A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Annual Report and Accounts 2015/16

Royal Brompton & Harefield NHS Foundation Trust

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Annual Report 2015-16

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Introduction

The following pages constitute the Annual Report of Royal Brompton & Harefield NHS Foundation Trust for its sixth full year as a Foundation Trust, for the period 1st April 2015 to 31st March 2016. The information contained in this Report is presented and prepared in accordance with the requirements set out by Monitor in the "*NHS Foundation Trust Annual Reporting Manual 2015-16*".

The Trust was shocked when, on 31st March 2016, our Chairman Sir Robert Finch passed away after a short illness. Sir Robert will be greatly missed by patients and staff of Royal Brompton and Harefield Hospitals, for whom he was a passionate and determined advocate.

Overall Performance

During 2015/16 the Trust cared for over 190,000 patients at our out-patient clinics and over 40,000 patients of all ages on our wards. The Trust maintained a green governance rating with Monitor and delivered its financial plan. More detailed information can be found both within this Annual Report and within the Quality Report. There follows a brief overview of the main areas of focus for the year.

Re-developments

The Trust remains committed, in order to meet pressing clinical need, to redeveloping premises at its current locations and is advancing plans for the re-development of both campuses.

Over the past twelve months the Trust's redevelopment plans for Royal Brompton Hospital have evolved. Royal Brompton's Fulham Wing opened in 1882 and the needs of modern healthcare bear little resemblance to those that existed at the time. For example, current national standards require more space for each patient to cater for modern equipment and to help prevent cross infection (single rooms are the gold standard). The design of the building means technological advances in patient care cannot be supported easily, if at all. Services are split across our Chelsea sites, causing discomfort and inconvenience for seriously ill patients, increasing anxiety and wasting their time. It is becoming increasingly difficult to attract the best expertise available to join our respiratory teams. Clinicians need to know that appropriate facilities are a very real prospect.

By disposing of land not currently used for clinical care, the Trust will be in a position to self-fund a vital extension to its Sydney Street campus, which will house respiratory inpatient care and be located on current Trust land. This will be a state-of-the-art facility, designed with the help of the Cystic Fibrosis Trust and other partners. It will be linked by bridges to the main hospital building in Sydney Street to facilitate easy movement of patients and staff. Detailed plans are not finalised but at least 80 beds will be available for the re-provision of respiratory inpatient care, along with diagnostic services. The new wing can be built in a three year timeframe once the necessary permissions and design work are completed and will enable clinical teams to continue their ground breaking work – treating more patients with serious respiratory conditions and developing new treatments in the fight against lung disease.

A modernised state-of-the art imaging centre will also be constructed to replace the current Imatron Unit, and will house three new MRI scanners and associated facilities. The space released in Fulham Wing will continue to be used in a clinical capacity for expanded and improved outpatient services, research, education and administration Fulham Wing will remain in clinical use for the foreseeable future.

The funding for this redevelopment is to be derived from the sale, with the benefit of planning permission for residential and retail uses, of a non-operational Trust property. Discussions with the relevant planning authority, the Royal Borough of Kensington & Chelsea, are well advanced and consultation with local residents and others is underway.

In recent months Transport for London has safeguarded the land identified for sale, and other non-operational Trust properties, pending a decision about a Crossrail 2 station in Chelsea. Discussions are in progress with Transport for London to agree how both parties can achieve their objectives should the decision to build in Chelsea, on the Trust's land, be taken.

The Trust intends to submit linked planning applications in summer 2016 for both the hospital extension and the non-operational property with a target date for securing approval by the end of the calendar year.

A parallel project supported by NHS England to jointly build a shared clinical facility with The Royal Marsden Hospital on the Trust's Chelsea campus was halted in January 2016, as it became apparent that central funding of monies to support capital expenditure would not be forthcoming in the present financial climate.

Redevelopment Plans at Harefield Hospital continue to progress. An extension to the Critical Care Unit and a new Imaging Centre are under construction and the Trust is working towards a new master plan for the site.

A new outpatient and diagnostic facility is due to open at Wimpole Street in June 2016. This will offer private outpatient appointments, as well as state of the art imaging and scanning services. The diagnostic services will be shared with NHS teams.

Financial landscape

An ongoing area of major challenge has been financial performance against the backdrop of changes to tariff made by NHS England and Monitor. The Trust provides highly specialised services that are not adequately recompensed through existing tariff arrangements alone. In previous years, financial balance has been achieved through a combination of income from both non-NHS sources and top up funding (Project Diamond) received from the Department of Health / NHS England in recognition of case complexity. While pleased that the planned financial outcome for 2015/16 was achieved, the Trust Board cannot stress enough the importance of ensuring that the costs of delivering specialised services are recognised in the tariff from April 2017 onwards. More details of financial performance are given on page 12 of this report.

The Trust is committed to the provision of high quality services for patients of all ages. Future plans and strategy revolve around the development of the Trust's infrastructure in order to ensure that our patients are cared for in an environment that is aligned with the expectations for healthcare in the 21st century.

Towards the end of 2015/16, NHS Improvement published requirements for provider Trusts and other bodies to participate in the production of 5 year Sustainability & Transformation Plans ('STPs'): these are intended to be 'place based', in other words to reflect geographical planning footprints. As a specialist tertiary provider we, along with a limited number of other specialist Trusts, do not fit sensibly in a geographic footprint. Instead, we and a handful of other London-based Trusts will be included in a STP to be led by NHS England – London although we have also participated in meetings of the NW London STP group.
The deadline for submission of STPs is 30 June 2016.

From 2017/18 it is intended that additional Sustainability & Transformation Funding will be allocated based solely on the quality of STPs as a means of transforming the provision of healthcare.

..... **Robert J Bell** **25th May 2016**
Chief Executive

..... **Neil Lerner** **25th May 2016**
Deputy Chairman

For queries regarding this Annual Report please contact, in the first instance:
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Who we are and what we do

Royal Brompton & Harefield NHS Foundation Trust is a national and international specialist heart and lung centre based in Chelsea, London and Harefield, Middlesex.

As a specialist Trust we only provide treatment for people with heart and lung disease. This means our doctors, nurses and other healthcare staff are experts in their chosen fields, and many move to our hospitals from throughout the UK, Continental Europe and beyond, so they can develop their particular skills even further.

We carry out some of the most complicated surgery, and offer some of the most sophisticated treatments available anywhere in the world. Consequently, our patients come from all over the UK and internationally, and not just from our local areas.

We help patients of all ages who have heart and lung problems. Our care extends from the womb, through childhood, adolescence and into adulthood. Our foetal cardiologists can perform scans at just 12 weeks, when a baby's heart valve is just over a millimetre in size, and our clinical teams regularly treat patients well into their 90s.

One of the reasons for our success is our teamwork. Our internationally acclaimed multidisciplinary clinical and research teams have become established over many years and they work together throughout the Trust to deliver seamless co-ordinated, specialist care to every patient.

From the moment they arrive, our patients become part of a supportive community of people who have benefited from more than 160 years of expert diagnosis, treatment and long-term care. Each member of staff is dedicated to patient care, from the very first contact a patient has with us to follow-up care at home or in the community.

Over the years, our experts have been responsible for several major medical breakthroughs – discovering the genetic mutation responsible for the heart condition dilated cardiomyopathy, founding the largest centre for the development of new treatments for cystic fibrosis in Europe, and pioneering intricate heart surgery for newborn infants.

Research programmes play a vital role at both our hospitals. This is because the most talented medical experts are rarely content with using tried and tested methods to treat their patients. The opportunity to influence the course of modern medicine by developing new treatments is a prospect which attracts them to specialist centres, where research opportunities are a fundamental part of delivering patient care.

Education is a key component underpinning the Trust's vision, and is essential to the delivery of high quality services.

❖ Our strategy

Our mission is to be the UK's leading specialist centre for heart and lung disease.

The Trust will achieve this mission by a strategy of focused growth in aspects of heart and lung treatment, particularly in congenital heart disease, arrhythmia, advanced lung diseases and heart failure. Our approach:

- Continual development of leading edge services through clinical refinement and research
- Effective and efficient delivery of core specialist treatment
- Managing the transition of more routine services to other centres to release capacity for new interventions.

Remaining an autonomous, specialist organisation is central to preserving and building on our strong clinical and organisational record.

However, we are equally convinced of the importance of effective partnerships, particularly with nearby Trusts and major academic bodies, to ensure a continuing pipeline of innovations to develop future treatments.

Our vision is to create a hospital environment that promotes world-class patient care and supports innovation, cutting edge research and education. Our ambition is to create new facilities equipped with the latest technology to accelerate the fight against heart and lung disease – two of the world's biggest killers.

Further information concerning the Trust's forward plans can be found in the Operational Plan for 2016/17 which has been submitted to Monitor. This document is also available through the Monitor web site.

Our 2014-19 Strategic Plan highlighted the Trust's ambitions to develop both the quality and capacity of its facilities in order to provide improved patient care. A key element was the proposal to redevelop Royal Brompton Hospital financed by the sale of certain Trust-owned properties with the benefit of planning permissions to enhance their values. This ambition has, at least into the medium-term, been thwarted by a combination of planning and 'political' factors.

However, the Strategic Plan also noted that the Trust was planning to invest in its Harefield Hospital facilities to provide new and improved capacity on that site (thereby accommodating a reconfiguration of services between our sites); to update/replace antiquated Trust-wide IT systems; and to establish additional private patient facilities in leased off-site premises.

The financial outcome achieved for 2015/16, in particular following the withdrawal of Project Diamond top up funding, meant that the Trust's ability to finance its capital programme through internally generated cash flow was significantly reduced. It has been necessary to defer some items of capital expenditure and to cancel others, but much of the investment was and remains committed. The planned programme is anyway essential to maintain the Trust's pre-eminent status as a nationally and internationally recognised specialist provider of cardiac and respiratory services.

Accordingly, the Trust during the year agreed with the Independent Trust Financing Facility a further £20m loan facility to fund continuing capital expenditures.

❖ Our Values

At the core of any organisation are its values: belief systems that are reflected in thought and behaviour.

Our values were developed by staff for staff. We have three core patient-facing values and four others which support them.

Our three **core** values are:

1. We care

We believe our patients deserve the best possible specialist treatment for their heart and lung condition in a clean and safe place.

2. We respect

We believe that patients should be treated with respect, dignity and courtesy and that they should be well informed and involved in decisions about their care. We always have time to listen.

3. We are inclusive

We believe in making sure our specialist services can be used by everyone who needs them, and we will act on any comments and suggestions which can help us improve the care we offer.

The following values support us in achieving them:

1. We believe in our staff

We believe our staff should feel valued and proud of their work and know that we will attract and keep the best people by understanding and supporting them.

2. We are responsible

We believe in being open about where our money goes, and in making our hospitals environmentally sustainable.

3. We discover

We believe it is our duty to find and develop new treatments for heart and lung disease, both for today's patients and for future generations.

4. We share our knowledge

We believe in sharing what we know through teaching, so that what we learn can help patients everywhere.

❖ Our position in the healthcare market

A growing market

Heart and lung diseases are the world's biggest killers. Overall, the demand for treatment is high and growing, as a result of both increased need and national policy initiatives to meet that need.

Our international role

The Trust does not operate in a single, local health economy. The Trust treats patients referred by the health services in other parts of the United Kingdom as well as treating patients referred from other countries, either though government schemes, or as private patients. The size of the patient population served by the Trust creates the opportunity to undertake research and development projects on a scale that is attractive to the research and development arms of global enterprises.

A strong reputation

Our strong reputation, both in the UK and internationally, enables us to maintain and grow our market position, both by developing new interventions and by securing referral patterns through established networks of referring hospitals.

NHS Services

The majority (over 80%) of the NHS services provided by the Trust are commissioned by NHS England. The bulk of the remainder is commissioned by Clinical Commissioning Groups (CCGs) which cover the whole population of England. The services commissioned by NHS England, and those commissioned by CCGs, are commissioner requested services covered by the Trust's NHS Provider Licence issued by Monitor.

Private Patients Unit

The Trust continues to build upon its world-class private patient business at both Royal Brompton and Harefield hospitals, under the brand name 'Royal Brompton and Harefield Hospitals Specialist Care' (RB&HH).

During 2015/16 the business has continued to see growth in both its UK and international markets driven by business development and marketing initiatives targeted at the UK self-pay and Middle East markets, as well as looking at new markets and services. The increasing demand for complex specialist care has resulted in an increase in our private patient income for the Trust to exceed £39m in 2015/16.

New Facilities and services

The Trust is due to open an outpatient and diagnostic facility at Wimpole Street in June 2016 offering private outpatient appointments in the prestigious Harley Street medical district, as well as state of the art imaging and scanning services

The facility will be the only centre in the UK that will offer Rubidium Cardiac PET scans, which provide a faster imaging protocol and less radiation burden to patients. In addition, the diagnostic facilities will include CT, MRI, echocardiography, lung function, non-invasive cardiology facilities, and x-ray.

