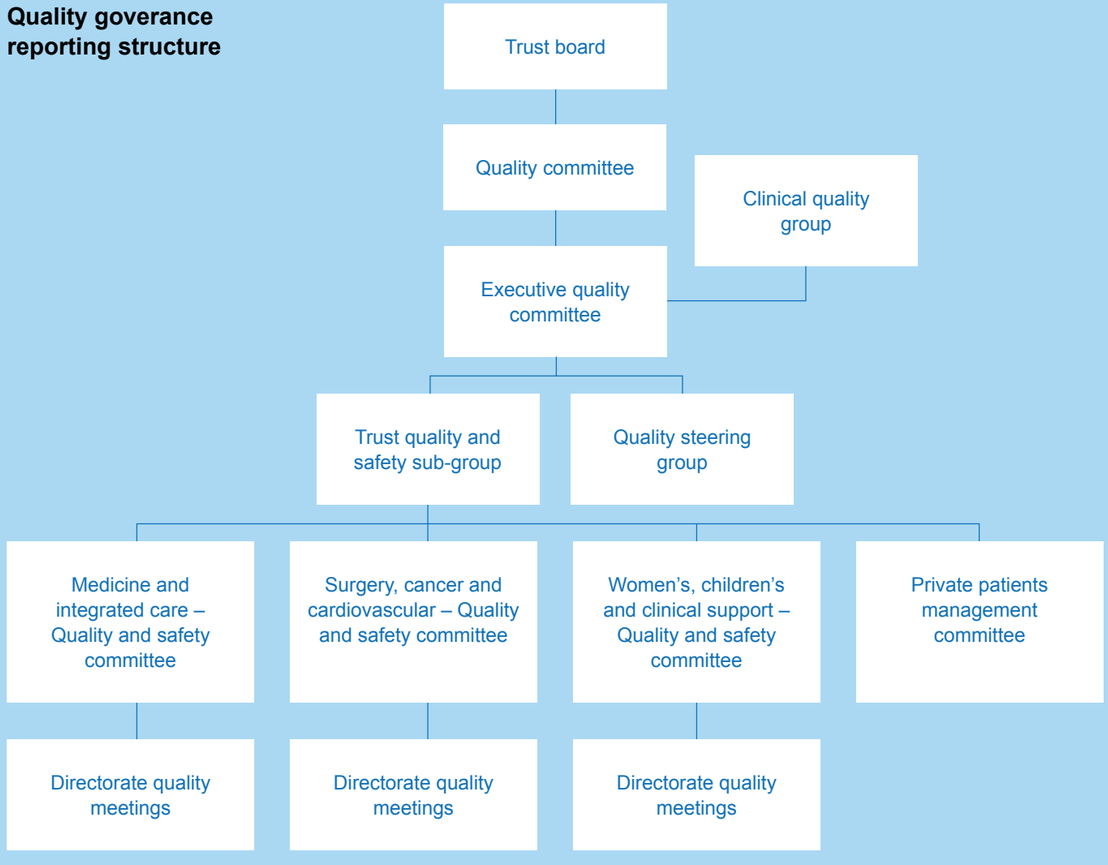
NB: A significant time delay was noted in reporting incidents to the DH information governance system. The figures represent an interim position as of May 2018. The final reported position will be known by early July 2018 when a further matching exercise has been completed and all outstanding reports have been returned; the final position will be made available on the Trust website.

Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. The Trust works closely with its commissioners throughout the year to monitor quality performance, and develop the annual quality account (available on the Trust website), acute quality schedule and priorities for the next year through the clinical quality groups ensuring that our quality agenda aligns with local and national priorities.

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

Quality goverance reporting structure



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

The Trust's quality strategy will be delivered through achievement of our quality goals, which are aligned to the five CQC quality domains. These goals are supported by specific annual targets with associated improvement programmes to ensure delivery. The targets are reviewed yearly and described in our quality account as the Trust's priorities for that year. Alongside the quality goals and targets are a number of structured quality improvement projects to drive change in priority areas. The combination of these elements makes up our quality improvement plan for the year ahead, which is defined in our quality account.

The data included within the quality account are subject to audit, by both a structured annual programme from the internal auditors, and specific item review by the external auditors. The external auditor performs limited scope procedures on two of the indicators shown in the quality accounts. For 2017/18, this limited assurance opinion has been provided in relation to our reporting of incidences of severe harm and death, and venous thromboembolism (VTE) risk assessments. The external auditor also performs a review of the consistency of the quality account in relation to the Trust's performance and communication with regulators in the year.

Other disclosures

Modern Slavery Act – 2017/2018 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

Pensions and remuneration

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

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

Cost allocation and charges for information

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

Equality disclosures

The Trust is committed to the promotion of equality of opportunity for all its employees. Our equal opportunities policy is to provide employment equality to all, irrespective of race, gender, disability, age, sexual orientation or religion. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The gender pay gap report (published on the Trust website for the first time in March 2018) demonstrates areas where the Trust will seek improvement in perceived or real gender inequality. Progress will be reported through the annual workforce equality data report, produced annually to provide information on how different groups of staff are affected by recruitment and human resources procedures and policies. This is available on our website:

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

Better payment for suppliers

The Trust supports the Prompt Payment Code which applies the following principle to payment practices: pay suppliers on time; give clear guidance to suppliers; and encourage good practice. The Trust's performance is summarised in the table in the accounts. The Trust recognises that issues in the early months of 2018 with its accounts payable contractor have meant a number of issues and delays in payment, and is working closely with the contactor to resolve these problems. As these issues are resolved it is likely that delayed (older) payments

will be made which will have the effect of worsening BPPC performance in the short to medium term and the Trust recognises the need to achieve a sustainable, high-level of performance in this area. Management intend to outline a plan to improve this during 2018/19. The Trust's performance is summarised in the notes to the annual accounts.

Emergency preparedness

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005. The Trust participates in the annual emergency preparedness, resilience and response (EPRR) assurance process carried out by NHS England; the Trust continues to be rated as having 'substantial' assurance, and an action plan is in place to address the last amber rated area.

Principles for Remedy

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

Other items

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

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

Chief executive officer's review of effectiveness

As Accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust board, the audit, risk and governance committee and quality committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In support of this:

- The head of internal audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal audits carried out (listed in appendix one) have provided assurance from substantial assurance to limited assurance; following the audit reports, management have accepted, and taken action to address, recommendations made. Management improvement plans for all audits given limited assurance are reviewed by the audit, risk and governance committee.
- Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that each has taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.
- The Trust board reviews risks to the delivery of the Trust performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety and quality, and workforce.
- The board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed. Internal audit have rated the framework as providing substantial assurance.
- The audit, risk and governance committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. The committee regularly receives reports on internal control and risk management matters from the internal and external auditors.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- During 2017/18, CQC inspected two of the Trust's core services, urgent and emergency services at St Mary's and Charing Cross hospitals, and surgery at St Mary's, Charing Cross and Hammersmith hospitals. The Trust also had its first inspection of the well-led domain at Trust level, a new type of inspection introduced by the CQC this year, for which it received a 'requires improvement' rating. Following these inspections, the Trust no longer has an 'inadequate' rating for any domain, in any service, at the Trust. The overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remain 'requires improvement'; and the Trust's overall ratings for each domain, and for the Trust overall, remain the same as they were in 2014. As outlined, the Trust is comprehensively addressing areas when potential for improvement was observed.
- NHS Improvement's Single Oversight Framework provides a structure for overseeing trusts and identifying potential support needs. The framework looks at five themes: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability (well-led). Trusts are then rated from one to four, according to these themes, with a four being those who need the most support. The Trust has been rated as a three within the framework, since its introduction in the autumn of 2016/17, reflecting the Trust's financial and operational challenges as outlined in the governance statement.

- The Trust has agreed a letter of undertakings with NHS Improvement, in which the regulator statement that it had 'reasonable grounds to suspect that that the Trust [is]… failing to comply with [certain] conditions' required of it. This relates mainly to non-compliance with required operational targets (A&E and referral to treatment), but also reflects concerns relating to longer-term financial sustainability and data quality in relation to certain aspects of patient activity. A position statement against each undertaking is submitted each month, and reported to each public Trust board; each of the areas of concern are detailed in the report in the relevant significant issues sections.
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; reports from external assessments; Deanery and Royal College assessments; accreditation of clinical services; and patient led assessments of the care environment.

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

Conclusion

The Trust board is committed to continuous improvement of its governance arrangements to ensure that systems are in place that ensure risks are correctly identified and managed and that serious incidents and incidence of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action so that the patients, service users and staff and stakeholders of Imperial College Healthcare NHS Trust can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

I consider that any significant issues are detailed in the body of the annual governance statement above, namely: ability to recruit and retain clinical staff, particularly in relation to ward-based nurses, midwives and radiographers; ability to achieve required performance targets in the emergency department and for elective surgery; risk of delayed treatment to patients awaiting planned procedures due to data quality problems which can also result in breach of contractual and regulatory requirement; ability to achieve and maintain financial stability; ability to secure broader health economy (sustainability and transformation partners) commitment to the Trust's clinical and financial transformation plans; and risk of failure of estates critical equipment and facilities that jeopardises Trust operations and increases clinical and safety risks. Action to address each of these areas is detailed in the relevant section of the corporate governance statement.

Professor Julian Redhead
Interim chief executive officer

25 May 2018

Remuneration and staff report

Remuneration report

Remuneration for the Trust's executive directors is determined by the remuneration committee of the board. Remuneration consists mainly of salary, which is inclusive of high cost area supplement, and pension benefits in the form of contributions to the NHS pension fund.

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

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

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

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based. Salary levels (which typically take effect from 1 April) for executive directors in 2017/18 are set out in the staff report.

Spot salaries are paid to 25 staff who are not executive directors. These are for posts that fall outside of agenda for change bands or where there is not an equivalent salary point on the pay scale on transfer into the organisation. These salaries are set by the relevant executive director with approval from the director of people and organisation development.

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

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

Pay multiples (subject to audit)

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the Trust and the median remuneration of all staff. The remuneration of the highest paid director in the financial year 2017/18 was £244,237 (£308,999 in 2016/17). This was 7.53 times (8.10 times in 2016/17) the median remuneration of the workforce, which was £32,429 (£38,143 in 2016/17). The change in the ratio from 8.10 (2016/17) to 7.53 this year is mainly due to a reduction in the highest paid director's remuneration as a result of the post being vacated and an interim being appointed. The remainder of the change is due to a slight decrease in median remuneration for the general workforce which is due to incremental drift, inflation and the grade mix of staff brought into the Trust to support increased activity.

In both 2016/17 and 2017/18 there were no employees who received remuneration in excess of the highest paid director. Remuneration ranged from £7,476 to £244,237 (£7,760 to £308,999 in 2016/17).

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

Remuneration tables

Salary and pension disclosure tables (subject to audit)

Remuneration report 2017/18

Salaries and allowances	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total remuneration
	(bands of £5,000)	(Total to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title	£000	£00	£000	£000	£000	£000
Non-executive director						
Sir Richard Sykes, Chairman	20 - 25	0	0	0	0	20 - 25
Sir Gerald Acher, Deputy chair	5 - 10	0	0	0	0	5 - 10
Dr Rodney Eastwood, Non-executive director[1]	0 - 5	0	0	0	0	0 - 5
Prof. Andrew Bush, Non-executive director	5 - 10	0	0	0	0	5 - 10
Peter Goldsbrough, Non-executive director	5 - 10	0	0	0	0	5 - 10
Sarika Patel, Non-executive director	5 - 10	0	0	0	0	5 - 10
Andreas Raffel , Non-executive director	5 - 10	0	0	0	0	5 - 10
Victoria Russell, Non-executive director[2]	5 - 10	0	0	0	0	5 - 10
Nick Ross, Designate Non-executive director[3]	5 - 10	0	0	0	0	5 - 10
Executive director						
Tracey Batten, Chief executive[4]	105 - 110	0	0	0	0	105 - 110
Ian Dalton, Chief executive officer[5]	100 - 105	0	0	0	80 - 82.5	180 - 185
Prof. Julian Redhead, Interim chief executive officer[6]	240 - 245	0	0	0	0	240 - 245
Richard Alexander, Chief financial officer	210 - 215	0	0	0	30 - 32.5	245 - 250
Prof. Tim Orchard, Interim medical director[7]	230 - 235	0	0	0	42.5 - 45	270 - 275
Dr. William Oldfield, Interim medical director[8]	205 - 210	0	0	0	152.5 - 155	355 - 360
Prof. Janice Sigsworth, Director of nursing	175 - 180	0	0	0	25 - 27.5	200 - 205

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash equivalent transfer value at 1 April 2017	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2018	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name and title	£000	£000	£000	£000	£000	£000	£000	£000
Non-executive directors								
Sir Richard Sykes, Chairman	0	0	0	0	0	0	0	0
Sir Gerald Acher, Deputy chair	0	0	0	0	0	0	0	0
Dr. Rodney Eastwood, Non-executive director[1]	0	0	0	0	0	0	0	0
Prof. Andrew Bush, Non-executive director	0	0	0	0	0	0	0	0
Peter Goldsbrough, Non-executive director	0	0	0	0	0	0	0	0
Sarika Patel, Non-executive director	0	0	0	0	0	0	0	0
Andreas Raffel , Non-executive director	0	0	0	0	0	0	0	0
Victoria Russell, Non-executive director[2]	0	0	0	0	0	0	0	0
Nick Ross, Designate Non-executive director[3]	0	0	0	0	0	0	0	0
Executive directors								
Tracey Batten, Chief executive[4]	0	0	0	0	0	0	0	0
Ian Dalton, Chief executive officer[5]	2.5 - 5	5 - 7.5	25 - 30	80 - 85	442	40	552	0
Prof. Julian Redhead, Interim chief executive officer[6]	0	0	0	0	0	0	0	0
Richard Alexander, Chief financial officer	2.5 - 5	7.5 - 10	25 - 30	85 - 90	506	70	581	0
Prof. Tim Orchard, Interim medical director[7]	2.5 - 5	0 - 2.5	55 - 60	85 - 90	652	71	729	0
Dr. William Oldfield, Interim medical director[8]	7.5 - 10	7.5 - 10	50 - 55	75 - 80	689	56	752	0
Prof. Janice Sigsworth, Director of nursing	0 - 2.5	5 - 7.5	80 - 85	250 - 255	1656	88	1761	0

1 Rodney Eastwood left the board on 30 June 2017

2 Victoria Russell joined the board on 1 July 2017

3 Nick Ross, was Designate Non-executive director from 1 September 2016

4 Dr. Tracey Batten left the Trust on 30 July 2017

5 Ian Dalton joined the Trust on 17 July 2017 and left on 3 December 2017. The real increase in CETV is pro-rata only to period of employment with the Trust. Previous and subsequent employers will account for any other change between the opening and closing CETV incurred during the period of employment with them

6 Prof. Julian Redhead was made Interim chief executive officer on 4 December 2017. The amount of £120k – £125k of his salary relates to payment for clinical role

7 Prof. Tim Orchard was made Interim joint medical director on 4 December 2017. The amount of £135k – £140k of his salary relates to payment for his clinical role

8 Dr. William Oldfield was made Interim joint medical director on 4 December 2017. The amount of £90k – £95k of his salary relates to payment for his clinical role

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

Remuneration report 2016/17

Salaries and allowances	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	Pension related benefits	Total remuneration
	(bands of £5,000)	(Total to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Non-executive directors						
Sir Richard Sykes, Chairman	20 - 25	0	0	0	0	20 - 25
Sir Gerald Acher, Deputy chair	5 - 10	0	0	0	0	5 - 10
Jeremy Isaacs, Non-executive director[1]	0 - 5	0	0	0	0	0 - 5
Dr. Rodney Eastwood, Non-executive director	5 - 10	0	0	0	0	5 - 10
Prof. Sir Anthony Newman Taylor, Non-executive director[2]	0 - 5	0	0	0	0	0 - 5
Sarika Patel, Non-executive director	5 - 10	0	0	0	0	5 - 10
Andreas Raffel , Non-executive director	5 - 10	0	0	0	0	5 - 10
Prof. Andrew Bush, Non-executive director[4]	0	0	0	0	0	0
Peter Goldsbrough, Non-executive director[5]	0	0	0	0	0	0
Executive directors						
Tracey Batten, Chief executive[6]	295 - 300	0	5 - 10	0	0	305 - 310
Richard Alexander, Chief financial officer	210 - 215	0	0	0	52.5 - 55	265 - 270
Dr. Julian Redhead, Medical director[3]	235 - 240	0	0	0	20 - 22.5	255 - 260
Prof. Janice Sigsworth, Director of nursing[7]	175 - 180	0	0	0	207.5 - 210	380 - 385

Pension benefits	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash equivalent transfer value at 1 April 2017	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2018	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-executive directors								
Sir Richard Sykes, Chairman	0	0	0	0	0	0	0	0
Sir Gerald Acher, Deputy chair	0	0	0	0	0	0	0	0
Jeremy Isaacs, Non-executive director[1]	0	0	0	0	0	0	0	0
Dr. Rodney Eastwood, Non-executive director	0	0	0	0	0	0	0	0
Prof. Sir Anthony Newman Taylor, Non-executive director[2]	0	0	0	0	0	0	0	0
Sarika Patel, Non-executive director	0	0	0	0	0	0	0	0
Andreas Raffel , Non-executive director	0	0	0	0	0	0	0	0
Prof. Andrew Bush, Non-executive director[4]	0	0	0	0	0	0	0	0
Peter Goldsbrough, Non-executive director[5]	0	0	0	0	0	0	0	0
Executive directors								
Tracey Batten, Chief executive[6]	0	0	0	0	0	0	0	0
Richard Alexander, Chief financial officer	2.5 - 5.0	10 - 12.5	25 - 30	75 - 80	410	96	506	0
Dr. Julian Redhead, Medical director[3]	0 - 2.5	0 - 2.5	50 - 55	140 - 145	782	75	857	0
Prof Janice Sigsworth, Director of nursing[7]	10 - 12.5	30 - 32.5	80 - 85	245 - 250	1,369	287	1,656	0

1 Jeremy Isaacs left the board on 30 September 2016

2 Prof. Sir Anthony Newman left the board on 31 August 2016

3 The amount of £135k – £140k of Dr. Julian Redhead's salary relates to payment for his clinical role

4 Prof. Andrew Bush joined the board on 1 September 2016

5 Peter Goldsbrough joined the board on 1 September 2016

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

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

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

Staff report

The headcount data is at 31 March 2018 and is for clinical and corporate divisions and R&D (excluding hosted and contracted services).

Workforce composition by staff group

At 31 March 2018 the Trust employed 11,789 staff. Approximately 69 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown below.