RB&HFT is the first heart and lung specialist NHS trust to open a private outpatients' facility in the Harley Street area. While the premises will be primarily for use by private patients, the diagnostics facilities will be shared with NHS teams.

During the coming year 2016/17 an additional private patients' treatment room will be opened at Royal Brompton and a proposal to open a new private ward and consulting rooms at Harefield Hospital will also be progressed.

Overseas Collaboration

2015/16 represented a new era of overseas collaboration for the Trust, as patient referral streams continue to grow from the Middle East market. During the year the Trust was involved in negotiations for a contract in connection with a new collaboration in Kuwait, and new business is gradually increasing from emerging markets such as China.

Our staff and consultants attended a number of health conferences throughout the Middle East to showcase some of our most pioneering treatments and procedures. We work closely with government departments, hospitals and other medical organisations across the Gulf region to promote clinical excellence and exchange clinical knowledge. In addition, the private patients' team joined a Healthcare UK senior delegation to visit a number of cities within China to gain a better understanding of the opportunities for the NHS and UK healthcare within this market.

Research and Development

Research is an integral component of the Trust's mission to provide better care for patients in the NHS and beyond. Research activities in the Trust are guided by a Board approved strategy that seeks to enhance and further the Trust's reputation in pioneering, world class cardiothoracic research.

During 2015/16, research income to the Trust (£11.9m) continued to rise in line with the Research Strategy to grow the business. Over 4,400 patients participated in our research endeavours with 2,161 patients taking part in NIHR portfolio research studies and 1,347 patients consenting to donate their tissue for retention within the Trust's ethically approved NIHR Biomedical Research Unit Biobanks.

In addition the Trust is part of West London NHS Genomic Medicine Centre and to date 47 Trust patients have consented to participation in this National 100k Genome project for rare diseases.

Other highlights include:

- Over £2m of funding awarded to Trust academics from a wide variety of funding bodies including the NIHR, Wellcome Trust, British Lung Foundation and the Health Foundation
- Over £500k of NIHR funding awarded to two allied health professional staff in dietetics and physiotherapy, to undertake prestigious research training fellowships
- Seven NIHR Senior Investigators. This award recognises the top 200 clinical and applied health researchers in the UK, with the Trust having appointments spanning the fields of cardiology, respiratory medicine, radiology and paediatrics
- Over 370 research publications associated with the Trust's two NIHR Biomedical Research Units and a recent RAND[1] analysis identified the Trust / Imperial College as nationally leading in both respiratory and cardiovascular diseases, and to be the highest ranked collaborative partnership in any field in terms of highly cited papers.

Our research activities are underpinned by Trust-wide research management and governance processes and in 2015 the Trust, via the Research Management Committee, launched a new initiative – the Research Development Programme for Allied Health Professionals and Nurses. This aimed to develop fundamental research skills amongst these staff groups, enabling them to engage effectively in the Trust's research activities and giving them the confidence to lead their own research projects. The programme was followed by a competitive pump priming funding scheme specifically for this underrepresented staff group, providing the means for them to lead research projects where they may not previously have had an opportunity. Four awards totalling £30k were made, funded by our two NIHR Biomedical Research Units.

An application is underway to secure further NIHR funding to support research in the future once the current funding allocation finishes at the end of the 2016/17 financial year.

[1] Bilbliometric analysis of highly cited publications of biomedical and health research in England, 2004–2013 by Salil Gunashekar, Sarah Parks, Clara Calero-Medina, Martijn Visser, Jeroen van Honk, Steven Wooding

Education

The Trust's vision is to be the UK's leading specialist centre for heart and lung disease in the UK. Education, and in particular the dissemination of knowledge and skills, underpins this vision, not only by ensuring that staff have the expertise to deliver these services but also by enhancing external reputation and influence so as to secure both a strong referral base and high-calibre clinical talent.

The Trust is currently working to develop a five year strategic plan for education. Delivery of the plan will be overseen by an Educational Board with members drawn from the medical consultant body, nursing, allied health professions and the learning and development team. The Educational Board will enable the Trust to draw together the various strands that make up the Trust's educational activities. This will enable existing activities to be co-ordinated and will facilitate the exploration of new income generating opportunities such as exist in online education, promotion of existing in-house courses and the development of a visitors and observers programme.

Going Concern

The Directors have carefully considered the financial position of the Trust and its expected future performance given the demanding financial context in which it is operating.

Key factors have included:

- Likely future developments in tariffs and specialist top ups
- Achievement of planned savings targets
- The level of planned capital expenditures
- The planned sale of an investment property, including its probability, quantum of sale proceeds and timing
- The intended expansion of private patient activities both in the UK and overseas to subsidise loss-making NHS work
- The availability of borrowings, including the continuation of the Trust's revolving credit facility

These factors have been the subject of sensitivity analysis against which the Trust's capacity to mitigate downside risks has been assessed.

Having made appropriate enquiries, the Directors have concluded that there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. Accordingly, they continue to adopt the going concern basis in preparing the accounts.

1.2 Performance Analysis

Trust Financial Performance for 2015/16

The Trust has reported a deficit for the year of £9.7m (2014/15 – deficit of £3.3m) after paying a dividend of £6.7m (2013/14 - £6.7m) on Public Dividend Capital. This reflected year on year income growth from patient care activities, including private patient activities and excluding the value of Project Diamond income as referred to below, of 1.3% together with the related costs of service. Growth in NHS income in the year was constrained by the Trust's block contract with NHS England which set a fixed quantum from this source.

From 1 April 2015 Project Diamond income was discontinued: this income had recognised that standard tariff payments were (and remain) insufficient to compensate the Trust for the complex procedures it undertakes as a tertiary healthcare provider. In the year 2014/15 this source had amounted to £13.1m. The planned introduction from 1 April 2015 of a revised basis of tariff, HRG 4+, which takes better account of case complexity than the existing reimbursement model, was unfortunately deferred (and has since been further deferred until 1 April 2017 at the earliest).

As well as the loss of Project Diamond income the Trust had to absorb cost increases and a general tariff reduction from 1 April 2015: it was therefore obliged for the first time in its existence as a Foundation Trust to budget a deficit for the year. The reported outcome is marginally better than the planned £10m shortfall although EBITDA at £5.8m was behind the planned figure of £9.2m.

Following a property valuation undertaken by a firm of independent valuers, the accounts reflect a net revaluation surplus of £3.5m (2014/15 – deficit of £0.6m) in relation to the Trust's investment properties and a surplus in other comprehensive income of £7.1m (2014/15 – £1.3m) in relation to its operational properties. In accordance with relevant accounting standards, the first is reflected in the result for the year and the second in the revaluation reserve. The surplus for the year also reflects a credit to operating income of £1.5m (2014/15 – charge of £3.5m): this represents the reversal of previously impaired consultancy costs for the redevelopment of Royal Brompton Hospital, certain of which have been assessed as having ongoing value in light of the Trust's revised redevelopment proposals, less the winding-down costs of abandoned proposals.

The Trust invested £24.7m (2014/15 – £27.6m) in fixed assets during the year under review of which £2.9m (2014/15 – £2.8m) was funded by donations from the Trust's linked Charity. These investments in the Trust's future operations reflect the need to maintain capital expenditures at levels above historical norms in order to expand, improve and replace facilities, equipment and IT systems.

In 2014 the Trust secured a £30m loan facility from the Independent Trust Financing Facility ('ITFF'). These funds are being drawn down over three years and will then be repayable over the following 12 years. In July 2015 the Trust secured a further £20m facility from the ITFF to be drawn down over the following two years and repayable over the following 12 years. Both facilities are being used to support the Trust's capital expenditure programme prior to commencing construction of the redeveloped Royal Brompton Hospital. At 31 March 2016 £27.5m had been drawn down against these facilities.

In 2014 the Trust also agreed a £10m borrowing facility from a private sector banking institution to enable it to fit out a proposed private patient diagnostic and outpatient facility in Wimpole Street. This will be drawn down within the next 12 months in line with the associated capital expenditure payment profile after which it will be repayable over the following five years. At 31 March 2016 £2.3m had been drawn down against these facilities.

During the year the Trust's cash position was aided by both the payment profile of the NHSE block contract and the continuing drawdowns against its ITFF loan facilities. In contrast, it was adversely affected by both the withdrawal of Project Diamond income and tariff reductions. Moreover, there continue to be substantial payment delays by certain private patient debtors.

The net impact of these factors resulted in the balance of net cash and cash equivalents climbing to £13.0m at 31 March 2016 from a net overdrawn position of £0.5m one year earlier.

Note: the accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.

Trust Performance Against Monitor Governance Indicators 2015/16

The following table shows performance against Monitor's Governance Indicators throughout 2015/16:

Monitor: Governance Indicators 2015/16										
Indicator	**Threshold**		**Q1**		**Q2**		**Q3**		**Q4**	
Clostridium difficile	Monitor de minimis = 12		1	Met	0	Met	0	Met	0	Met
18 weeks RTT Incomplete Pathway	92%		91.7%	Not Met	92.1%	Met	91.8%	Not Met	89.31%	Not Met
Cancer – 14 day Urgent GP Referral	93%	Not Assessed (N/A) if 5 cases or fewer in a quarter	100%	Met	<5	N/A	<5	N/A	<5	N/A
Cancer – 31 day 1st treatment	96%		100%	Met	100%	Met	96.8%	Met	96.64%	Met
Cancer – 31 day subsequent treatment	94%		100%	Met	100%	Met	100%	Met	95.88%	Met
Cancer – 62-day wait for cancer first treatment - post local breach re-allocation	85%		47.2%	Not Met	69.1%	Not Met	50%	Not Met	62.26%	Not Met

All of the indicators have been met apart from the 62 day cancer waiting time target and the 18 weeks RTT incomplete pathway target.

During 2015/16 the Trust continued to work through the action plan which followed from the clinical review, commissioned by the Trust's Medical Director, of the Lung Cancer Service. The root cause of the breach of the target remains largely late referrals received from other Trusts. In many cases patients are referred to the Trust after day 62 has already passed. The Trust engaged with both Monitor and NHS England in the work that was done during 2015/16 on measurement of the target. On 10th December 2015, the Trust gave a presentation, as an example of good practice in system leadership, during the National Cancer Breach Allocation Summit. The National Cancer Breach Allocation Guidance published since then will be implemented during 2016/17. NHS Improvement has confirmed to the Trust that it will be able to comply with the Risk Assessment Framework, while reporting using the new National Breach Allocation guidance from Quarter 1 2016/17.

The Trust has also responded to the pressures experienced with regards to the 18 week referral to treatment target for the incomplete patient pathway. The Elective Care Intensive Support Team (IST) was invited by the Chief Operating Officer to work with the Trust during the year, and an action plan was developed in conjunction with the IST. This plan was subsequently reviewed by NHS England and a trajectory for improvement has been included within the NHS Standard Contract for 2016/17. The quality of the data underpinning the reporting of the 18 week referral to treatment time target has been a focus for improvement during 2015/16.

Further details of non-financial performance, and on data quality with respect to the 18 week referral to treatment time target, are given in the Quality Report 2015/16 which can be found at Annex 1 of this document.

Operational and Financial Performance by Division

Royal Brompton Heart Division (including Children's services)

Royal Brompton Heart Division generated total income of £137.3m and a contribution of £19.7m in 2015/16, £1.7m behind plan. This is an increase in overall income from 2014/15, when the division generated £135.1m, but a fall in the level of contribution, which was £22.2m in 2014/15.

Total NHS income was £114.1m in 2015/16 in line with the £113.9m of income generated in 2014/15. Adult cardiac surgery generated income of £11.5m compared to £12.1m in 2014/15, £1.3m below plan. The shortfall was due to a decrease in elective activity volumes of 110 spells, but was partially offset by an increase in the complexity of procedures and in the number of inter-hospital transfers and emergency spells. Restrictions to surgical capacity during the development of the Trust's first hybrid theatre (which opened in November 2015) reduced elective activity.

Adult cardiology income was behind plan in 2015/16 by £0.4m and activity by more than 200 spells. In a reverse of 2014/15, there was more elective activity than planned offset by a reduction in emergency activity. Additional 'out-of-hours' work continued to be undertaken throughout much of the year in order to keep up with increasing demand, particularly for implantable cardioverter defibrillators (ICDs) and trans-catheter aortic valve implants (TAVIs), which grew from 284 and 74 respectively in 2014/15 to 324 and 112 in 2015/16.

Children's services income was behind plan by £0.5m and 133 spells in congenital heart surgery. Despite the reduced numbers, the complexity of patients resulted in increased lengths of stay and additional extra corporeal membrane oxygenation (ECMO) support for patients in PICU. Significant progress has been made in the recruitment of permanent paediatric nurses, but the vacancy rate remained at 13% for ward nursing staff across the children's wards during the year (this vacancy factor remains higher than in other areas of the Trust). This has caused particular pressure while staffing services such as ECMO which require 2-to-1 nursing.