Headcount by Trust staff group	Headcount
Admin and clerical	1,841
Allied health professional (qualified)	628
Allied health professional (unqualified)	92
Doctor (career grade)	38
Doctor (consultant)	1,022
Doctor (training grade)	1,530
Nursing (qualified)	3,721
Nursing (unqualified)	1,004
Pharmacist	131
Scientific and technical (qualified)	813
Scientific and technical (unqualified)	337
Senior manager	632
Trust total	**11,789**

Workforce composition by sex

Seventy-one per cent of our workforce is female and 29 per cent is male. The high proportion of female workers is typical of NHS organisations. The proportion of male employees increases in more senior roles. The gender tables below show that at the end of 2017/18 women accounted for 57 per cent of senior managers, 23 per cent of board directors and 30 per cent of executive directors. There are five directors who are defined both as executive team members and as board directors.

Gender – all	Headcount
Female	8,337
Male	3,452
Trust total	**11,789**

Gender – senior management	Headcount
Female	354
Male	260
Trust total	**614**

Gender – board of directors	Headcount
Female	3
Male	10
Trust total	**13**

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

Workforce composition by age and ethnicity

Age group	Headcount
16-19 years	9
20-29 years	2,389
30-39 years	3,596
40-49 years	2,933
50-59 years	2,136
60 years and over	726
Trust total	**11,789**

Ethnic origin	Headcount
White - British	3,153
White - Irish	403
White - any other White background	1,518
Mixed - White and Black Caribbean	74
Mixed - White and Black African	68
Mixed - White and Asian	83
Mixed – any other mixed background	177
Asian or Asian British - Indian	893
Asian or Asian British - Pakistani	210
Asian or Asian British - Bangladeshi	133
Asian or Asian British - Any other Asian background	1,091
Black or Black British - Caribbean	474
Black or Black British - African	1,066
Black or Black British - Any other Black background	448
Chinese	191
Any other ethnic group	640
Undefined	796
Not stated	371
Trust total	**11,789**

Average staff numbers (subject to audit)

Average staff numbers	Total	Permanently employed	Other	Total prior year	Prior year permanently employed	Prior year other
Medical and dental	2,083	2,075	8	1,974	1,929	45
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,556	2,413	143	2,406	2,260	146
Healthcare assistants and other support staff	1,698	1,644	54	1,428	1,391	37
Nursing, midwifery and health visiting staff	4,206	3,969	237	3,863	3,676	187
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	959	826	133	890	773	117
Social care staff	0	0	0	0	0	0
Healthcare science staff	628	628	0	559	559	0
Other	0	0	0	0	0	0
TOTAL	**12,130**	**11,555**	**575**	**11,120**	**10,588**	**532**
Staff engaged on capital projects (included above)	16	15	0	11	11	0

The workforce composition statistics are based on headcount of substantively employed staff whereas the average staff numbers also take account of bank and agency, and are based on WTE.

The analysis of staff costs

	2017-18			2016-17		
	Permanent £000s	Other £000s	Total £000s	Permanent £000s	Other £000s	Total £000s
Salaries and wages	452,264	78,060	530,324	423,012	78,993	502,005
Social security costs	51,233	2,417	53,650	45,439	1,912	47,351
Apprenticeship levy	2,254	140	2,394	0	0	0
Employer contributions to NHS BSA	53,722	832	54,554	50,740	623	51,363
Other pension costs	18	4	22	15	4	19
Termination benefits	333	0	333	243	0	243
Total employee benefits	**559,824**	**81,453**	**641,277**	**519,449**	**81,532**	**600,981**
Employee costs capitalised	946	335	1,281	678	323	1,001
Gross employee benefits ex. capitalised costs	**558,878**	**81,118**	**639,996**	**518,771**	**81,209**	**599,980**

Separate to the table above consultancy spend in 2017/18 was £291k (£5,541k in 2016/17).

Sickness absence

Low sickness absence is an indicator of effective leadership, good people management and staff wellbeing and as such this an important key performance indicator for the Trust. In 2017/18, the Trust achieved a sickness absence rate of 6.2 average days sick per whole time equivalent, which is 2.9 per cent, against a target of 3.1 per cent. This compares to a rate of 3.0 per cent in the previous year.

Employment of staff with disabilities

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

Off-payroll arrangements

It is Trust policy that all substantive staff should be paid through the payroll wherever possible.

NHS bodies are required to disclose specific information about off-payroll engagements.

Off-payroll engagements longer than six months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	26
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	13

New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	7
Of which :	
Number assessed as caught by IR35	2
Number assessed as not caught by IR35	5
Number engaged directly (via PSC contracted to the entity) and are on the entity's payroll	2
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off - payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (2017/18)	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both on payroll and off-payroll engagements (2017/18)	16

Exit packages (subject to audit)

In 2017/18 the Trust approved severance payments to 31 staff.

Exit packages

2017/18								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	9	53,138	12	43,696	21	96,834	0	0
£10,000-£25,000	3	57,570	1	16,843	4	74,413	0	0
£25,001-£50,000	5	170,640	0	0	5	170,640	0	0
£50,001-£100,000	1	52,067	0	0	1	52,067	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
Total	**18**	**333,415**	**13**	**60,539**	**31**	**393,954**	**0**	**0**

2016/17								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	2,464	2	4,373	3	6,837	0	0
£10,000-£25,000	2	34,649	1	17,200	3	51,849	0	0
£25,001-£50,000	1	26,284	0	0	1	26,284	0	0
£50,001-£100,000	2	181,297	1	55,822	3	237,119	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
Total	**6**	**244,694**	**4**	**77,395**	**10**	**322,089**	**0**	**0**

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

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

Exit packages - other departures analysis

	2017-18		2016-17	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	1	17	0	0
Exit payments following employment tribunals or court orders	12	44	4	77
Total	**13**	**61**	**4**	**77**

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

Trade union facility time publication report

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017, meaning that NHS employers are required to publish information on trade union officials and facility time – the time off from an employee's normal role to undertake trade union duties and activities when they are elected as a trade union representative.

The below data refers to the relevant period which is 1 April 2017 – 31 March 2018.

Trade union representatives

The total number of employees who were trade union representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	61
FTE employee number	60.3

Percentage of time spent on facility time

How many employees who were trade union representative officials employed during the relevant period spent a) 0 per cent, b) 1-50 per cent, c) 51-99 per cent or d) 100 per cent of their working hours on facility time.

Percentage of time	Number of employees
0 per cent	45*
1-50 per cent	16*
51-99 per cent	0
100 per cent	0

*This data is based on self reporting from individual trade union representatives.

Percentage of pay bill spent on facility time

Total cost of facility time	£26,776
Total pay bill	£639.996m
Percentage of the total pay bill spent on facility time	0.004 per cent

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were trade union representatives during the relevant period on paid trade union activities.

Time spent on paid trade union activities as a percentage of total paid facility time hours	87.55 per cent

Overall, 88 per cent of paid facility time was spent on paid non-statutory trade union activities, while 12 per cent was spent on paid statutory trade union duties.

Chief financial officer's review

I am pleased to be able to report that, despite an immensely challenging financial environment, the Trust successfully delivered the financial plan agreed with the regulator. As a reward for this performance the Trust received a significant share of the sustainability and transformation fund (STF) which moved our reported bottom line performance from significant deficit into small surplus. Regrettably this funding is not available for investment in patient care. More significantly, in 2017/18 the Trust also substantially reduced its underlying financial deficit through sustainable measures and this is encouraging for the future. The search for efficiencies becomes more difficult each year but as the whole service continues to face this reality, larger, collaborative, system change to benefit patients and taxpayer becomes the requirement of each part of the healthcare delivery system and we have a responsibility to help lead this.

During 2017/18 the Trust met all four statutory financial duties (see table opposite) and met its financial plan for the year. This performance included delivering efficiencies of £43.1m. The receipt of £25.5m STF, which was not planned at the outset of 2017/18, meant that the Trust delivered a small cumulative statutory surplus and did not breach that statutory duty to breakeven as had been feared. The financial performance in 2017/18 demonstrates that the Trust recognises the need to minimise its underlying financial deficit by setting stretching but achievable budgets.

Statutory financial duties and going concern

Duty	Requirement	Achievement
Breakeven duty	To ensure total expenditure does not exceed income, on a year-on-year cumulative basis	Achieved – cumulative surplus of £10m remaining
External financing limit (EFL)	To remain within DH borrowing limit	Achieved – external financing of £9.3m
Capital absorption rate of 3.5 per cent	To pay a dividend of 3.5 per cent to the DH	Achieved
Capital resource limit (CRL)	To ensure capital expenditure is within the limit set by DH	Achieved – net spend of £46.7m

Before STF, the Trust delivered a year-end deficit of £22.5m, £2.6m favourable to the planned deficit of £25.1m. The Trust received £25.5m of STF, £14.5m which was allocated based on financial performance and an additional £11m bonus and incentive funding. The overall Trust position after STF was therefore a £3m surplus, £7.5m favourable to the plan, entirely due to the additional STF and winter funding received.

Achieving our statutory breakeven duty has been and will continue to be dependent upon receipt of STF which for 2018/19 we have included in our plan (having committed to the target set us by the regulator). Failure to meet the plan jeopardises all of the STF and would cause the Trust to fail its breakeven duty. While the Trust is committed to meeting its plan, it should be noted that the precarious condition of our estate and the related challenge to increase capacity to meet demand represent significant and difficult-to-mitigate risks to the plan. Failure to commit to the target jeopardises necessary funding to both maintain and potentially redevelop the estate. Our auditors have confirmed that it remains appropriate for the Trust to prepare accounts on a going concern basis, but have noted the material uncertainty in their auditor's report; please note 1.1.2 in the accounts where Trust management explain in more detail the risks mentioned above.