Also in paediatrics, the nationally commissioned service for primary ciliary dyskinesia (PCD) is now fully commissioned for both the diagnosis and management of the condition. The long term ventilation (LTV) service has completed the national roll-out of its innovative 'hospital-to-home' service model and has continued to develop the service into other areas, including ECMO in 2015/16. It is expected that this will be commissioned on a national basis in 2016/17.

The adult ECMO service was on plan in 2015/16, after levels of activity increased in the second six months of the year. Patient retrievals from Scotland and Northern Ireland in addition to the Trust's designated zone continued in 2015/16.

Private patient income at £21.7m (2014/15: £20.0m) was above plan by £1.4m, despite the plan including expected revenues from additional capacity which was not available during 2015/16. This was primarily due to activity increases, particularly in adult cardiac surgery.

Pay costs increased from £70.0m in 2014/15 to £72.7m in 2015/16, with an overspend of £1.5m against budget focused in three key areas: paediatric ward nursing was £1.0m overspent due to increased activity and complexity of patients on PICU; £0.4m additional spend in anaesthetics and critical care to cover sickness and vacancies in the rota in AICU and theatres; and additional payments made to consultant staff to run extra lists in order to manage additional demand and waiting-time pressures (£0.2m overspent). Divisional non-pay costs were £44.9m, an increase from £42.8m in 2014/15 representing an overspend of £1.9m against budget for the additional activity described above.

Harefield Heart Division

Harefield Heart division was £1.6m below its contribution target for 2015/16, ending the year with a contribution of £15.8m. This compares to a contribution of £16.1m in 2014/15.Total income for the year was £95.5m, £1.0m above plan, driven by high levels of NHS activity. This is a decrease in total income of £1.4m from 2014/15. Inpatient and day-case spell volumes were 299 behind plan for the year at 6,623. This represents a decrease of 457 spells from 2014/15 (7,080).

NHS cardiac surgery activity was 142 spells below the plan set for the year, leading to an unfavourable financial position of £1.4m against an income target of £12.5m. Total cardiac surgery spells of 1,126 are a decrease of 100 spells compared to 2014/15, when 125 spells were carried out in additional, off-site capacity. NHS cardiology activity ended the year 172 spells behind plan; however this represents a decrease of 369 spells from 2014/15. Despite the shortfall against plan, due to a favourable case-mix cardiology exceeded its income target of £17.6m. 25 heart and 49 lung transplants were undertaken in 2015/16 and 39 Ventricular Assist Device (VAD) implants, compared with 25 heart, 49 lung transplants and 47 VAD implants in 2014/15.

Private patient income at £5.1m was £0.3m below plan (2014/15: £5.0m). This position was driven by an under-performance in cardiac surgery, off-set in part by over-performance in cardiology. In total, private patient income remained at the same level earned in 2014/15.

There have been higher pay costs than budgeted, predominantly within nursing and junior medical posts. The nursing overspend of just under £1.4m was driven by the high levels of vacancies, supernumerary costs due to new starters at times during the year (particularly on ITU), and short-term sickness filled using bank and agency staffing. Additional junior medical costs were largely due to the cost of covering vacancies within the surgical rota. Total pay costs in 2015/16 at £47.0m increased by £0.9m from 2014/15.

The division also experienced high non-pay costs through the year, as a direct consequence of the complex and highly-dependent patients treated, with particular growth seen in the volumes of high cost devices used, such as implantable cardioverter defibrillators (ICDs) and trans-catheter aortic valves (TAVI), which grew from 253 and 66 respectively in 2014/15 to 287 and 99 in 2015/16. Total non-pay costs in 2015/16 at £32.7m reduced by £2.0m from 2014/15.

Lung Division

Lung division continues to experience growth in income as a result of increased activity. However, this has been achieved at a worse margin than planned, due to higher pay and non-pay costs than both 2014/15 and plan. The division generated total income of £84.3m in 2015/16, an increase of £2.4m on 2014/15 (£81.9m), spending £56.8m (2014/15: £56.4m); resulting in a contribution of £27.5m. Of total income, NHS services accounted for £78.3m (2014/15: £76.1m), and private practice £5.7m (2014/15: £5.6m).

Spell volumes in respiratory medicine at Royal Brompton were 694 below target in the year, although they exceeded 2014/15 activity levels by 1%. Service developments, which started later than planned in the year, are now due to make an impact in 2016/17. Development of a hybrid theatre, resulting in temporary capacity restrictions, led to thoracic surgery on the Royal Brompton site falling below activity and income targets by 8% and 9% respectively, albeit remaining at the levels of 2014/15.

Respiratory activity at Harefield continues to grow and ended the year ahead of plan by 192 spells. Activity and income grew, exceeding 2014/15 by 12% and 7% respectively. Thoracic surgery on the Harefield site is now operating at full capacity and exceeded 2014/15 levels, and the 2015/16 target, by 20%.

Environmental Matters

Carbon Management

The Trust is committed to reducing carbon emissions in line with the Department of Health's NHS Carbon Reduction Strategy 2009 which included a target to reduce emissions by 10% by 2015 against a 2007 baseline together with meeting the Climate Change Act targets (reductions of 34% by 2020, 50% by 2025 and 80% by 2050 all against a 1990 baseline). A Carbon Management Plan has been developed in order to set out how the Trust will make progress towards achieving the targets set out in the Department of Health's strategy. The Trust's current Carbon Management Plan (CMP) was formally approved by the Operational Management Team in March 2014. However, as a world-renowned heart and lung clinical and research centre, the Trust faces particular challenges as it balances the requirements to develop sustainably whilst providing continual advances in medical technology and patient care, together with increasing demand for the our specialist services, which often requires new facilities and medical equipment. It is not possible to fully assess the impact of this continued expansion and consequently the Trust is unable to set an absolute target at this time. Therefore, to reflect this challenge the Trust plans to adopt energy performance KPI's of tonnes CO_2/patients treated and m^2 to demonstrate progress of the CMP.

Following the adoption of the plan the Trust established a Carbon Management Group (CMG) chaired by the Head of Estates & Facilities, to work with departments throughout the Trust in order to implement the plan. Membership of the group includes representation from Estates, Nursing, Transport, IT, Human Resources and Trade Unions and it meets quarterly. A project register has been created and this is updated regularly to show where savings can be achieved and the progress made. There are currently 61 projects identified although it should be noted that most savings can only be achieved through capital investment with a payback period of several years.

An interest free Salix Energy Efficiency loan of £56k was secured during 2015/16 to implement energy efficiency improvements to 14 ventilation units within Sydney Wing. It is anticipated that these measures will achieve energy cost savings of £53k per year and emission reductions of 239tCO_{2e} (this is almost 1% of the CMP reduction target). Additionally the Estates department have implemented a number of LED low energy lighting schemes as part of refurbishment projects.

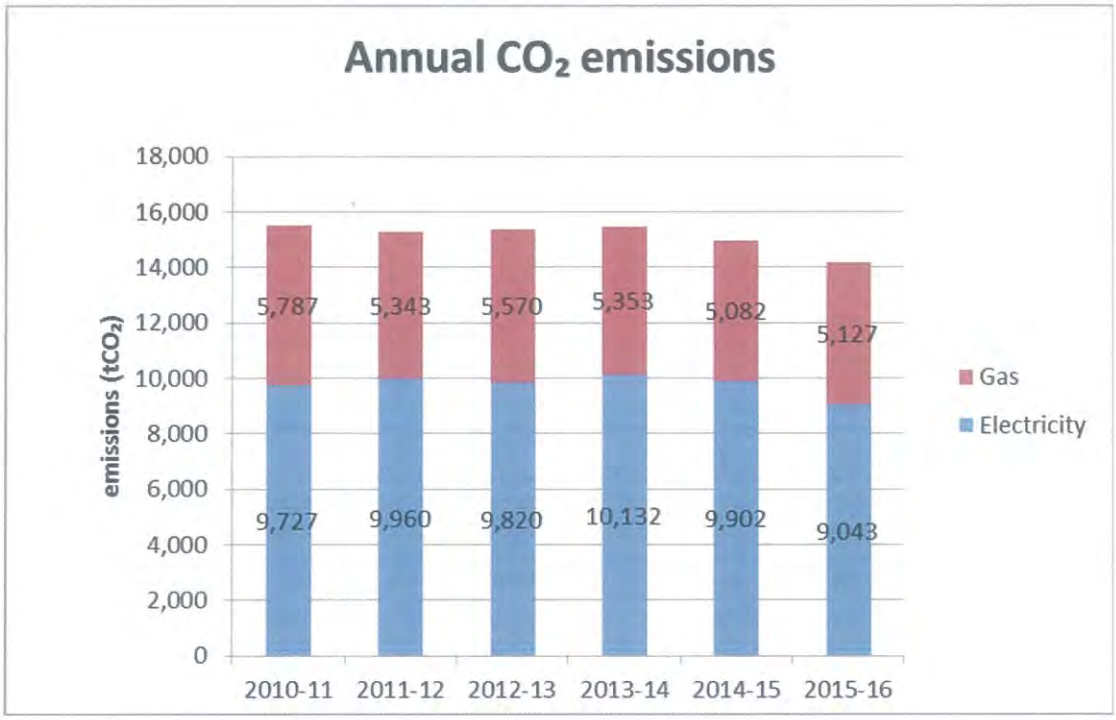
To complement the CMG a Green Committee has been set up on each site to promote sustainability and environmental issues including staff awareness, waste, recycling, transport policies and procurement. The Committee is chaired by the Site Services Manager and has members from across all departments on both sites.

Carbon Reduction Commitment

The Trust continues actively to participate in the Carbon Reduction Commitment Energy Efficiency Scheme and reports annually in July of each year as required.

CRC emissions for 2015/16 are currently projected to be 14,170 tCO_2. This represents a 5.4% fall on the previous year, largely owing to a sharp fall in electricity consumption of 8.7% which is a substantial improvement although there was a slight increase in gas consumption.

For comparison purposes reports from previous years were 15,514 tCO_2 in 2010/11; 15,303 tCO_2 in 2011/12; 15,390 tCO_2 in 2012/13; and 15,484 tCO_2 in 2013-14 and 14,984 tCO_2 in 2014-15. These are illustrated in the chart below:



The total cost of emissions in 2015/16 was in the region of £227k. This is a sharp rise owing to the cost per tonne of CO_2 rising from £12 to around £16 (depending on when allowances are paid for). The charge is levied by the government. The rate is set by the Department of Energy and Climate Change (DECC) and the amount collected goes into central government funds. After the rise to £16 it will continue to be reassessed each year in line with the Retail Price Index. It should also be noted that it was announced in the recent budget that the CRC is to be abolished in 2019 with the existing Climate Change levy (CCL) increasing. The effect is expected to be revenue neutral.

Social, Community and Human Rights Issues

The Trust has an Equality and Diversity Policy. This policy was updated during 2015 and reissued on 21st October 2015.

The policy sets out the intentions of the Trust with respect to ensuring that there are equal opportunities in the workplace, that dignity at work is safeguarded and that any issues pertaining to bullying and harassment are identified and addressed.

The Equality and Diversity Steering Group monitors the effectiveness of the policy and ensures that it is kept up to date. This group is chaired by the Director of Human Resources.

The policy is linked to the core behaviours expected of employees. These have been promoted during 2015/16 through the identification of ambassadors throughout the organisation. This has helped to ensure that the core behaviours are championed, and that staff are made aware of good practice.

Directors' Statement

This Performance Report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, as updated by NHS Improvement in May 2016.

..... **Robert J Bell** **25th May 2016**

Chief Executive

On behalf of the Board of Directors

2. Accountability Report

2.1 Directors' Report

Introduction

The Trust was authorised as a Foundation Trust on 1st June 2009. A Foundation Trust is a public benefit corporation. The powers of the Trust are set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. The Trust governance arrangements are enshrined in the Trust's Constitution. This makes provision for the Trust to be supported by a membership drawn from 3 constituencies, a public constituency, a staff constituency and a patient constituency. The Constitution also makes provision for a Council of Governors comprising both elected and appointed parties. The elected parties are drawn from the membership and the appointed parties represent key stakeholders with whom the Trust is engaged. During 2013/14 the Constitution was updated to take into account the changes contained in the Health and Social Care Act 2012. These changes were approved by the Trust Board and the Council of Governors and were ratified by the members at the Annual Members' Meeting. During 2014/15 there was one further minor amendment to the Constitution, to increase the maximum number of Non-Executive Director posts from 7 to 8. This change was ratified by the members at the Annual Members' Meeting held on 21st July 2014.

The governance structures of the Trust comprise:

The Council of Governors, with one committee, the "Nominations & Remuneration Committee of the Council of Governors" which is responsible for appointing the Chairman of the Trust Board and the Non-Executive Directors and also for setting and reviewing their remuneration.

Operational management is devolved to the Board of Directors. In turn, the Board has established three Board Committees to facilitate its direction and monitoring role: the Audit Committee, Risk & Safety Committee and Nominations & Remuneration Committee. These Committees enable the Board to discharge its responsibilities with regard to management of the risk and control environment within which the Trust operates and to oversee senior managers' pay and conditions.

The Board Committees' memberships exclusively comprise Non-Executive Directors, although Executive Directors also attend meetings and participate.

Non-Executive Directors are appointed to provide an independent perspective on, and challenge to, the discharge of the responsibilities of the Accounting Officer, who has delegated certain of his powers and functions to his colleague Executive Directors. All but one of the Non-Executive Directors are considered to be independent. Professor Kim Fox is considered to be a non-independent Non-Executive Director by virtue of his previous employment with the Trust. .

Detailed disclosures regarding the Council of Governors, the Board of Directors and each of the Committees are set out in the next section of this Annual Report.

Other committees, whose members are drawn from both Executive and Non-Executive Directors, include the Redevelopment Advisory Steering Group and the Finance Committee. However, these are not formal committees of the Trust Board.

Council of Governors, Trust Board and Committees

Council of Governors

The role of the Council of Governors is to appoint or remove the Chairman and other Non-Executive Directors of the Trust; to approve the appointment of the Chief Executive and to decide the remuneration and expenses and other terms and conditions of the Non-Executive Directors. The Council of Governors should receive and consider the Trust annual accounts, any auditor's reports on those annual accounts and the annual report from the Board of Directors. The Council of Governors provides views to the Board of Directors in respect of forward plans. The Council of Governors is consulted by the Board of Directors in relation to strategic matters affecting the Trust and should also approve and review the membership strategy. The Council of Governors also approves any purchase or sale of Trust property assets.

The Governor's Council met four times during 2015/16. Details of attendance, including that of Board members, are given in the table on pages 22 and 23 of this report.

Nominations & Remuneration Committee of the Council of Governors

One new Non-Executive Director, Mr Luc Bardin, was appointed by this Committee during 2015/16.

Three independent Non-Executive Directors were re-appointed during 2015/16. Dr Andrew Vallance-Owen and Ms Lesley-Anne Alexander were re-appointed for second terms of 3 years, and Mr Neil Lerner was re-appointed for a term of 1 year.

The remuneration of the Chairman and the NEDs has remained unchanged since 2014/15.

Members of the Committee during 2015/16 have included:

- Mr Ray Puddifoot
- Dr Adrian Lepper (stepped down May 2015)
- Dr Andrew Morley-Smith

Mr Puddifoot has served on the Committee since its inception. Dr Andrew Morley-Smith joined the committee during 2012/13. On 25th February 2016 the Council of Governors approved the appointment of the following members of the Committee:

- Mr George Doughty
- Mrs Chhaya Rajpal

The Council of Governors

Name	Date of Appointment/ Election	Term of Appointment	Constituency	Attendance Record Council of Governors
Governors				
Mr George Doughty	1.9.14	3 years	public	4/4
Mr Robert Parker	1.1.16	3 years	public	1/1
Ms Jennifer Sano	1.1.16	3 years	public	1/1
Mr Anthony Connerty (Term ended 3.10.15)	1.09.14	3 years	public	2/2
Mr Brian Waylett (Term ended 3.10.15)	3.10.12	3 years	public	1/2
Mrs Chhaya Rajpal	1.7.15	3 years (2nd term)	patient	1/4
Mr Tim Mack	1.1.16	3 years	patient	1/1
Mr Guthrie McKie (Term ended 20/12/15)	1.1.13	3 years	patient	2/3
Mrs Brenda Davies	1.12.13	3 years	patient	3/4
Mr Peter Kircher	1.12.13	3 years (2nd term)	patient	4/4
Mr Edward Waite	1.7.15	3 years (2nd term)	patient	4/4
Mr Stuart Baldock	1.7.15	3 years	patient	2/4
Dr Ejikeme Uzoalor	1.12.13	3 years	patient	4/4
Dr Adrian Lepper (Term ended 31.5.15)	1.6.12	3 years (2nd term)	patient-carer	0/0
Ms Caroline Karlsen	1.7.15	3 years	patient-carer	3/4
Dr Andrew Morley-Smith	1.6.15	3 years (2nd term)	staff	3/4
Dr Claire Hogg	26.2.14	3 years	staff	2/4
Mrs Anne McDermott	1.6.15	3 years	staff	2/4
Mrs Elizabeth Henderson	1.1.16	3 years	staff	1/1
Ms KD (Katherine) Denney (Resigned 8.2.16)	1.7.15	3 years	staff	3/3
Councillor Lady Victoria Borwick, MP	1.6.15	1 year (Re-appointment)	L.B. Kensington & Chelsea	1/4
Mr Ray Puddifoot MBE	1.6.15	1 year (Re-appointment)	L.B. of Hillingdon	3/4
Professor Mary Morrell	1.1.14	3 years	Imperial College, London	3/4

Other Attendees including **Board Members:**				
Chairman				4/4
Chief Executive				4/4
Interim Medical Director *Commenced 14/12/15*				1/1
Medical Director *Left the Trust on 11/12/15*				2/3
Associate Chief Executive - Finance				4/4
Chief Operating Officer				3/4
Director of Nursing & Governance				3/4
Director of Performance & Trust Secretary				4/4
Director of Service Development				4/4
NED N Lerner (Deputy Chairman)				2/4
NED: P Dodd				4/4
NED: K Owen				3/4
NED: A Vallance-Owen				2/4
NED: Lesley – Anne Alexander				2/4
NED: R Jones				4/4
NED: L Bardin *Commenced 1/6/15*				0/3
Non-independent NED: Prof K Fox				1/4

Governors' Interests

PUBLIC CONSTITUENCY 1: North West London	
DOUGHTY, George	None
PUBLIC CONSTITUENCY 2: Bedfordshire & Hertfordshire	
APPEL, Kenneth	Member: Harefield Hospital Rebeat Club Co-coordinator for the supply of non NHS funded Requirements Harefield Hospital Sometime assistant at Harefield Hospital Pavilion NICE, Assessor Advisory Committee of Clinical Excellence Awards Member: East of England Steering Committee for Abdominal Aortic Aneurysm/Vascular Surgery Rapid Response Service Development Member: NW London Cardiac network Member: Hertfordshire Health watch Member: Watford and Three Rivers Locality Patient Group Board Chair of Committee to Monitor the Prevention/Treatment of Specific Medical Conditions

PUBLIC CONSTITUENCY 3: South of England	
PARKER, Robert	None
CONNERTY, Anthony	
PUBLIC CONSTITUENCY 4: Rest of England & Wales	
SANO, Jennifer	Member Lay Governance Group Royal College of Pathologists.
WAYLETT, Brian Peter	None
PATIENT CONSTITUENCY: North West London	
RAJPAL, Chhaya	None
MACK, Tim	Trustee and non-executive board member Children's Food Trust Guide Dogs for the Blind, London Engagement Team
McKIE, Guthrie	An elected Councillor for the Harrow Road Ward in the City of Westminster. Member of the Labour Party Director, 26 Sutherland Place Management Limited
PATIENT CONSTITUENCY: Beds & Herts	
DAVIES, Brenda	None
KIRCHER, Peter	Member, Harefield Hospital ReBeat Club
PATIENT CONSTITUENCY: South of England	
WAITE, Edward	Councillor: Sevenoaks Town Council Non-executive director Stag Community Arts Centre Sevenoaks.
PATIENT CONSTITUENCY: Elsewhere	
BALDOCK, Stuart	Member of the Conservative Party Associate Member of the Conservative Medical Society
UZOALOR, Ejikeme	None
PATIENT CONSTITUENCY: Carers	
KARLSEN, Caroline	Director, C-Squared Consulting Ltd Trustee of the Cystic Fibrosis Trust
LEPPER, Adrian Murray	Member: Hertfordshire Healthwatch (voluntary) Company Secretary and Director: Chilterns Woodland Project Ltd (voluntary)

STAFF CONSTITUENCY	
HOGG, Claire	Director, S. Padley Ltd Trustee of the Brompton Fountain Charity
MORLEY-SMITH, Andrew	Employee (Fixed-term contract), Chelsea and Westminster Hospital NHS Foundation Trust Clinical Research Fellow, Imperial College London
McDERMOTT, Anne	None
HENDERSON, Elizabeth	Administrator League of Friends (Royal Brompton)
LINDSAY, Alistair	Director, Regent's Park Heart Clinics
DENNEY, KD (Katherine)	None
BALFOUR-LYNN, Ian	Member RCPCH Council (Representative of Sub-specialists) Member cystic fibrosis Clinical Reference Group Chair Cystic Fibrosis group, European Respiratory Society

APPOINTED:	
BORWICK, Victoria (Royal Borough of Kensington & Chelsea) MP	Royal Borough of Kensington and Chelsea appointee to Governing Body Member of Parliament for Kensington (Conservative Party) Founder and Trustee: Edwin Borwick Charitable Trust Director: Poore Ltd, Second Poore Ltd Member: The Conservative Party Husband is a Trustee of the Royal Brompton & Harefield Charity
PUDDIFOOT, Ray (London Borough of Hillingdon) MBE	Leader: London Borough of Hillingdon Chairman: Health and Wellbeing Board London Borough of Hillingdon Member, the Conservative Party, The Conservative Councillors Association Member: Leaders Committee London Councils Member: London Congress Hon. Member: Harefield Transplant Club Member: London Councils Executive, Lead on Adult Social Care Member: London Health Board
MORRELL, Professor Mary (Imperial College London)	Trustee and President of the British Sleep Society Trustee and executive board member of the Physiological Society Trustee of Porter Progress UK (Charity)

Governors' Expenses

Dr Ejikeme Uzoalor	£114.12
Mr Peter Kircher	£215.88
Mrs Chhaya Rajpal	£28.00
Mr Robert Parker	£29.65
Mrs Brenda Davis	£179.13
Mr Stuart Baldock	£100.00
Mr Edward Waite	£113.00
Mr Adrian Lepper	£69.14

These expense claims cover travel expenses for attendance at:

- meetings of the Council of Governors
- attendance at PLACE (patient led assessment of the care environment) meetings
- GovernWell courses (National Training Programme for NHS Foundation Trust Governors provided by the Foundation Trust Network)
- Governors' Working Groups meetings
- Interview panels for the appointment of Non-Executive Directors

Trust Board and Committees

The Board of Directors is appointed to exercise all of the powers of the Trust on its behalf. The membership of the Board of Directors meets the requirements of the NHS Foundation Trust Code of Governance in respect of balance, completeness and appropriateness, being currently composed of 7 independent Non-Executive Directors, 1 non-independent Non-Executive Director, 6 Executive Directors and a Chairman who is Non-Executive. The arrangements for appointment and removal of Non-Executive Directors are set out in the Trust Constitution. Non-Executive Directors are appointed for a period of 3 years in the first instance.

Details of Operation

Between 1 April 2015 and 31 March 2016, the Trust Board convened on 9 occasions.

Composition and Committee Duties

Name	Roles	Attendance Record			
		Trust Board	Audit Committee	Risk & Safety Committee	Nominations & Remuneration Committee of the Trust Board*
Sir Robert Finch	Chairman	8/9	-	-	3/3
Robert Bell	Chief Executive	8/9	-	-	
Executive Directors					
Robert Craig	Chief Operating Officer	7/9	-	-	
Joy Godden	Director of Nursing & Clinical Governance	9/9	-	-	
Prof Tim Evans	Medical Director; Deputy Chief Executive	6/9	-	-	
Dr Richard Grocott-Mason	Interim Medical Director	2/2	-	-	
Nicholas Hunt	Director of Service Development	9/9	-	-	
Richard Paterson	Associate Chief Executive – Finance	9/9	-	-	

Non-Executive Directors	Roles	Trust Board	Audit Committee	Risk & Safety Committee	Nominations & Remuneration Committee of the Trust Board*
Lesley-Anne Alexander	Nomination and Remuneration Risk & Safety Committee	9/9	-	4/4	3/3
Luc Bardin	Audit Committee	6/7	1/3	-	-
Philip Dodd	Risk & Safety Committee	8/9	-	3/4	-
Prof Kim Fox		8/9	-	-	-
Richard Hunting (Term ended 30th April 2015)	Chairman Nomination and Remuneration Committee; Audit Committee	1/1	1/1	-	-
Richard Jones		9/9	-	-	-
Neil Lerner	Deputy Chairman Chair of Audit Committee, Risk & Safety Committee	8/9	5/5	4/4	-
Kate Owen	Chair - Nomination and Remuneration Committee, Audit Committee	9/9	4/5	-	3/3
Dr Andrew Vallance - Owen	Chair - Risk & Safety Committee Audit Committee Nomination and Remuneration Committee	9/9	5/5	4/4	3/3
Other Attendees					
Richard Connett	Director of Performance & Trust Secretary	9/9	5/5	4/4	

Note - The Chief Executive and the Executive Directors, although attendees at Board Committee meetings, are not formally members of those Committees.