In year, the Trust was successful in our application to join the NHS Improvement Financial Improvement Programme 2 with work focusing on the women's, children's and clinical support division. In addition, the Trust delivered phase one of its extensive specialty review programme, a clinically-led process to help develop a refreshed clinical strategy, built upwards from specialty level plans. The programme has three interrelated work streams – clinical services, sustainability and workforce. As well as underpinning a refreshed clinical strategy, the programme outputs will contribute to a financial recovery plan.

There is a growing impetus to align and co-design change and transformation across north west London, building on the sustainability and transformation plan (STP) and its implementation over the past year or so. Although the Trust has, to date, been part of STP projects, including transforming outpatient services, it will need to significantly increase its involvement and external collaboration as it evolves its own strategic development programme to drive longer-term and larger-scale change and help achieve financial sustainability.

Financial performance metrics

From October 2016, the Trust has been monitored based on the Single Oversight Framework. This was updated in November 2017. This uses five key metrics to measure the financial risk of an organisation. Each metric has a rating from 1-4 with 1 being the best performance (i.e. lowest risk) and 4 the worst. These ratings are then combined to give an overall score. If any metric has a score of 4 then the overall rating cannot score better than a 3.

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

The poor score for liquidity is due to our low cash balances. As there is one metric on which the Trust scores a 4 the Trust cannot score higher than 3, (without this override, the average of the five metrics is 2).

Income and expenditure

In April 2018, the NWL Pathology service was established as a joint operation between Imperial College Healthcare NHS Trust, Chelsea and Westminster Hospital NHS Foundation Trust and the Hillingdon Hospitals NHS Foundation Trust. The operation brings together the pathology services at the three stakeholder trusts and is hosted by Imperial College Healthcare NHS Trust. As the service is hosted by the Trust, all income and expenditure (including that previously incurred by the other partners) is shown in the Trust's position. This has the effect of increasing the income by £16m and expenditure by a similar value compared to 2016/17.

The Trust's total operating revenue (see notes 3 and 4 to the accounts), before the allocation of STF, grew six per cent, or £64m, against the previous year. This increase in income included a £46m increase in clinical commissioning income (£18m from clinical commissioning groups and a £28m increase in income commissioned nationally for specialised services) and an increase in respect of NWL Pathology.

The total operating expenditure (see note 5 to the accounts) was £1,147m. After adjusting for the asset revaluation explained below, overall expenditure has increased by five per cent, or £50m, when compared to the previous year. This increase has been driven primarily by the cost of delivering additional activity, together with costs associated with inflation, other NHS policy driven cost pressures alongside high costs of maintaining a poor quality estate and some additional costs required to reduce patient waiting times. This position includes the increase in respect of NWL Pathology.

In line with established accounting practice, the Trust commissioned an independent professional firm to undertake a valuation of its estate. The accounts record an overall net reduction of £6.8m in the value of the Trust asset base, £5.8m of this was recorded within operating expenditure. This revaluation is excluded from the Department of Health and Social Care's assessment of the Trust's breakeven duty.

The Trust's efficiency programme was initially set at £54m, and delivered £43.1m against this. All efficiency plans are risk assessed and reviewed by the medical and nursing directorates for impact on patient safety, quality and experience, which are rigorously monitored. Separately, the programme support office maintains a framework to assure the effective delivery of these improvement programmes. The key themes included increased productivity through delivering greater NHS activity with minimal expenditure increase, as well as increases in private work. It also included reduced costs through reviewing key contracts, negotiating better prices with suppliers, and reducing overheads.

Capital expenditure

The Trust continues to invest in its capital infrastructure to help achieve its strategic service objectives. During 2017/18, the Trust invested a total of £57.4m to modernise its estate, deal with the most critical backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2017/18 included:

- Backlog maintenance £17.9m
- Medical equipment £3.8m
- IT investment £10.1m (including £4m global digital exemplar funding).

Liquidity, cash and working capital

The Trust focused successfully on improving its cash management throughout the year; remaining within its external financing limit (EFL), with a year-end cash position of £24.5m. This is supported by £15.8m of the Department of Health and Social Care's revolving working capital facility which is considerably less than the anticipated borrowings when the cash plan was developed at the start of the financial year, reflecting improved cash management practices.

Financial outlook

The Trust has entered 2018/19 with a significant underlying deficit, and has therefore set another challenging target for improving productivity and cost reduction with an efficiency programme totalling £48m; around 4.1 per cent of turnover. These savings are consistent with those achieved in 2017/18 and are above the four per cent required by NHS Improvement.

Taking into account the known pressures to the Trust from national and local decisions, such as changes to research and development funding models and junior doctor contracts, a planned deficit of £20.6m has been set by the Trust board. Delivery of this target makes the Trust eligible for STF funds of £34.2m taking its plan, after STF, to a surplus of £13.6m.

The Trust will continue to need to invest a significant portion of its available capital to meet a very significant programme of backlog maintenance across its estate and has submitted a request for additional support to achieve this without jeopardising essential investment in other areas of Trust activity. The capital programme has been set at £37m excluding external donations and financing. Additionally, the Trust has applied for a further £46m to fund essential investment which cannot be funded from internal sources. The Trust continues to work with partners including local commissioners and sector provider trusts in developing business cases which will deliver the very best care for patients across north west London. The Trust continues to actively explore the extent to which funding, commercial and public, can be secured to provide new facilities for patients and will seek to make full use of the recommendations of the Naylor Report if it is fully adopted.

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

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Imperial College Healthcare NHS Trust (the 'trust'):

- give a true and fair view of the financial position of the trust as at 31 March 2018 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements of the trust which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 32.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 80;
- the table of pension benefits of senior managers and related narrative notes on page 81; and
- the table of pay multiples and related narrative notes on page 80.

The financial reporting framework that has been applied in their preparation is applicable law and the 'Accounts Direction'.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Local Audit and Accountability Act 2014 (the 'Act') and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (FRC's) Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that, whilst the Trust has a balanced plan for 2018/19, there are significant risks to the trust's cash flows which cannot easily be mitigated without access to further as yet uncommitted borrowing. As stated in note 1.1.2, these events or conditions, along with the other matters as set forth in note 1.1.2 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt on the company's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

Responsibilities of directors

As explained more fully in the directors' responsibilities statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the trust or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinions on other matters

In our opinion:

- the parts of the Remuneration Report subject to audit has been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Conclusion on the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required to report to you if, in our opinion the trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, with the exception of the matters reported in the basis for qualified conclusion paragraph below, we are satisfied that, in all significant respects, Imperial College Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

As disclosed in the Annual Governance statement, the Trust is subject to a series of undertakings that have been agreed with NHS Improvement following the receipt of formal notification from NHS Improvement on 7 November 2017 that it had "reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following equivalent conditions to that of the Monitor License in breach of the following conditions of its license: FT4 (5) (a)-(c) (d)." These conditions relate to the establishment of effective governance procedures, compliance with healthcare standards set by regulators; data quality to provide information on quality of care; and compliance with the duty to operate efficiently, economically and effectively.

Whilst the Trust has been performing work to respond to undertakings and address these concerns, at 31 March 2018 the undertakings were still extant.

Additionally, the Trust currently relies on the receipt of Sustainability and Transformation Funding (STF) in order to deliver a balanced budget. Note 1.1.2 in the financial statements refers to management's assessment that there are material uncertainties with regards to going concern, in particular with funding the ongoing backlog maintenance of the estate in order to deliver services. Additionally, there is no certainty that STF will be available from 2019/20 and in the absence of STF the forecast for that year shows a funding shortfall.

The issues above are evidence of weaknesses in proper arrangements for securing economy, efficiency and effectiveness in its use of resources, including the sustainable delivery of services.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Comptroller & Auditor General in December 2017, as to whether the trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

Respective responsibilities of the accounting officer and auditor

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the trust's resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the Act to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Comptroller & Auditor General in December 2017.

We report if significant matters have come to our attention which prevent us from concluding that the trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Matters on which we are required to report by exception

We are required to report in respect of the following matters if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's (NHS Improvement) guidance; or
- we refer the matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act (2014).

We have nothing to report in respect of these matters.

Certificate

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

Use of our report

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

Craig Wisdom,
ACA (Engagement Lead)
For and on behalf of Deloitte LLP
Appointed Auditor
St. Albans, UK

Date: 29 May 2018

Financial statements

Statements of accounts

Statement of comprehensive income for the year ended 31 March 2018

	Note	2017/18 £000	*Restated* 2016/17 £000
Operating income from patient care activities	3	973,974	890,148
Other operating income	4	186,829	206,427
Operating expenses	5	(1,146,852)	(1,070,788)
Operating surplus/(deficit) from continuing operations		**13,951**	**25,787**
Finance income	10	104	104
Finance expenses	11	(1,216)	(1,190)
PDC dividends payable		(10,105)	(12,157)
Net finance costs		**(11,217)**	**(13,243)**
Surplus/(deficit) for the year		**2,734**	**12,544**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(1,042)	379
Total comprehensive income/(expense) for the period		**1,692**	**12,923**
Financial performance for the year			
Surplus/(deficit) for the year		**2,734**	12,544
Impairments (excluding IFRIC 12 impairments)		**5,804**	(20,670)
Adjustments in respect of donated and government grant asset reserve elimination		**(5,515)**	(7,204)
Control total performance		**3,023**	(15,330)

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

Statement of financial position as at 31 March 2018

	Note	31 March 2018 £000	*Restated* 31 March 2017 £000
Non-current assets			
Intangible assets	13	3,247	3,393
Property, plant and equipment	14	494,135	483,432
Total non-current assets		**497,382**	**486,825**
Current assets			
Inventories	15	13,071	13,674
Trade and other receivables	16	165,354	107,699
Cash and cash equivalents	17	24,464	20,975
Total current assets		**202,889**	**142,348**
Current liabilities			
Trade and other payables	18	(174,615)	(129,757)
Borrowings	20	(1,583)	(1,352)
Provisions	21	(44,971)	(43,891)
Other liabilities	19	(35,041)	(24,330)
Total current liabilities		**(256,210)**	**(199,330)**
Total assets less current liabilities		**444,061**	**429,843**
Non-current liabilities			
Borrowings	20	(33,603)	(32,609)
Provisions		-	(7)
Total non-current liabilities		**(33,603)**	**(32,616)**
Total assets employed		**410,458**	**397,227**
Financed by			
Public dividend capital		706,383	694,844
Revaluation reserve		1,714	2,756
Income and expenditure reserve		(297,639)	(300,373)
Total taxpayers' equity		**410,458**	**397,227**

The notes on pages 101 to 126 form part of these accounts.