The table in the Governors section of this report demonstrates that Executive and Non-Executive members shown above have also been in attendance at meetings of the Council of Governors in order to understand the views of Governors. Non-Executive Directors also attended the Annual Members' Meeting at which the views of members were expressed. It should also be noted that certain Governors are also regularly present at meetings of the Trust Board.

Directors' Interests

The Trust has an obligation under the terms of its Constitution as a Foundation Trust, to compile and maintain a register of Directors' interests, which might influence their role. The register is available to the public, in accordance with the Freedom of Information Act, through written application to the Trust's Chief Executive. The Trust is also required to publish in its annual report the directorships of any member of the Board in companies that are likely to, or seek to, conduct business with the NHS. In this context declarations of the directors of Royal Brompton & Harefield NHS Foundation Trust are as follows:

Chairman (to 31st March 2016)

Sir Robert Finch
Director & Chairman, GHP Russia Real Estate Development
Governor, Legal Education Foundation
Trustee, LSO Endowment Trust
Hon Colonel, Inns of Court City and Essex Yeomanry
Magistrate, City of London Bench (non-active)
Trustee, National Heart & Lung Institute Foundation
Trustee, Royal Brompton & Harefield Hospitals Charity
Honorary Bencher, Lincoln's Inn
Shareholder, Recognition Health

Deputy Chairman

Mr Neil Lerner
Council Member; Royal National Lifeboat Institution (RNLI)
Member RNLI Finance & Audit Committee
Board Member, LMS Capital Plc

Senior Independent Director

Dr Andrew Vallance-Owen MBE
Chair, Private Healthcare Information Network
Chair, Royal Medical Foundation of Epsom College
Chair, Ethics Advisory Panel, Medicover (Poland)
Director, Institute of Cardiovascular Medicine & Science
Chair, Association of Independent Healthcare Organisations, Cosmetic Surgery Forum
Member, Department of Health Cosmetic Interventions Advisory Board
Member, NHS England Patient Reported Outcomes Advisory Group
Trustee, Barrett's Oesophagus Campaign

Non-Executive Directors

Mrs Lesley-Anne Alexander CBE
CE – Royal National Institute of Blind People (RNIB) plus RNIB Group subsidiaries, companies and charities
Chair – Red Door Ventures
Chair – UK Vision Strategy
Non-Executive Director – Circle Housing Association
Member – National Council for Voluntary Organisation (NCVO)
Member – British Judo Association
Fellow – Royal Society of Arts (RSA)
Member – Labour Party

Mr Luc Bardin
Director, Strategic Partnering Ltd
Director, The Strategic Brand Ltd
Adjunct Professor, Imperial College Business School
Advisory Board Member, MSc Strategic Marketing, Imperial College Business School
Advisor, UK Government Cabinet Office on Strategic Partnering

Mr Philip Dodd
Director, Wastewater Management Holdings Limited
Director, Ayr Environmental Services Limited
Director, API Holdco Limited
Director, Agecroft Properties (No.2) Limited
Director, Semperian Holdco Limited
Director, Semperian Borrowerco Limited
Director, Marlborough Facilities Limited
Director, Abergavenny Facilities Limited
Director, Monmouth Facilities Limited
Director, The Hospital Company (Dartford) Holdings Limited
Director, The Hospital Company (Dartford) Group Limited
Director, The Hospital Company (Dartford) Limited
Director, The Hospital Company (Dartford) Issuer PLC
Director, The Hospital Company (Dartford) Holdings 2005 Limited
Director, The Hospital Company (Dartford) 2005 Limited
Alternate Director, Road Management Services (Darrington) Holdings Limited
Alternate Director, Road Management Services (Darrington) Limited
Alternate Director, Road Management Services (Finance) plc
Alternate Director, Celtic Roads Group (Dundalk) limited
Director, North Wilshire Schools Limited
Alternate Director, Albion Healthcare (Oxford) Holdings Limited
Alternate Director, Albion Healthcare (Oxford) Limited
Director, White Horse Education Partnership Limited
Director, Mercia Healthcare (Holdings) Limited
Director, Healthcare Providers (Gloucester) Limited
Director, Gloucester Healthcare Partnership Limited
Director, G4S IP 2 Limited
Director, Bexley PPP Health Services Limited
Health & Safety Director, Bexley PPP Health Services Limited
Director, Black Country PPP Health Services Limited
Health & Safety Director, Black Country PPP Health Services Limited
Director, Redbridge PPP Health Services Limited
Director, Hertford PPP Health Services Limited
Director, Liskeard PPP Health Services Limited
Director, West Mendip PPP Health Services Limited
Director, South Essex PPP Health Services Limited
Director, Herts & Essex PPP Health Services Limited
Director, First Priorities PPP Health Services Limited
Director, Epping PPP Maintenance (Health) Services Limited
Director, New Forest PPP Health Services Limited
Director, GH North Northampton Holdings Limited
Director, GH North Northampton Holdings Limited
Director, GH Rotherham Limited
Director, GH North Northampton Limited
Director, Albion Healthcare (Doncaster) Holdings Limited
Director, Albion Healthcare (Doncaster) Limited
Director, Mercia Healthcare Limited

Prof Kim Fox
Head, National Heart and Lung Institute (NHLI)
Director, Institute of Cardiovascular Medicine & Science (ICMS)
Director, Versalius Trials Ltd
Trustee, National Heart & Lung Institute
Trustee, Magdi Yacoub Institute
Adviser, Servier Pharmaceuticals Ltd
Adviser, European Society of Cardiology (Past President)
Data and Safety Monitoring Board Member, TauRx Pharmaceuticals.
Advisor, ARMGO Pharmaceuticals

Mr Richard Hunting CBE (as at 30th April 2015)
Chairman, Hunting Plc
Chairman, CORDA, preventing heart disease and stroke
Chairman, Royal Brompton & Harefield Hospitals Charity
Director, Institute of Cardiovascular Medicine and Science
a joint venture between RBHFT and the Liverpool Heart & Chest Hospital Foundation Trust

Mr Richard Jones
Director, RJ Real Estate Consulting Ltd
Trustee, Bishops' Stortford Baptist Church
Member, Royal Institution of Chartered Surveyors
NED, Commercial Development Advisory Group at TfL

Ms Kate Owen
Fellow, Windsor Leadership Trust (Charity)
Governor, University of Reading
Trustee, Imperial College Union

Executive Directors

Mr Robert J .Bell (to 31st March 2016)
Visiting Professor, Imperial College
Trustee, Royal Brompton & Harefield Hospitals Charity
Board Member, Imperial College Health Partners
Director, Institute of Cardiovascular Medicine and Science

Professor Timothy Evans (as at 14th December 2015)
Board Member, Faculty of Intensive Care Medicine
Board Member, Faculty of Pharmaceutical Medicine
Honorary Civilian Consultant in Intensive Care Medicine, Army
Editor in Chief, Future Hospital Journal (Royal College of Physicians)
Shareholder, Recognition Health
Board member, Nuffield Trust
Chair, National Cardiac Benchmarking Collaborative

Dr Richard Grocott-Mason
Director, RM Grocott-Mason Ltd

Mr Richard Paterson
KPMG - Provision of ad hoc Consultancy Services

Mr Robert Craig
Nothing to declare

Ms Joy Godden
Nothing to declare

Mr Nicholas Hunt
Chair, Governing Body of Manor Farm Community Junior School

Directors' Resumes

Deputy Chairman

Mr Neil Lerner is an experienced accountant specialising in all aspects of risk management. He has played a key role in the development of ethical standards for the accountancy profession, globally and in the UK. After becoming partner at leading international provider of professional services, KPMG, in 1984, Mr Lerner held a number of senior positions, including head of privatisations, head of corporate finance and head of transaction services business for KPMG UK, and chairman of the KPMG Global Professional Indemnity Insurance Group. He retired from the firm in 2006 and currently holds a number of non-executive posts. Mr Lerner began acting as Chairman of the Trust on 31st March 2016, following the passing of Sir Robert Finch.

Non-Executive Directors

Mr Andrew Vallance-Owen FRCSEd trained as a surgeon in Newcastle upon Tyne but, after holding various positions on the staff of the BMA including head of policy development, became group medical director of Bupa in 1995. Following his retirement from Bupa in 2012, he has taken up a number of non-executive roles; he is chair of the Private Healthcare Information Network and the Royal Medical Foundation of Epsom College. He has a strong interest in outcome measurement, clinical audit and greater clinical accountability, and is a passionate advocate of patient feedback in service improvement and shared decision making. Mr Vallance-Owen studied medicine at Birmingham University where he received an Honorary Doctorate.

Mrs Lesley-Anne Alexander CBE has been chief executive of the Royal National Institute of Blind People (RNIB) since January 2004, prior to which she was director of operations for the Peabody Trust and director of housing for the London Borough of Enfield. She joined Royal Brompton & Harefield NHS Foundation Trust as a non-executive director in February 2013.

Lesley-Anne currently chairs both the UK Vision Strategy and Red Door Ventures. She was awarded a CBE in The Queen's 2012 Birthday Honours list in recognition of her services to the voluntary sector.

Mr Luc Bardin was appointed to the Board in June 2015 and brings a wealth of experience in leadership and strategic transformation to the Trust. He spent many years in executive roles with BP plc, including group chief sales and marketing officer, CEO of multiple businesses, and CEO and founder of the "Strategic Accounts" division. He was a group vice president for 12 years and a member of the BP Downstream ExCo. His career in global business leadership spans 30 years and, alongside BP, he has worked for Burmah Castrol, Hoechst and Pechiney groups.

Since January 2014, he has been chairman of Strategic Partnering Ltd and is the author of *Strategic Partnering - remove chance and deliver consistent success*, published in 2013. Mr Bardin is an adjunct professor at Imperial College Business School, and has an MBA and qualifications in engineering, political science and finance.

Mr Philip Dodd was formally appointed to the Trust Board on 21 July 2014. He has previously been a member of the Council of Governors where he has represented North West London since the very beginning of the Trust's application to become a Foundation Trust. While in the role of Governor, he was an active fundraiser as well as serving on the Nominations and Remuneration Committee of the Council of Governors. His involvement with Royal Brompton & Harefield NHS Foundation Trust started at Harefield Hospital in 1993 when his son, at eight weeks old, had the first of two successful operations. Mr Dodd has broad experience in management having held directorships in over 25 companies.

Mr Richard Jones joined the Trust Board as a non-executive director in February 2014. He is an experienced real estate executive director. He brings to the Board extensive expertise in investment and asset performance and management gained from a long career with Aviva Investors as Head of European Life Funds, Managing Director UK Real Estate and, most recently, Managing Director of Aviva Clients and Global Asset Management. While in this role he was a member of the Aviva Investors Global Real Estate Board, chair of the Real Estate Operational Management Group and chair of the Real Estate Sustainability Group. Mr Jones is the Chairman of the Trust's Redevelopment Advisory Steering Group and he also attends the Finance Committee.

He is currently a member of the Royal Institution of Chartered Surveyors (MRICS) and a non-executive director of the Transport for London Commercial Property Advisory Group.

Ms Kate Owen runs a consulting business advising on change and development in organisations. She retired as vice president executive development at BP in 2005 having worked with the company for 24 years. Her 35-year industry career spanned line management, general HR work, training and organisational transformation. Her previous experience was in retail and the public sector. She spent nine years on the Board of HM Revenue and Customs, was chair of the Conference Board (Europe) Organisation and Business Council, a member of the Ministry of Defence Armed Forces Training and Education Steering Group and a member of the UK Government Risk Review Steering Group. Ms Owen is currently a Governor of Reading University, a Trustee of Imperial College Union and a Fellow of the Windsor Leadership Trust.

Non-Independent Non-Executive Director

Professor Kim Fox is a consultant cardiologist at the Trust as well as professor of clinical cardiology and head of the National Heart and Lung Institute, Imperial College, London. Professor Fox is a Director of the Institute for Cardiovascular Medicine and Science (in partnership with Liverpool Heart and Chest Hospital) and is the Diana Princess of Wales Chair in Cardiovascular Medicine and Science. He was appointed as non-executive director (non-independent) to the Trust Board on 1 June 2013.

Executive Directors

Mr Robert J Bell joined the Trust as chief executive in March 2005, from the William Osler Health Centre, Ontario, Canada, where he was president and chief executive officer. He has had over 40 years' international experience in hospital and health services management. He is a member of the Board of Directors of Imperial College Health Partners and the Institute of Cardiovascular Medicine and Science. He has previously held positions as vice president, Health Care and Life Sciences Market Sectors, Cap Gemini, Ernst & Young Canada Inc; partner at Ernst & Young and KPMG (Peat Marwick), Toronto; vice president, Hilton Universal Hospitals UK Ltd, London; vice president, International Services, Extendicare Inc (London and Toronto); executive director of District Health Councils in the Ministry of Health, Ontario; Treasury Board officer, Management Board of Cabinet, Government of Ontario; and systems engineer, Hospital for Sick Children, Toronto. He is a Bachelor of Applied Science in Industrial Engineering and a Master of Public Administration. In 2014 he was appointed a visiting Professor of Global Health Innovations by Imperial College.