The financial statements on pages 97 to 126 were approved by the board on 23 May 2018 and signed on its behalf by

Professor Julian Redhead
Interim chief executive officer
25 May 2018

Statement of changes in equity for the year ended 31 March 2018

	Public dividend capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**694,844**	**(300,373)**	**2,756**	**397,227**
Surplus/(deficit) for the year	-	2,734	-	**2,734**
Impairments	-	-	(1,042)	**(1,042)**
Revaluations	-	-	-	-
Public dividend capital received	11,539	-	-	11,539
Taxpayers' equity at 31 March 2018	**706,383**	**(297,639)**	**1,714**	**410,458**

Statement of changes in equity for the year ended 31 March 2017

	Public dividend capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total £000
Taxpayers' equity at 1 April 2016 – brought forward	**694,744**	**(312,917)**	**2,377**	**384,204**
Surplus/(deficit) for the year	-	12,544	-	**12,544**
Impairments	-	-	379	**379**
Revaluations	-	-	-	-
Public dividend capital received	100	-	-	**100**
Taxpayers' equity at 31 March 2017	**694,844**	**(300,373)**	**2,756**	**397,227**

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating expenditure. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of cash flows

	Note	2017/18 £000	*Restated* 2016/2017 £000
Cash flows from operating activities			
Operating surplus/(deficit)		13,951	25,787
Non-cash income and expense:			
Depreciation and amortisation	5.1	36,263	34,529
Net impairments	6	5,804	(20,670)
Income recognised in respect of capital donations	4	(6,934)	(8,503)
(Increase)/decrease in receivables and other assets		(57,443)	7,474
(Increase)/decrease in inventories		603	1,200
Increase/(decrease) in payables and other liabilties		43,576	(6,636)
Increase/(decrease) in provisions		1,073	(2,487)
Net cash generated from/(used in) operating activities		**36,893**	**30,694**
Cash flows from investing activities			
Interest received		110	104
Purchase of intangible assets		-	(150)
Purchase of property, plant, equipment and investment property		(45,387)	(44,793)
Sales of property, plant, equipment and investment property		3,716	-
Receipt of cash donations to purchase capital assets		6,935	8,503
Net cash generated from/(used in) investing activities		**(34,626)**	**(36,336)**
Cash flows from financing activities			
Public dividend capital received		11,539	100
Movement on loans from the Department of Health and Social Care		(1,226)	14,579
Movement on other loans		2,451	705
Other interest paid		(1,219)	(1,190)
PDC dividend (paid)/refunded		(10,323)	(11,781)
Net cash generated from/(used in) financing activities		**1,222**	**2,413**
Increase/(decrease) in cash and cash equivalents		**3,489**	**(3,229)**
Cash and cash equivalents at 31 March	17.1	**24,464**	**20,975**

Notes to the accounts

Notes to the accounts

Note 1 accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the entity's ability to continue as a going concern. Financial statements should be prepared on a going concern basis unless there is an intention to cease activities or there is no realistic alternative but to do so. Current guidance is that Department of Health and Social Care bodies should prepare their financial statements on a going concern basis unless informed by the Department of Health and Social Care of the intention for dissolution without transfer or service or function to another entity.

The Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate for the foreseeable future.

The Trust board has considered the advice in the Department of Health and Social Care's GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

In line with its expectation of continued operation the Trust's 2018/19 plan has been submitted to NHS Improvement and the board has accepted the control total, thereby meeting the conditions for allocation of sustainability and transformation funding (STF). The Trust is consequently planning to deliver a surplus during 2018/19 and on this basis management has the reasonable expectation that the Trust will continue to have adequate resources to service its operational activities in cash terms for the next 12 months.

The Trust's 2018/19 plan is for an agreed control total of a deficit of £20.6m prior to STF of £34.2m. The Trust's future cashflows are highly dependent on making this plan, which includes areas of uncertainty, such as the ability to meet the cost improvement targets, and to maintain the condition of the estate required to deliver the planned services, which could impact on the attainment of the control total and the receipt of the STF on which the Trust depends. As disclosed on page 71 of the annual report the Trust's estate is in a poor condition due to its age and this gives two specific causes for concern. Firstly, should the Trust miss its financial target and not qualify for STF then there is little flexibility in the capital programme to release additional cash to mitigate the shortfall. Secondly should the level of expenditure required by the estate exceed that planned for then this would require further departmental funding which is not yet committed. Additionally, there are cashflow risks which do not impact surplus, for example, should provisions disclosed in note 21.1 crystallise during the year, this would result in a potentially significant outflow of cash resources, meaning that the Trust would not be able to meet its liabilities as they fell due without additional departmental funding. For these reasons, there is a material uncertainty about the financial viability of the Trust if it does not receive centrally agreed funding which may cast significant doubt as to the Trust's ability to continue as a going concern. No adjustments have been made to the financial statements as a result of this potential uncertainty.

The Trust board, however, is in regular contact with the Department of Health and Social Care, and as such, should any of these circumstances arise, has a reasonable expectation that funding would be provided, although this funding is not yet committed.

Note 1.2 Critical judgements and key sources of estimation uncertainty in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see 1.2.2) that management have made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.1.1 Land and buildings valuation

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See note 1.7 for further details.

In line with this policy land and building assets are valued using the Modern Equivalent Asset (MEA) approach. Both physical and functional obsolescence is applied to buildings, to reflect their actual characteristics and value. As part of this process management consider whether an alternative rebuild location remains appropriate.

The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes although the MEA aligns with the Trust's proposals for site redevelopment.

The valuation is based on assumptions made by a suitably qualified professional in accordance with HM Treasury Guidance. The valuer provided the Trust with a valuation of land and building assets. This process leads to revaluation adjustments as set out in note 14 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

Note 1.2.2 Key sources of estimation uncertainty

The following are the estimations that management have made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.2.1 Provisions

Where the Trust is subject to challenge or outcome on as yet undetermined matter e.g. employment tribunal, redundancy claim, pay claims, etc. the Trust takes a prudent view and provides for such claims within the accounting period in which they arose. See note 1.14 for further details.

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events.

Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.The carrying amounts of the Trust's provisions are detailed in note 21 to these accounts.

Note 1.2.2.2 Allowance for impairment of receivables

The provision for impairment of receivables is based on assumptions concerning the future and other sources of information about the age and recoverability of the debt. Management provides for the potential of impaired receiveables according to its classification, age and status (i.e. disputed or otherwise). Management uses its judgement to decide when to provide against other specific debts which are considered are risk of impairment other than the risk generated by classification, age and status.

The carrying amounts of the Trust's provisions are detailed in note 16 to these accounts.

Note 1.3 Interests in other entities

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its full share of the assets, liabilities, income and expenses for North West London Pathology (NWLP) which it is a joint operator of with a corresponding debtor or creditor with the other joint operators for their share of operational performance.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement

Valuation

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

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

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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the statement of comprehensive income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of

construction and residual interests in off-statement of financial position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

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

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the statement of comprehensive income as an item of 'other comprehensive income'.

Impairments

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses.
A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9 Other relevant asset disclosures

Note 1.9.1 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation or amortisation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Assets which is are be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.9.2 Donated and grant funded assets

Donated and grant funded assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other assets in that class.

Note 1.10 Inventories

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

Note 1.11 Cash and cash equivalents

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

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the statement of comprehensive income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of comprehensive income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the statement of financial position date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the statement of comprehensive income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the statement of comprehensive income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.

Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the statement of financial position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment. The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease.

The annual finance cost is charged to finance costs in the statement of comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the statement of financial position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 21 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable. Contingent liabilities are not recognised unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets)

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility

(iii) any PDC dividend balance receivable or payable.

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

Note 1.17 Value added tax

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

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The Department of Health and Social Care GAM does not require the following standards and interpretations to be applied in 2017/18. These standards are either being implemented in 2018/19 or are still subject to implementation. Following the release of the 2018/19 Department of Health and Social Care Group Accounting Manual in May 2018, the Trust is assessing the likely impact of IFRS 9 and IFRS 15 (and the adaptations included in the GAM).

IFRS 9 Financial Instruments:
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Department of Health and Social Care released the 2018/19 GAM during May, addressing some, but not all, of the potential NHS-specific issues in implementing IFRS 9 and IFRS 15. The Trust has not yet performed a full impact analysis of the effect of implementing these standards and is still assessing the impact following publication of the GAM.

Note 1.22 Restatement

In some instances the Trust has deemed it appropriate to represent prior year disclosures. These adjustments although not strictly required under UK generally accepted accounting practice are reclassifications between lines and have no bottom line impact on last year's accounts.This is intended to ensure that the classification of current and prior year disclosures are aligned and, in so doing, make the accounts of greater value to the reader. Where a disclosure has been restated, the disclosure will be marked with the heading 'restated'.

Note 2 Operating Segments

The Trust board led by the Chief executive officer is the Chief operating decision maker within the Trust. It is the duty of the Chief operating decision make to consider classes of activities, services or locations that constitute discrete operating segments meriting separate disclosure within the accounts. The Trust provides a range of healthcare services to which are reported internally in four divisional categories: surgery, cancer and cardiovascular services; medicine and integrated care; women's and children's and clinical support services; corporate services. The Trust is also party to a joint arrangement for the North West London Pathology Hub. However, having considered the requirements, the Trust board considers that for the purpose of statutory reporting the Trust's activities fall under the single heading of healthcare. Consequently, there are no additional disclosures to made as regards the statutory accounts with regard to operating segments.

Note 3 Operating income from patient care activities

	2017/18 £000	2016/17 £000
Acute services		
Elective income	158,692	140,334
Non elective income	234,638	188,971
First outpatient income	55,685	41,209
Follow up outpatient income	67,540	58,041
A & E income	34,027	30,846
High cost drugs income from commissioners (excluding pass-through costs)	116,056	120,936
Other NHS clinical income	186,528	234,647
Community services		
Community services income from CCGs and NHS England	12,690	9,869
Income from other sources (e.g. local authorities)	7,203	7,267
All services		
Private patient income	50,659	46,014
Other clinical income	50,257	12,014
Total income from activities	**973,974**	**890,148**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	*Restated* 2016/17 £000
NHS England	353,783	326,271
Clinical commissioning groups	508,501	490,358
Department of Health and Social Care	391	117
Other NHS providers	39,155	4,647
NHS other	2,763	540
Local authorities	7,203	7,228
Non-NHS: private patients	50,686	46,014
Non-NHS: overseas patients (chargeable to patient)	4,483	3,844
NHS injury scheme	2,273	7,026
Non NHS: other	4,736	4,103
Total income from activities	**973,974**	**890,148**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	4,483	3,844
Cash payments received in-year	1,468	2,088
Amounts added to provision for impairment of receivables	1,548	2,769
Amounts written off in-year	1,001	1,190

Note 4 Other operating income

	2017/18 £000	*Restated* 2016/17 £000
Research and development	47,717	51,339
Education and training	57,934	59,054
Receipt of capital grants and donations	6,934	8,503
Charitable and other contributions to expenditure	2,218	1,650
Non-patient care services to other bodies	17,835	32,959
Sustainability and transformation fund income*	25,537	25,450
Rental revenue from operating leases	2,038	5,102
Income in respect of staff costs where accounted on gross basis	6,966	9,720
Other income	19,650	12,650
Total other operating income	**186,829**	**206,427**

* The Trust received £25.5m of STF income comprising £14.5m core STF, £2.6m incentive for undershooting the Trust's control total and an STF bonus of £8.4m as calculated by NHS Improvement.

Note 5.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	14,868	30,439
Purchase of healthcare from non-NHS and non-DHSC bodies	15,467	12,654
Staff and executive directors costs	639,663	599,736
Remuneration of non-executive directors	72	69
Supplies and services - clinical (excluding drugs costs)	135,616	100,400
Supplies and services - general	36,949	34,857
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	124,872	124,924
Inventories written down	405	959
Consultancy costs	291	5,541
Establishment	7,524	7,297
Premises	45,926	41,806
Transport (including patient travel)	13,799	13,303
Depreciation on property, plant and equipment	34,588	33,130
Amortisation on intangible assets	1,675	1,399
Net impairments	5,804	(20,670)
Increase/(decrease) in provision for impairment of receivables	4,790	11,616
Audit fees payable to the external auditor		
audit services- statutory audit	112	137
other auditor remuneration (external auditor only)	18	18
Internal audit costs	307	369
Clinical negligence	30,332	27,575
Legal fees	1,166	546
Insurance	570	440
Research and development	25,539	25,146
Education and training	2,381	2,155
Rentals under operating leases	1,350	7,234
Redundancy	333	244
Hospitality	103	135
Other	2,332	9,329
Total	**1,146,852**	**1,070,788**

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £0m).

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Analysis of net impairments:		
Changes in market price charged to statement of comprehensive income	5,804	(20,670)
Impairments charged to the revaluation reserve	1,042	(379)
Total net impairments	**6,846**	**(21,049)**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	501,954	460,553
Social security costs	53,650	47,351
Apprenticeship levy	2,394	-
Employer's contributions to NHS pensions	54,554	51,363
Pension cost - other	22	19
Termination benefits	333	243
Temporary staff (including agency)	28,370	41,452
Total staff costs	**641,277**	**600,981**
Of which		
Costs capitalised as part of assets	1,281	1,001

Note 7.1 Retirements due to ill-health

During 2017/18 there were five early retirements from the trust agreed on the grounds of ill-health (five in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £311k (£343k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

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

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

a) Accountancy valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website

and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

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

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

Note 9 Operating leases

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	2,038	5,102
Total	**2,038**	**5,102**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year	1,127	1,056
- later than one year and not later than five years	3,283	2,164
- later than five years	1,649	1,655
Total	**6,059**	**4,875**

Note 9.2 Imperial College Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Imperial College Healthcare NHS Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	1,350	7,234
Total	**1,350**	**7,234**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year	1,505	1,709
- later than one year and not later than five years	4,407	4,155
- later than five years	2,164	1,914
Total	**8,076**	**7,778**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	104	104
Total	**104**	**104**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,216	1,190
Total finance costs	**1,216**	**1,190**

Note 12 Other gains/(losses)

The Trust disposed of one asset in-year at NBV (£3.7m). There was no gain or loss on disposal of these asset.

Note 13.1 Intangible assets - 2017/18

	Internally generated information technology £000	Total £000
Valuation/gross cost at 1 April 2017 – brought forward	**8,775**	**8,775**
Additions	-	-
Reclassifications	1,529	**1,529**
Gross cost at 31 March 2018	**10,304**	**10,304**
Amortisation at 1 April 2017 – brought forward	**5,382**	**5,382**
Provided during the year	1,675	**1,675**
Reclassifications	-	-
Amortisation at 31 March 2018	**7,057**	**7,057**
Net book value at 31 March 2018	**3,247**	**3,247**
Net book value at 1 April 2017	**3,393**	**3,393**

Note 13.2 Intangible assets – 2016/17

	Internally generated information technology £000	Total £000
Valuation/gross cost at 1 April 2016 – as previously stated	**8,775**	**8,775**
Additions	-	-
Reclassifications	-	-
Valuation/gross cost at 31 March 2017	**8,775**	**8,775**
Amortisation at 1 April 2016 – as previously stated	**3,983**	**3,983**
Provided during the year	1,399	1,399
Reclassifications	-	-
Amortisation at 31 March 2017	**5,382**	**5,382**
Net book value at 31 March 2017	**3,393**	**3,393**
Net book value at 1 April 2016	**4,792**	**4,792**

Note 13.3 Useful economic lives of intangible assets

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

Note 14.1 Property, plant and equipment – 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 – brought forward	**63,286**	**304,191**	**62,278**	**154,105**	**44,322**	**936**	**629,118**
Additions	-	6,044	49,302	2,029	-	7	57,382
Impairments	-	(29,746)	-	-	-	-	(29,746)
Reversals of impairments	7,930	-	-	-	-	-	7,930
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	34,763	(45,082)	4,476	4,175	139	(1,529)*
Disposals/derecognition	-	-	-	(3,716)	-	-	(3,716)
Valuation/gross cost at 31 March 2018	**71,216**	**315,252**	**66,498**	**156,894**	**48,497**	**1,082**	**659,439**
Accumulated depreciation at 1 April 2017 – brought forward	**-**	**1,436**	**-**	**111,733**	**31,964**	**553**	**145,686**
Provided during the year	-	19,708	-	9,583	5,189	108	34,588
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	(14,970)	-	-	-	-	(14,970)
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2018	**-**	**6,174**	**-**	**121,316**	**37,153**	**661**	**165,304**
Net book value at 31 March 2018	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**
Net book value at 1 April 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**

Note 14.2 Property, plant and equipment – 2016/17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016 – as previously stated	**59,021**	**308,495**	**21,867**	**147,064**	**44,148**	**936**	**581,531**
Additions	-	-	40,411	7,041	174	-	47,626
Impairments	-	(4,304)	-	-	-	-	(4,304)
Reversals of impairments	4,265	-	-	-	-	-	4,265
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2017	**63,286**	**304,191**	**62,278**	**154,105**	**44,322**	**936**	**629,118**
Accumulated depreciation at 1 April 2016 – as previously stated	**-**	**4,476**	**-**	**101,261**	**27,453**	**454**	**133,644**
Provided during the year	-	18,048	-	10,472	4,511	99	33,130
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	(21,088)	-	-	-	-	(21,088)
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2017	**-**	**1,436**	**-**	**111,733**	**31,964**	**553**	**145,686**
Net book value at 31 March 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**
Net book value at 1 April 2016	**59,021**	**304,019**	**21,867**	**45,803**	**16,695**	**482**	**447,887**

*Asset reclassification has occurred between tangible and intangible assets.