Mr Robert Craig is the Chief Operating Officer. He joined Harefield Hospital in 1995, having previously worked in community and general hospital services. Following the Trust merger in 1998, he became site director at Harefield and, in 2001, deputy director of operations for the Trust. Mr Craig has also fulfilled the roles of director of governance & quality (2003-2006) and director of planning & strategy (2006-2009) – in the latter post, he was responsible for the Trust's Foundation Trust application. He was appointed to his current role in mid 2008.

Dr Grocott-Mason, consultant interventional cardiologist, has worked at Harefield Hospital regularly since 1999 and was appointed divisional director of the heart division in October 2014. He has also held roles at The Hillingdon Hospitals NHS Foundation Trust, including clinical director for medicine, and joint medical director and responsible officer. He was appointed as Interim Medical Director of the Trust on 27th January 2016.

Mr Richard Paterson served the Trust as interim director of finance in January 2011 for a six-month term. He subsequently joined the Trust as associate chief executive - finance and was appointed to the Board on 26 October 2011. He worked at KPMG, accountants and business advisers, for 40 years, appointed to the partnership in 1986 and retiring in 2010. In addition to client responsibilities for listed companies and public interest entities, his management roles included: six years in charge of KPMG UK's infrastructure, government and healthcare division; head of markets for KPMG's Europe, Middle East and Africa region; and executive chair of the global professional indemnity insurance committee, a committee of the international board of KPMG. Mr Paterson continues to provide ad hoc consultancy services to KPMG.

Ms Joy Godden, interim director of nursing and clinical governance, joined the Trust in 1996 and was general manager of the lung division between 2004 and 2015, with a broad portfolio that has included a number of corporate projects.

The Nomination and Remuneration Committee of the Trust Board recommended that Ms Godden be appointed as Director of Nursing and Clinical Governance at its meeting on 29th July 2015. The appointment was ratified by the Trust Board on 29th July 2015.

The Audit Committee Report

Role and responsibilities

The Committee's terms of reference state that it will provide the Trust Board with an independent and objective evaluation of the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that support the achievement of the organisation's objectives. Within this overarching framework the Committee:

- Ensures that a regular review is undertaken of governance, risk management and internal controls;
- Maintains oversight of the Trust's financial systems, financial information and financial reporting in compliance with relevant law, guidance and regulation;
- Reviews and monitors the effectiveness of the Trust's internal audit and counter-fraud functions;
- Reviews and monitors the effectiveness of the external audit process and of the external auditor's independence and objectivity; and
- Assesses the disclosures in the narrative sections of the Annual Report to ensure that they are fair, balanced and understandable.

In carrying out its activities the Committee is cognisant of the interest of the Trust's governors and members.

Composition of the Committee

The members of the Committee who served during the period under review are disclosed on page 27 of this Annual Report. Committee meetings are also regularly attended by the Chief Executive Officer, Associate Chief Executive – Finance, Chief Operating Officer, Medical Director, Trust Secretary and other senior members of the finance team.

Dr Vallance-Owen chairs the Risk & Safety Committee, whose agenda links closely to that of the Audit Committee, particularly as regards risk identification and management. Neil Lerner, who chaired the Audit Committee until 26 April 2016, is also a member of the Risk & Safety Committee. While he is Acting Chairman of the Trust, he is no longer permitted, under its constitution, to chair the Audit Committee. Accordingly, since that date, following the Committee meeting, this responsibility has been assumed by Luc Bardin until Neil Lerner can again take on the role.

Summary of Committee meetings

Since the approval of the 2014/15 Annual Report and Accounts the Committee has met on five occasions. These sessions considered the following subjects:

- July 2015
    - Reports from internal audit and counter-fraud services
    - Health sector developments
    - Internal audit plan for 2015/16
    - Counter fraud survey results and NHS Protect self-review tool
    - Counter fraud annual report

- October 2015
    - Reports from internal audit and counter-fraud services
    - Health sector developments
    - External audit plan for 2015/16
    - Tender process for internal audit
    - Notification of an audit of reference costs
    - Review of the Trust conflict of interest policy

- February 2016
    - Reports from internal audit and counter-fraud services
    - Health sector developments
    - The appointment of internal auditors to the Trust
    - Annual self-assessment – quality governance framework

- April 2016
    - Progress reports from internal audit and counter fraud services
    - Draft 2015/16 annual reports from internal audit (including draft Head of Internal Audit Opinion) and counter-fraud services
    - Draft 2016/17 work plans for internal audit and counter-fraud services
    - External audit status report
    - Review of Trust counter fraud and corruption policy

- May 2016
    - Final draft of 2015/16 Report and Accounts
    - External audit reports on financial and quality accounts

The Committee's responsibilities and activities dovetail with those of the Finance and Risk & Safety Committees and procedures are in place to avoid both omission and duplication.

In addition to these regularly scheduled meetings, the Committee in October 2015 invited written proposals from firms wishing to apply for the role of internal auditor to the Trust. Three firms applied and were subsequently interviewed by a panel which included Trust Non-Executive and Executive Directors. The panel unanimously recommended that KPMG LLP be reappointed as internal auditor to the Trust.

Significant issues relating to the Annual Report and Accounts
The principal issues addressed included:

- The adequacy of provisions; for example in relation to contractual disputes. These provisions are financially significant and, by their nature, judgemental.

- The impact on the financial statements of the independent revaluation of the Trust's operational and investment properties as at 31 March 2016 which built on the corresponding exercise one year earlier.

- In light of continuing pressures on NHS revenues, the Trust's ability to continue in operation as a going concern. The Committee considered cash flow projections for both 2016/17 and 2017/18 in both base case and sensitised versions, following which

it recommended that the Trust Board make the statement on page 11 of this Annual Report.

- The capitalisation of fixed assets including IT hardware and software, the inception of depreciation on additions and, where appropriate, the timing and extent of impairment charges. In particular the Committee considered the Trust's decision to reverse part of the past impairment of consultancy costs associated with its proposed redevelopment of Royal Brompton Hospital given the new focus of this project.

- The findings of the external auditors with regards to the Quality Report and in particular the outcome of the testing of data quality in respect of the 18 week referral to treatment time

All these matters were resolved to the satisfaction of the Committee and of the Trust's external auditors without requiring adjustments to the draft annual accounts. Where adjustments are proposed by the auditors, the Committee considers both their nature and their materiality to the accounts in deciding whether to record them.

Risk management and internal control

In tandem with the Risk & Safety Committee, which principally focuses on clinical and related risks, the Audit Committee keeps under review the overall risk profile and the financial risks to which the Trust is exposed. In this work it is informed not only by management but also by reports from internal and external auditors. It also considers the output of the Trust's counter-fraud provider. From all these sources of data the Committee seeks to assess the quality and adequacy of the internal financial controls in place at the Trust.

No new major financial risks were identified during the year.

One amber/ red (categorised as 'partial assurance with improvements required') internal audit report was issued by KPMG LLP during the year under review. This included one 'red rated' recommendation for improvement:

- To establish a detailed action plan to demonstrate compliance with information governance toolkit requirements.

All recommendations have been accepted by management and the necessary actions have been agreed and are underway.

There were a number of other less significant recommendations for improvements in systems and processes by the Trust's external and internal auditors: the Committee closely monitors the implementation by executive management of all auditor recommendations.

There are no high priority recommendations outstanding at the end of the year under review and of the low and medium priority recommendations none is overdue.

The Trust's counter fraud service did not identify any matters of significant financial concern during the year under review either emerging from its own work programme or from reports by members of staff or the public.

External audit

The Committee engages regularly with the external auditor over the course of the financial year. A summary of the meetings of the committee, and the significant issues relating to the Annual Report and Accounts is given above: they include consideration of the external audit plan, matters arising from the audit of the Trust's financial statements, the review of the Trust's quality accounts and any recommendations on control and accounting matters proposed by the auditor. There are also private sessions held with the external auditor at which executive management is not present.

The Audit Committee regularly carries out an evaluation of the effectiveness of the external audit process. This is achieved through assessment by individual Committee members, and attendees, of performance against a set of pre-determined criteria.

Internal audit

Each year the Committee reviews and approves the internal audit plan, internal audit reports throughout the year and the internal auditor's annual report and head of internal audit opinion. These items are discussed with the internal auditors at Committee meetings as are the outstanding recommendations from both internal and external auditors and how these are responded to by management.

As noted above, KPMG LLP was reappointed as internal auditor to the Trust following a tender process on a three year contract commencing 1 April 2016.

The Risk & Safety Committee Report

Role and responsibilities

The Committee provides the Trust Board with independent and objective evaluation of whether the systems and processes in place in the Trust to manage risks, especially patient safety risks, are complete, appropriate, and working as intended and, through its work, will encourage continuous quality improvement.

In respect of risk management, the Committee reviews the trust's overall risk management systems, including clinical, infrastructure and risks to compliance with the terms of its NHS Provider Licence and, in particular, the Quality Governance Framework. Financial and corporate risks are overseen by the Audit Committee.

The Committee seeks assurance that the organisation has appropriate risk management processes in place to ensure delivery of the annual plan, and to ensure compliance with the registration requirements of the quality regulator.

In respect of financial and other risks covered by the Audit Committee, it draws on the work of that committee.

In respect of risks relating to patient safety and health & safety, the Committee reviews all sources of assurance on patient safety, clinical effectiveness, and patient and staff experience. These include:

- Performance reports;
- Internal assessments - including, but not limited to, any reviews by internal audit and clinical audit; and
- External assessments - including, but not limited to, any reviews by Department of Health arm's length bodies or regulators / inspectors and professional bodies with responsibility for the performance of staff or functions.

In carrying out its activities the Committee is cognisant of the interest of the Trust's governors and members.

Composition of the Committee

The members of the Committee who served during the period under review are disclosed on page 27 of this Annual Report. Committee meetings are also regularly attended by the Chief Executive Officer, Associate Chief Executive – Finance, Chief Operating Officer, Medical Director, Director of Nursing & Clinical Governance and Director of Performance & Trust Secretary.

Dr Vallance-Owen chairs the Risk & Safety Committee, whose agenda links closely to that of the Audit Committee, particularly as regards risk identification and management. The chairman of the Audit Committee, is also a member of the Risk & Safety Committee.

Summary of Committee meetings

Since the approval of the 2015/16 Annual Report and Accounts the Committee has met on four occasions. These sessions considered the following subjects:

- July 2015
  - Lampard Report (Savile Investigations)
  - Review of mortality out of hours and other Intelligent Monitoring results
  - Learning from 'never events'
  - Review of the Trust's top risks
  - Updates from infection control, safeguarding, complaints and the matrons
  - Quality Improvement – SPRINT simulation training

- October 2015
  - Review of cancer services
  - Review of controlled drugs management
  - Review of weekend HSMR and NICOR results
  - Nursing Strategy
  - Updates from safeguarding, serious incidents, complaints and the matrons
  - Quality Improvement – pressure ulcer management

- February 2016
  - Cancer review
  - Quality Indicator Assurance Framework
  - Review of controlled drugs
  - Emergency Planning, Resilience and Response assurance
  - Review of risk register and Risk Management Strategy
  - Updates from serious incidents, complaints and the matrons
  - Quality Improvement – improved efficiency and quality of care in CF clinics

- April 2016
  - Cancer review
  - Radiation safety
  - Update on Quality & Safety Strategy 2015-18 and Quality Report 2015-16
  - Review of health and safety
  - Review of end of life care
  - Safeguarding update
  - Findings from the inpatient survey 2015
  - Updates on serious incidents, complaints, safeguarding
  - Quality Improvement – the paediatric patient journey

The Committee's responsibilities and activities dovetail with those of the Audit Committee and procedures are in place to avoid both omission and duplication.

Significant issues addressed in 2015-16

The principal issues addressed included:

- The provision of cancer services – the Trust provides one of the largest first-time lung cancer resection services in the country, and routinely achieves outcomes which are better than the national average. The Committee was assured that the service provided by the Trust was of a high standard, despite the challenge in meeting the 62 day cancer target.

- Review of mortality following acute myocardial infarction, as a result of an alert letter issued by the CQC. Following an in-depth review it was identified that this alert did not reflect the quality of care provided, but was a reflection of the approach to data analysis used by Dr Foster. Both the Risk & Safety Committee and the CQC agreed with this.

- Focus on Quality Improvement initiatives. Each meeting has included a detailed quality improvement presentation from the front line staff leading the particular programme. This provides a clear connection between staff delivering patient improvement initiatives and Board members who have oversight of the risk and safety agenda across the organisation.

Risk management and internal control

In tandem with the Audit Committee, the Risk & Safety Committee keeps under review the overall risk profile and has a particular focus on the clinical risks to which the Trust is exposed. In this work it is informed not only by management, but also by staff working at the frontline and in some cases also by reports from internal and external auditors or other review mechanisms. From all these sources of data the Committee seeks to assess the quality and adequacy of the internal controls in place at the Trust.