Note 14.3 Property, plant and equipment financing – 2017/18

Net book value at 31 March 2018	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned – purchased	71,216	288,135	60,492	31,824	11,344	421	463,432
Owned – government granted	-	1,285	185	396	-	-	1,866
Owned – donated	-	19,658	5,821	3,358	-	-	28,837
NBV total at 31 March 2018	**71,216**	**309,078**	**66,498**	**35,578**	**11,344**	**421**	**494,135**

Note 14.4 Property, plant and equipment financing – 2016/17

Net book value at 31 March 2017	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	63,286	285,429	54,664	38,597	12,358	383	454,717
Owned - government granted	-	1,305	185	472	-	-	1,962
Owned - donated	-	16,021	7,429	3,303	-	-	26,753
NBV total at 31 March 2017	**63,286**	**302,755**	**62,278**	**42,372**	**12,358**	**383**	**483,432**

Note 14.5 Useful economic of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life years	Max life years
Buildings, excluding dwellings	25	60
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	10	10

Note 15.5 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	7,228	5,655
Consumables	5,654	7,760
Energy	189	259
Total inventories	**13,071**	**13,674**

Inventories recognised in expenses for the year were £128,439k (2016/17: £166,340k). Write-down of inventories recognised as expenses for the year were £405k (2016/17: £959k).

Note 16.1 Trade receivables and other receivable

	31 March 2018 £000	*Restated* 31 March 2017 £000
Current		
Trade receivables	112,479	69,549
Capital receivables (including accrued capital related income)	332	332
Accrued income	56,197	58,463
Provision for impaired receivables	(21,826)	(33,886)
Prepayments (non-PFI)	8,071	6,563
Interest receivable	-	6
PDC dividend receivable	295	77
VAT receivable	6,334	4,711
Other receivables	3,472	1,884
Total current trade and other receivables	**165,354**	**107,699**
Of which receivables from NHS and DHSC group bodies	109,749	75,950

Note 16.2 Provision for impairment of receivables

	31 March 2018 £000	*Restated* 31 March 2017 £000
At 1 April as previously stated	**33,886**	**25,820**
Increase in provision	4,790	11,616
Amounts utilised	(16,850)	(3,550)
At 31 March	**21,826**	**33,886**

Note 16.3 Credit quality of financial assets

	31 March 2018 Trade and other receivables £000	*Restated* 31 March 2017 Trade and other receivables £000
Ageing of impaired financial assets		
0-30 days	467	3,095
30-60 Days	32	840
60-90 days	491	1,197
90-180 days	4,640	1,915
Over 180 days	16,196	26,839
Total	**21,826**	**33,886**
Ageing of non-impaired financial assets		
0-30 days	29,349	-
30-60 Days	27,982	-
60-90 days	12,031	15,993
90-180 days	15,243	8,589
Over 180 days	6,048	25,609
Total	**90,653**	**50,191**

Note 17.1 Cash and cash equivalents movements

	2017/18 £000	2016/17 £000
At 1 April	20,975	24,204
Net change in year	3,489	(3,229)
At 31 March	**24,464**	**20,975**
Broken down into:		
Cash at commercial banks and in hand	124	111
Cash with the Government Banking Service	24,340	20,864
Total cash and cash equivalents as in SoCF	**24,464**	**20,975**

Note 17.2 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Monies on deposit	68	59
Total third party assets	**68**	**59**

Note 18.1 Trade and other payables

The Trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	46,848	24,074
Capital payables	23,252	11,257
Accruals	77,600	75,582
Social security costs	7,834	6,922
Other taxes payable	6,738	2,298
Accrued interest on loans	28	30
Other payables	12,315	9,594
Total current trade and other payables	**174,615**	**129,757**
Of which payables from NHS and DHSC group bodies	19,392	13,948

Note 18.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2017 £000
Outstanding pension contributions	8,060	7,518

Note 19 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	35,041	24,330
Deferred grants	-	-
Total other current liabilities	**35,041**	**24,330**

Note 20 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	1,226	1,226
Other loans	357	126
Total current borrowings	**1,583**	**1,352**
Non-current		
Loans from the Department of Health and Social Care	30,497	31,723
Other loans	3,106	886
Total non-current borrowings	**33,603**	**32,609**

The Trust is party to five loans as follows:

Loan 1 – capital investment of £24.5m. Commencing 15 March 2011 and continuing until settled on 31 March 2031. Fixed interest rate of 3.95%

Loan 2 – working capital facility of £15.8m. Commencing 7 April 2016 and continuing until settled on 31 March 2021. Fixed interest rate of 3.5%

Loan 3 – energy efficiency loan of £1m. Commencing 10 March 2017 and continuing until settled on 1 February 2021. Interest free loan

Loan 4 – energy efficiency loan of £1.05m. Commencing 20 October 2017 and continuing until settled on 1 April 2023. Interest free loan

Loan 5 – joint arrangement loan of £1.6m. Commencing 1 April 2017. Interest free loan, non-repayable subject to going concern of the arrangement

Note 21.1 Provisions for liabilities and charges analysis

	Redundancy £000	Legal claims £000	Other £000	*Restated* Total £000
At 1 April 2017	**351**	**109**	**43,438**	**43,898**
Arising during the year	242	400	15,681	16,323
Utilised during the year	(316)	(20)	(6,290)	(6,626)
Reversed unused	(179)	-	(8,445)	(8,624)
At 31 March 2018	**98**	**489**	**44,384**	**44,971**
Expected timing of cash flows:				
- not later than one year	98	489	44,384	44,971
- later than one year and not later than five years	-	-	-	-
- later than five years	-	-	-	-
Total	**98**	**489**	**44,384**	**44,971**

Note 21.2 Clinical negligence liabilities

At 31 March 2018, £397,194k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Imperial College Healthcare NHS Trust (31 March 2017: £305,678k).The other classification within provisions includes provisions against a number of potential liabilities, details of which cannot be disclosed due to commercial sensitivity. As has been disclosed in note 1.1.2, there is significant uncertainty as to the timing of these outflows.

Note 22 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(87)	(71)
Gross value of contingent liabilities	**(87)**	**(71)**
Net value of contingent assets	**-**	**-**

Note 23 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	3,761	8,673
Total	**3,761**	**8,673**

Note 24 Financial instruments

Note 24.1 Financial risk management

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

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

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

The Trust also borrows from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31 March 2018 is in receivables from customers, as disclosed in the trade and other receivables note. At the 31 March 2018 the main customer debts totaled £47.9m for which the Trust feels it has made adequate provision.

Liquidity risk

Liquidity risk reflects the risk that the Trust will have insufficient resources to meet its financial liabilities as they fall due. Management have noted areas of uncertainty affecting liquidity in the going concern disclosure in note 1.12. Mitigating this, the Trust's operating costs are incurred in relation to contracts with CCGs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure from internally generated resources. The Trust's strategy is to manage liquidity risk by ensuring that the Trust has sufficient funds to meet all of its potential liabilities as they fall due. Liquidity forecasts are produced regularly to ensure the utilisation of current facilities is optimised and liquidity is maintained. The Trust also continually assesses its loan funding.

Note 24.2 Carrying values of financial assets

	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	150,654	**150,654**
Cash and cash equivalents at bank and in hand	24,464	**24,464**
Total at 31 March 2018	**175,118**	**175,118**

	Restated Loans and receivables £000	*Restated* Total book value £000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	82,247	**82,247**
Cash and cash equivalents at bank and in hand	20,975	**20,975**
Total at 31 March 2017	**103,222**	**103,222**

Note 24.3 Carrying value of financial liabilities

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease	35,186	35,186
Trade and other payables excluding non financial liabilities	151,995	151,995
Provisions under contract	23,118	23,118
Total at 31 March 2018	**210,299**	**210,299**

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease	33,961	33,961
Trade and other payables excluding non financial liabilities	115,166	115,166
Total at 31 March 2017	**149,127**	**149,127**

Note 24.4 Maturity of financial liabilities

	31 March 2018 £000	*Restated* 31 March 2017 £000
In one year or less	176,696	116,518
In more than one year but not more than two years	-	-
In more than two years but not more than five years	17,798	16,804
In more than five years	15,805	15,805
Total	**210,299**	**149,127**

Note 25 Losses and special payments

	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	20	93	39	47
Bad debts and claims abandoned	217	15,418	342	1,212
Stores losses and damage to property	12	403	14	960
Total losses	**249**	**15,914**	**395**	**2,218**
Special payments				
Compensation under court order or legally binding arbitration award	2	6	5	34
Ex-gratia payments	60	1,582	99	20
Total special payments	**62**	**1,588**	**104**	**54**
Total losses and special payments	**311**	**17,502**	**499**	**2,272**

The Trust had two high value losses exceeding £300k.

Note 26 Related parties

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

The Department of Health and Social Care is regarded as a related party. During the year 2017/18 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below detailing income and expenditure for the year along with the debtor and creditor as at 31 March 2018.

2017/18	Creditor £000s	Debtor £000s	Income £000s	Expenditure £000s
Department of Health and Social Care	0	480	42,238	5
NHS England	22	43,111	392,831	5
NHS Foundation Trusts including:				
Chelsea and Westminster	2,224	5,044	26,912	5,507
CCGs including:				
Brent	794	2,440	65,220	0
Camden	83	1,580	8,535	0
Central London (Westminster)	335	6,654	62,130	11
Ealing	993	2,610	78,045	0
Hammersmith and Fulham	815	9,763	91,932	406
Harrow	124	854	12,466	0
Hillingdon	81	560	13,340	0
Hounslow	160	1,368	34,458	0
Richmond	31	338	10,320	0
West London (Kensington & Chelsea & Qpp)	461	6,989	76,729	23
NHS Trusts	4,329	4,185	5,094	7,819
Other NHS Bodies including:				
Health Education England	0	1,272	57,448	6
NHS Litigation Authority	0	11	0	30,826
NHS Pension Scheme	8,060	0	0	54,554
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	1,281	26	262	7,777
Other				
Imperial College London	2,482	5,223	8,247	23,472
Imperial Health Charity	30	2,411	8,769	376
HM Revenue and Customs	14,572	6,334	0	56,044

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

2016/17	Creditor £000s	Debtor £000s	Income £000s	Expenditure £000s
Department of Health	23	211	47,172	0
NHS England	408	31,149	360,540	48
NHS Foundation Trusts including:				
Chelsea and Westminster	1,864	2,628	20,065	3,182
CCGs including:				
Brent	938	1,611	61,113	0
Camden	88	669	8,060	0
Central London (Westminster)	640	3,973	56,615	375
Ealing	1,181	2,963	76,522	0
Hammersmith and Fulham	733	5,449	86,183	400
Harrow	124	670	12,568	0
Hillingdon	139	600	12,890	0
Hounslow	171	1,430	33,753	0
Richmond	157	93	9,947	0
West London (Kensington & Chelsea & Qpp)	493	3,173	72,507	9
NHS Trusts	4,329	4,319	4,950	8,437
Other NHS Bodies including:				
Health Education England	95	1,166	60,208	9
NHS Litigation Authority	10	0	54	28,098
HM Revenue and Customs	9,220	4,711	0	47,351
NHS Pension Scheme	7,517	0	0	51,363
NHS Bodies outside DH Group including:				
NHS Blood & Transplant	106	15	405	7,326
Other				
Imperial College London	2,537	916	7,677	1,975
Imperial College Healthcare Charity	0	496	7,757	627
HM Revenue and Customs	11,656	3,230	0	37,366

Note 27 Events after the reporting date

There are no events after the end of the reporting period that warrant disclosure in these accounts.

Note 28 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	157,636	522,267	164,400	518,951
Total non-NHS trade invoices paid within target	129,732	413,185	128,391	398,730
Percentage of non-NHS trade invoices paid within target	**82.30%**	**79.11%**	**78.10%**	**76.83%**
NHS Payables				
Total NHS trade invoices paid in the year	5,255	78,301	5,967	61,199
Total NHS trade invoices paid within target	2,776	45,802	3,205	40,271
Percentage of NHS trade invoices paid within target	**52.83%**	**58.49%**	**53.71%**	**65.80%**

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

Note 29 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Net cash (generated from)/used in operations	(25,351)	(26,226)
Net cash (generated from)/used in investing activities	34,626	44,839
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**9,275**	**18,613**
External financing limit (EFL)	13,946	18,653
Under/(over) spend against EFL	4,671	40

Note 30 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	57,382	47,626
Less: Disposals	(3,716)	-
Less: Donated and granted capital additions	(6,935)	(8,503)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	46,731	39,123
Capital Resource Limit	47,529	39,123
Under/(over) spend against CRL	798	-

Note 31 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus/(deficit) (control total basis)	3,023
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus/(deficit)	3,023

Note 32 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)	(15,330)	3,023
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283	6,953	9,976
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905	1,096,575	1,160,803
Cumulative breakeven position as a percentage of operating income		3.76%	4.24%	3.25%	4.08%	5.59%	7.01%	2.18%	0.63%	0.86%

Appendix one

List of internal audits completed in 2017/18, and relevant assurance level

System	Type	Assurance assessment
Board assurance framework	Assurance	Substantial assurance
Capital programme monitoring	Assurance	Substantial assurance
Specialist services pass through costs equipment and drugs	Assurance	Substantial assurance
Learning lessons from complaints	Assurance	Substantial assurance
Venous thromboembolism (VTE)	Assurance	Substantial assurance
ICT – project reviews – GDE project	Assurance	Substantial assurance
Disciplinary procedure	Assurance	Substantial assurance
Grievance procedure	Assurance	Substantial assurance
Occupational health	Assurance	Reasonable assurance
Mortality governance guide	Assurance	Reasonable assurance
ICT – disaster recovery and system resilience (Cerner 724)	Assurance	Reasonable assurance
ICT – project reviews – depart inpatient discharge project	Assurance	Reasonable assurance
ICT – cardiology system	Assurance	Reasonable assurance
IG toolkit v15 part two	Assurance	Reasonable assurance
Private patients	Assurance	Reasonable assurance
Mandatory and statutory training	Assurance	Reasonable assurance
Divisional clinical governance reviews: women's, children's and clinical services	Assurance	Reasonable assurance
Divisional clinical governance reviews: surgery, cancer and cardiovascular	Assurance	Reasonable assurance
Divisional clinical governance reviews: medicine and integrated care	Assurance	Reasonable assurance
Imperial Private Healthcare clinical governance review	Assurance	Reasonable assurance
Financial ledger	Assurance	Reasonable assurance
Accounts receivable	Assurance	Reasonable assurance
Payroll assurance	Assurance	Reasonable assurance
Business continuity planning	Assurance	Reasonable assurance
Workforce utilisation – e-rostering*	Assurance	Reasonable assurance
Maternity waiting times*	Assurance	Reasonable assurance
Renal dialysis income data quality	Compliance	Reasonable assurance
Neonatal critical care income data quality	Compliance	Reasonable assurance
Overseas visitors	Assurance	Limited assurance
Accounts payable	Assurance	Limited assurance

Strategic procurement*	Assurance	Limited assurance
Consultant job planning performance follow up review*	Assurance	Limited assurance
RTT procedures*	Assurance	Limited assurance
Diagnostics procedures*	Assurance	Limited assurance
Paediatrics critical care income data quality	Compliance	Limited assurance
Cardiology community services income data quality*	Compliance	Limited assurance
Ophthalmology community services income data quality*	Compliance	Limited assurance
Radiology income data quality	Compliance	Limited assurance
Radiotherapy income data quality*	Compliance	Limited assurance
CPR escalation*	Compliance	Limited assurance

*reports remained in draft as at 25 May 2018

A number of further reviews were undertaken where an assurance level was not appropriate/ required:

- Divisional governance overview
- Budget maturity assessment*
- Data quality framework*
- Readiness assessment EU general data protection regulations (EU GDPR).

Appendix two

Trust board declarations of interest

Trust board of directors – declarations of interests

Sir Richard Sykes – Chairman
- Advisor - Healthcare at Home
- Director – EDBI Pte Ltd
- Chairman – Singapore Biomedical Sciences International Advisory Council
- Chairman – UK Stem Cell Foundation
- Non-Executive Chairman – NetScientific plc
- Chairman – Royal Institution of Great Britain
- Chancellor – Brunel University
- Chairman – PDS Biotechnology Corporation

Sir Gerald Acher – Deputy chairman
- Vice Chairman – Motability
- President – Young Epilepsy
- Chairman – Brooklands Museum Trust
- Chairman – Chatterbus CIO
- Chairman – Cobham Conservation and Heritage Trust
- Trustee – Motability 10th Anniversary Trust

Sarika Patel – Non-executive director
- Board – Royal Institution of Great Britain
- Director – London General Surgery
- Commissioner and Board member – Board of the Gambling Commission
- Board member – Office of Nuclear Regulation

Dr Andreas Raffel – Non-executive director
- Senior Adviser – Rothschild
- Member of board of trustees – University of Bristol
- Deputy Chair – Change Grow Live
- Member international advisory board – Cranfield School of Management
- Member of advisory board – Flagstone Investment
- Management Senior Advisor – Moonfare

Professor Andrew Bush – Non-executive director
- Chairman – Publications Committee of the European Respiratory Society (sit on the Executive and Steering Committees)
- Senior Investigator – NIHR
- 15 various research grants (information available upon request)

Peter Goldsbrough – Non-executive director
- Non-Executive Director – R J Young (Properties) Ltd
- Non-Executive Director – Jenkinsons Holding Ltd
- Senior Advisor – The Boston Consulting Group
- Visiting Professor – Institute of Global Health Innovation, Imperial College London
- Spouse – Non-Executive Director, NHS England

Victoria Russell – Non-executive director
- Partner – Fenwick Elliott LLP
- Deputy Chairman – Livery Committee
- Trustee and Committee Member – Sulgrave Club for Young People

Dr Julian Redhead – Interim chief executive officer
- Royal Society Prevention of Accidents
- Medical Director – Fortius Clinic
- Major incident doctor – London Ambulance Service
- Doctor – Chelsea Football Club
- Stadium Doctors Ltd
- Shareholder – Fortius Clinic
- Shareholder – Opus Clinic
- CQC inspector
- Private practice at Fortius Clinic and at the Trust

Professor Janice Sigsworth – Director of nursing
- Honorary professional appointments – King's College London, Bucks New University and Middlesex University
- Trustee – General Nursing Council Trust
- Clinical adviser – NMC review of pre-registration nursing standards
- Chair – Shelford chief nurses group

Richard Alexander – Chief financial officer
- Non-Executive Director – HDI (Health Data Insights)
- Ex-Oracle employee and current shareholder

Professor Timothy Orchard – Interim medical director
- Pharmaceutical Advisory Boards (adhoc) – Vifor Pharma, Celgene, Abbvie and Ferring
- Medical Advisor – NW London Crohn's and Colitis UK
- Private practice at the Trust and the London Clinic

Dr William Oldfield – Interim medical director
- Nil

Imperial College Healthcare
NHS Trust

Charing Cross Hospital

Fulham Palace Road
London W6 8RF

020 3311 1234

Hammersmith Hospital

Du Cane Road
London W12 0HS

020 3313 1000

Queen Charlotte's & Chelsea Hospital

Du Cane Road
London W12 0HS

020 3313 1111

St Mary's Hospital

Praed Street
London W2 1NY

020 3312 6666

Western Eye Hospital

Marylebone Road
London NW1 5QH

020 3312 6666

www.imperial.nhs.uk

Follow us @imperialNHS