No new major risks were identified during the year. The red/amber rated Top Trust risks are:

- ***Failure to achieve expected standards of clinical care*:** progress has been made in moving towards 7 day working, raising the intensity and breadth of our ward-based care, and managing better the onward pathway of care for our patients beyond our hospitals. However of more significance is the rapidly changing nature and magnitude of risks relating to care management, investigation and intervention in a growing population of elderly patients with complex co-morbidities, an expanding group of patients with adult congenital heart disease and advances in ante-natal diagnosis. The advent of new technologies such as percutaneous heart valve implants and increasing expertise in mechanical support modalities such as LVAD and ECMO has created a new set of clinical risks that we are only just starting to understand and attempt to mitigate.

- ***Information technology (IT) not meeting clinical needs*:** the Trust is in the process of implementing a number of key projects to improve the performance and reliability of the IT infrastructure and introduce new/improved functionality in a number of clinical and administrative areas. Delivery of the three major projects to improve clinical and / or administrative functionality – Patient Administration System (PAS) replacement, Electronic Prescribing and Medicines Administration (EPMA), Electronic Document Management (EDM) – is under way, with good engagement and positive feedback from users; however there is a long way to go until they are fully implemented and the potential impact from the reconfiguration of some patient-facing administrative processes is yet to be fully understood. But the Trust's underlying IT infrastructure (e.g. the wireless network) has been put on a more robust footing, the IT strategy is fully aligned with the Trust's strategy, and a comprehensive framework of controls is now in place that has enabled tighter project governance.

- ***Estates - Out-of-date areas, unsuitable for patients/staff, Estates – General maintenance backlog) and Failure to execute property redevelopment programme effectively and within budget*:** there are mid- and long-term redevelopment plans for our two hospitals, which have now substantially changed in scope and circumstances over the past 18 months, with a focus on building a new wing for respiratory patients on the Sydney Street car park at Royal Brompton Hospital and on continued evolutionary development at Harefield Hospital These remain within the highest scoring risks, but an increased amount of capital has been allocated to target the highest risk items on the maintenance backlog following a comprehensive prioritisation exercise in November 2015.

- ***Failure to maintain adequate liquidity*:** there is a deteriorating macroeconomic backdrop for the UK health system, manifested most clearly in reduced tariffs, which could significantly affect our financial performance and on-going liquidity. This risk is overseen by the Audit Committee.

The Risk & Safety Committee has also overseen production of the Quality Report for 2015/16, reviewed progress against the Quality Priorities for 2015/16, and approved the selection of Quality Priorities for 2016/17. The Quality Report for 2015/16 can be found in Annex 1 of this document.

Performance Evaluation of the Board of Directors

Monitor requires that an external evaluation of the Trust Board be undertaken every 3 years. There was extensive evaluation of the Trust Board immediately prior to Foundation Trust authorisation in 2009 and a further external evaluation was commissioned and delivered during 2012. The review was undertaken by DAC Beachcroft LLP and the Foresight Partnership and included examination of the governance of the Board and its principal Committees, namely the Audit Committee and the Risk & Safety Committee. The evaluation consisted of interviews with Directors, observations of Board and Committee meetings in March and April 2012, gathering of views from focus groups of staff and Governors and a comprehensive review of Board documentation. Matters that were examined included: strategy, risk, operational performance and quality management. In addition, a skills inventory was compiled for Board members, to assist with succession planning. The conclusions from the Board evaluation exercise were presented to Board members in May 2012 and recommendations were implemented as appropriate.

The externally facilitated 'Well Led' governance review of the Trust Board is due by the end of 2016/17. A tender exercise to award the contract for evaluation will take place in June 2016 with the intention that the review will take place in quarter three or quarter four of 2016/17.

During 2015/16, the Board carried out a self-appraisal exercise. Analysis of the responses has shown general satisfaction with support and infrastructure, albeit some Board members commented that Board papers should be more concise. With regards to Leadership, the responses were very positive. There was a general view that the Board was effective; but there was a concern regarding the ability of the Trust to manage the risks facing the organisation caused by external pressures – such as inadequate tariffs in respect of complex specialist procedures provided by the Trust.

A self-assessment against the Quality Governance Framework was reviewed by the Audit Committee on 22nd February 2016. This review, and subsequent work, concluded that the Trust met the Monitor requirement, the self-assessment score totalling 1.0, against a Monitor threshold of less than four. This review was submitted to the Care Quality Commission as part of the information request made prior to their planned inspection.

Board of Directors

Board of Directors

The Board of Directors brings a wide range of experience to the Trust and during 2015/16 has continued to ensure effective governance of the organisation. The Directors have been responsible for preparing this annual report and the associated accounts and quality report 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, business model and strategy.

During 2015/16 the Board comprised:

Non-Executive Directors	Executive Directors
Chairman; Sir Robert Finch (to 31 March 2016)	Chief Executive; Robert J Bell
Deputy Chairman; Neil Lerner	Medical Director & Deputy Chief Executive; Professor Timothy Evans (to December 2015)
Mr Andrew Valance-Owen (Senior Independent Director from 2nd April 2014)	Interim Medical Director; Dr Richard Grocott- Mason (from 14 December 2015)
Richard Hunting (to 30th April 2015)	Associate Chief Executive – Finance; Richard Paterson
Philip Dodd	Chief Operating Officer; Robert Craig
Kate Owen	Director of Nursing & Clinical Governance; Joy Godden
Richard Jones	
Lesley-Anne Alexander	Director of Service Development; Nick Hunt
Professor Kim Fox	
Luc Bardin (from June 2015)	

Further details of Board members, and their periods of office, are provided in Section 3 of this Annual Report.

Directors' Statement

So far as the Directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware. The Directors have taken all steps that they ought to have taken, as directors, in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

R. J. ..... **Robert J Bell** **25th May 2016**
Chief Executive

On behalf of the Board of Directors

Disclosures in the public interest

Monitor guidance indicates that a set of key disclosures should be incorporated into the Annual Report.

Income Disclosures required by Section 42 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England, during the financial year 2015/16, was greater than the income received from the provision of goods and services for any other purposes.

Goods and services for the purposes of the health service in England continued to be delivered throughout 2014516 and there was no detrimental impact on these services as a result of the other income received during this period.

Countering Fraud and Corruption

The Trust contracts with TIAA Ltd to provide counter-fraud services. TIAA Ltd is an accredited counter-fraud specialist. Investigations are carried out as required and outcomes reported to the Audit Committee.

Remuneration - salary and pension entitlements of directors

Details of the salary and pension entitlements of directors are set out in the Annual Remuneration Report, page 46 of this document.

Accounting Policies for Pensions and Retirement Benefits

Accounting policies for pensions and retirement benefits are set out in note 8 of the Accounts, Annex 2 of this document.

Interest Paid under the Late Payment of Commercial Debts (Interest) Act 1998

Information regarding these is disclosed in note 11 of the Accounts.

Staff Consultations

During 2015/16 there were three organisational change proposals at Harefield Hospital. Two of these were in the operating theatres and related to the operating department practitioners / anaesthetic practitioners' night rotas, and the theatre porter rotas. The third consultation related to the consolidation of imaging and general portering.

There were two consultations in Laboratory Medicine on changes to out of hours working arrangements. These related to Blood Sciences (cross site) and Tissue Typing (Harefield Hospital).

There were two consultations in the Lung Division with regards to organisational change in Pharmacy (revision of the six day rota) and within Lung Function (revision of on-call for blood gases).

Public Consultations

Details of consultations with stakeholder groups engaging with the Trust around selection of quality priorities for 2016/17 are given in the Quality Report.

Consultation with local residents and others is underway in relation both to the hospital extension and to the non-operational property to be sold.

Ill-health Retirements

Details of ill-health retirements during the period are disclosed in note 11.2 of the Accounts.

Other Operating Revenues
Details of Other Operating Revenues are disclosed in note 4 of the Accounts.

Data Loss/Confidentiality Breach
There were no serious incidents involving data loss in the period.

Cost Allocation and Charging Requirements
The Trust has complied with HM Treasury and Office of Public Sector Information guidance with regard to cost allocation and charging.

Value of Fixed Assets
As noted in the section of this report dealing with Trust Financial Performance for 2015/16, the Trust's land and buildings were revalued as at 31st March 2016 by independent valuers.

Donations
The Trust has made no charitable or political donations during the period.

Events since 31 March 2016
There have been no post-balance sheet events requiring disclosure.

Financial Instruments
The extent to which the Trust employs financial instruments is set out in note 23 to the Accounts.

Related Party Transactions
The Trust shares a number of transactions with Imperial College including joint appointments of consultants / professors and joint research programmes.

Enhanced Quality Governance Reporting

The Trust was authorised as a Foundation Trust in 2009. This was before assessment against the Quality Governance Framework (QGF) formed part of the authorisation process.

On 23rd April 2013 a self-assessment against the Quality Governance Framework was presented to the Risk and Safety Committee and this was followed up early in 2014 by a further review by KPMG, the Trust's internal auditor. This review scored the Trust at 2 against the Quality Governance Framework.

During 2014/15 and 2015/16 the Trust undertook further self-assessments against the Quality Governance Framework. The 2015/16 self-assessment was reviewed by the Audit Committee on 22nd February 2016. There followed further work, and close liaison, between the Director of Performance and Trust Secretary and the Head of Internal Audit. The outcome of this was a score of 1.0. Monitor mandates a score of less than 4, in order for an organisation to be deemed to have reached the standard Monitor requires for the issue of an NHS Provider Licence. The Trust has therefore achieved a good score against the Quality Governance Framework. The score of 1.0 is due to two amber / green areas in connection with potential risks to quality (QGF 1B) and processes for escalating and resolving issues (QGF 3B). The eight other areas were deemed green (zero score).

It should be noted that there are no material inconsistencies between this self-assessment against the Quality Governance Framework, the Trust's Annual Governance Statement included in this Annual Report, and the annual and quarterly statements required by the Risk Assessment Framework, the Corporate Governance Statement and the Quality Report 2015/16.

2.2 Remuneration Report

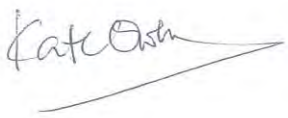
Annual Statement of Remuneration

The Chief Executive has confirmed, in line with the Foundation Trust Annual Reporting Manual 2015/16 (s7.51), that the definition of senior managers to be used covers the chairman, and the executive and non-executive members of the Trust Board.

The Nominations and Remuneration Committee of the Trust Board met on 4th March 2015 in order to decide the remuneration of the Chief Executive and the other executive directors for the 2015/16 financial year. There were no changes to the remuneration of the Chief Executive, or the executive directors during the year, apart from the pay of the Chief Operating Officer and the Associate Chief Executive – Finance, which increased as shown in the table on page 50 of this report.

Two new executive directors were appointed during 2015/16:

- Ms Joy Godden was appointed as Director of Nursing and Governance. This appointment was recommended at the meeting of the Nominations and Remuneration Committee of the Trust Board held on 29th July 2015 and ratified by the Trust Board later that day. .
- Dr Richard Grocott-Mason was appointed as Interim Medical Director following the departure of Professor Timothy Evans. The recommendation for this appointment was formulated at the meeting of the Nominations and Remuneration Committee of the Trust Board held on 28th October 2015 and ratified by the Trust Board on 27th January 2016.



..... **Date 25th May 2016**

Kate Owen;
Chairman of the Nominations and Remuneration Committee of the Trust Board

During 2015/16, the Nominations and Remuneration Committee of the Council of Governors met on 13th May 2015 and decided to recommend that Mr Luc Bardin be appointed as a Non-executive Director. This recommendation was ratified by the Council of Governors on 1st June 2015.

The Committee also met on 11th February 2016 to formulate recommendations concerning the extension of the appointment of Mr Neil Lerner by one year; and the reappointment of Mrs Lesley-Anne Alexander and Dr Andrew Vallance-Owen, each for a second term of three years. These recommendations were ratified by the Council of Governors on 25th February 2016.

Remuneration of the Non-executive Directors will be reviewed for 2016/17 once the outcome of staff pay negotiations is known.

..... **Date 25th May 2016**

Raymond Puddifoot MBE;
Chairman of the Nominations and Remuneration Committee of the Council of Governors

Senior Managers' Remuneration Policy

The Trust policy is for all Executive Directors to be on permanent Trust contracts with six months' notice. Salaries are awarded on an individual basis, taking into account the skills and experience of the post holder, and comparable salaries for similar posts elsewhere. Benchmarking salary data are taken from other NHS organisations and other public sector bodies where appropriate. Pay is also compared with that of other staff on nationally agreed Agenda for Change Terms and Conditions, and Medical and Dental Terms and Conditions. Remuneration consists mainly of salaries (which are subject to satisfactory performance) and pension benefits in the form of contributions to the NHS Pension Fund.

The policy for Non-Executive Directors is to appoint on fixed term contracts of 3 years. Non-Executive Directors are not generally members of the Pension Scheme, and receive their emoluments based on benchmarking data for similar posts elsewhere in the NHS.

Future Policy Table

Item	Salary / Fees	Taxable Benefits	Annual Performance related Bonus	Long Term Related Bonus	Pension Related Benefits
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	Ensures recruitment / retention of a high calibre Medical Director	None Paid	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives
How the component Operates	Paid in even twelfths	None disclosed	Clinical Excellence Award; only available to medical staff	None Paid	Contributions paid by both employee and employer
Maximum payment	As set out in note 36 of the Accounts	None disclosed	As set out in note 36 of the Accounts	None Paid	Lifetime allowance for taxation purposes; £1m from April 2016
Framework used to assess performance	Trust appraisal system	None disclosed	Clinical Excellence Awards	None Paid	N/A
Performance Measures	Tailored to the post concerned	None disclosed	Tailored to the post concerned	None Paid	N/A
Performance period	Concurrent with the financial year	None disclosed	Concurrent with the financial year	None Paid	N/A
Amount paid for minimum level of performance and any further levels of performance*	Salaries / Fees are agreed on appointment and set down in the contract of employment	None disclosed	There are a number of different levels of clinical excellence awards and the amount awarded depends upon an external assessment of the individual undertaken by their peers.	None Paid	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any overpayments may be recovered	None disclosed	Any overpayments may be recovered	None Paid	N/A

*In the case of the Interim Medical Director, the Clinical Excellence Award is based upon his standing within the specialty of Cardiology. This is assessed by his peers, not by the Trust, although the payment is made by the Trust.

Annual Report on Remuneration

Nominations & Remuneration Committee of the Trust Board

The Nominations and Remuneration Committee of the Trust Board (composed of Non-Executive Directors) met on 29th July and 28th October 2015, and on 2nd March 2016, under the Chairmanship of Ms Kate Owen.

In discharging its responsibilities to oversee the remuneration of the executive directors, the Committee has taken into account information concerning the performance of the executive directors supplied by the Chief Executive.

The policy on the pay of executive directors during 2015/16 was that there would be no general uplift of salaries in terms of cost of living payments. Comparison with salaries paid to directors of comparable health care organisations was used to facilitate decision making regarding remuneration to be paid for 2016/17.

Each of the senior managers undergoes appraisal by the Chief Executive. The Chief Executive is in turn appraised by the Chairman. The Chief Executive undertakes an objective-setting exercise with each senior manager and performance against these objectives is kept under review by the Chief Executive. The system used was developed by the Trust HR Director and has been tailored to the requirements of the organisation.

The Committee has been advised by the Hay Group in respect of benchmarking rates of pay for senior managers across London. The Hay Group is not connected to anyone at the Trust in any respect, and does not provide any other services to the organisation.

The contracts of senior managers are normally awarded on the basis of a substantive contract.

Nominations & Remuneration Committee of the Council of Governors

The Nominations and Remuneration Committee of the Council of Governors (composed of Governors) met on 13th May 2015 and 11th February 2016, under the Chairmanship of Councillor Raymond Puddifoot.

In discharging its responsibilities to oversee the remuneration of the Chairman and the non-executive directors, the Nomination & Remuneration Committee of the Council of Governors has taken into account information concerning the performance of the Chairman and the non-executive directors.

When determining remuneration for 2015/16 the Nominations and Remuneration Committee of the Council of Governors has been advised by the Director of Human Resources. When preparing this advice, the Director of Human Resources benchmarked remuneration against that paid by similar organisations across the London area.

The following Table shows the date of appointment of directors, together with the type of contract issued and the unexpired term of appointment where applicable:

Name	Role	Date Appointed	Contract / Unexpired Period at 31st March 2016
Sir Robert Finch	Chairman	1 Jan 09 Renewed 24 Feb 15	-
Mr Robert J Bell	Chief Executive	28 Mar 05	Substantive contract no end date specified
Mr Neil Lerner	Non-Executive Director and Deputy Chairman	1 Feb 10 Renewed 25 Feb 16	10 months
Prof Timothy Evans	Medical Director and Deputy Chief Executive	1 Apr 06	Left 11th December 2015
Dr Andrew Vallance-Owen	Senior Independent Director	26 Feb 13 Renewed 26 Feb 16	35 months
Mrs Lesley-Anne Alexander	Non-Executive Director	26 Feb 13 Renewed 25 Feb 16	35 months
Prof Kim Fox	Non-Executive Director	1 Jun 13	2 months
Mr Richard Hunting	Non-Executive Director	1 Jan 07 Renewed 1 Jan 15	Left 30 April 2015
Mr Richard Jones	Non-Executive Director	25 Feb 14	11 months
Ms Kate Owen	Non-Executive Director	6 Oct 10 Renewed 16 Oct 13	6 months
Mr Philip Dodd	Non-Executive Director	21 Jul 14	16 months
Mr Robert Craig	Chief Operating Officer	22 Oct 08	Substantive contract no end date specified
Ms Joy Godden	Director of Nursing and Clinical Governance	29 July 15	Substantive contract no end date specified
Dr Richard Grocott-Mason	Interim Medical Director	14th December 2015	Substantive contract no end date specified
Mr Nicholas Hunt	Director of Service Development	23 Jul 14	Substantive contract no end date specified
Mr Richard Paterson	Associate Chief Executive - Finance	26 Oct 11	18 months

The standard notice period for an executive director is 3 months. No termination payments have been made during the reporting period and none is planned during 2016/17.

Salary and Pension Entitlements of Directors (Audited Information)

£000 unless otherwise stated	1 April 2015 - 31 March 2016								1 April 2014 - 31 March 2015							
	Salary	Other Remuneration (Clinical salary)	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses	Salary	Other Remuneration	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses
	(bands of £5000)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	rounded to the nearest £100
Sir Robert Finch Chairman	60 - 65						60 - 65	2100	60 - 65						60 - 65	100
Robert J. Bell Chief Executive	260 - 265					nil	260 - 265	4000	260 - 265					nil	260 - 265	7600
Prof. T Evans Medical Director (to 14/12/15)	45 - 50	100 - 105					145 - 150		50 - 55	135 - 140		40 - 45			230 - 235	100
Dr Richard Grocott-Mason Medical Director (from 14/12/15)	15 - 20	35 - 40		10 – 15*			65 - 70									
Robert Craig Chief Operating Officer	155 - 160					nil	155 - 160		150 - 155					nil	150 - 155	
Joy Godden Director of Nursing & Governance (from 29/07/15)	75 - 80					nil	75 - 80									
Dr Caroline Shuldham Director of Nursing & Governance (to 27/02/15)									85 – 90					nil	85 - 90	100
Richard Paterson Associate Chief Executive - Finance	195 - 200						195 - 200	100	185 - 190						185 - 190	
Nick Hunt Director of Service Development	125 -130					nil	125 - 130		85 - 90					nil	85 - 90	

*Clinical Excellence Award

£000 unless otherwise stated	1 April 2015-31 March 2016								1 April 2014-31 March 2015							
	Salary	Other Remuneration (Clinical Salary)	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses	Salary	Other Remuneration	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses
	(bands of £5000)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	rounded to the nearest £100
Richard Hunting Non-Executive Director (to 30/04/15)	0 - 5						0 - 5		15 - 20						15 - 20	
Kate Owen Non-Executive Director	15 - 20						15 - 20		15 - 20						15 - 20	
Neil Lerner Non-Executive Director	25 - 30						25 - 30	800	25 - 30						25 - 30	800
Dr Andrew Vallance-Owen Non-Executive Director	20 - 25						20 - 25		20 - 25						20 - 25	
Lesley-Anne Alexander Non-Executive Director	15 - 20						15 - 20		15 - 20						15 - 20	
Kim Fox Non-Executive Director	0 - 5	30 - 35					30 - 35		0 - 5	30 - 35					30 - 35	
Richard Jones Non-Executive Director	15 - 20						15 - 20	1000	15 - 20						15 - 20	800
Philip Dodd Non-Executive Director	15 - 20						15 - 20		10 - 15						10 - 15	
Luc Bardin Non-Executive Director (from 01/06/15)	10 - 15						10 - 15									

Prime Minister's Ministerial and Parliamentary Salary

£142,500 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. This currently equates to the Prime Minister's ministerial and parliamentary salary. The Cabinet Office approvals process does not apply to NHS foundation trusts but is considered a suitable benchmark above which NHS foundation trusts should make this disclosure.

It can be seen from the table on page 47 of this report that four members of the Trust Board receive a salary greater than £142,500, disclosed pro rata as required. The Nominations and Remuneration Committee of the Trust Board has taken steps to satisfy itself that this level of remuneration is reasonable through benchmarking comparisons with Trusts of a similar size and complexity.

Fair Pay Multiple Requirements (Audited Information)

	2015/16	2014/15
Pay of Median Trust Officer	36,002	36,068

The highest paid officer of the Trust (total remuneration £260k-£265k, 2014/15 £260k-£265k) represented a multiple of 7.29 times that of the median employee (2014/15: 7.28).

Pension Entitlements of Directors
(Audited Information)

Name and title	Real increase/ (decrease) in pension at retirement age at 31 March 2016 (bands of £2,500) £000	Real increase/ (decrease) in lump sum at retirement age at 31 March 2016 (bands of £2,500) £000	Total accrued pension at retirement age at 31 March 2016 (bands of £5,000) £000	Lump sum at retirement age to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2015 £000
Robert J. Bell Chief Executive	5.0 - 7.5	0 - 2.5	40.0 - 45.0	25.0 - 30.0	n/a	n/a	736
Prof. T Evans Medical Director (to 14/15/15)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Richard Grocott-Mason Medical Director (from 14/12/15)	2.5 - 5.0	10.0 - 12.5	50.0 - 55.0	150.0 - 155.0	971	48	899
Robert Craig Chief Operating Officer	2.5 - 5.0	10.0 - 12.5	55.0 - 60.0	155.0 - 160.0	942	72	847
Joy Godden Director of Nursing (from 29/07/15)	7.5 - 10.0	27.5 - 30.0	40.0 - 45.0	125.0 - 130.0	843	186	639
Nick Hunt Director of Service Development	0 - 2.5	0.25 - 5.0	55.0 - 60.0	170.0 - 175.0	n/a	n/a	n/a

Pension calculations are provided by NHS Pensions Agency (NHSPA).

Professor Timothy Evans has withdrawn from the NHS Pension Scheme.
Nick Hunt is over normal retirement age of 60 for 1995 Section therefore a CETV is not applicable
Robert Bell is over the normal retirement age of 65 in the existing scheme, therefore CETV calculation is not applicable

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

There is no CETV for employees who have reached retirement age as defined by the scheme of which they are a member. Officers who were over the retirement age for 'the 1995 section', and who have now changed to 'the 2008 section' with its higher retirement age, will have acquired a CETV during the year.

Real increase (decrease) in CETV - this reflects the change in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Off Payroll Arrangements

In May 2012, HM Treasury published 'Review of the tax arrangements of public sector employees' the focus of which was the minority of individuals who are engaged to provide services within the public sector do not have PAYE and NICs deducted at source, and are therefore 'off-payroll'. The review recommended that for all new engagements and contract renewals:

- Board members and/ or senior officials with significant financial responsibility should be on the organisation's payroll, unless there are exceptional circumstances, in which case the Accounting Officer should approve the arrangements, and such exceptions should exist for no longer than six months; and
- engagements of more than six months in duration, for more than a daily rate of £220 (deemed 'highly paid') , should include contractual provisions that allow the Trust to seek assurance regarding the PAYE and NICs obligations of the individual, and to terminate the contract if that assurance is not provided.

The Trust engages 'highly paid' individuals off-payroll in circumstances where the engagement is of a project and/ or specialist nature and as such does not fit the requirements of a permanent role and has put in place the contractual provisions as recommended in the review. The tables below, which follow reporting requirements as defined in the Annual Reporting Manual, disclose the position at the Trust at 31 March 2016.

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months	**Number of engagements**
No. of existing engagements as of 31 March 2016	38
Of which:	
Number that have existed for less than one year at the time of reporting	15
Number that have existed for between one and two years at the time of reporting	15
Number that have existed for between two and three years at the time of reporting	3
Number that have existed for between three and four years at the time of reporting	2
Number that have existed for four or more years at the time of reporting	3

All existing off-payroll arrangements, outlined above, have at some point been subject to risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and. where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months	**Number of engagements**
Number of new engagements, or those that reached six months in duration between 1 April 2015 and 31 March 2016	28
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	28
Number for whom assurance has been requested	28
Of which:	
Number for whom assurance has been received	28
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

The Trust employees 17 individuals deemed 'Board members and/ or senior officials with significant financial responsibility'. All of these were on-payroll between 1st April 2015 and 31st March 2016.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2015 and 31 Mar 2016	**Number of engagements**
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	17

Reporting of compensation schemes - exit packages year ended 2015/16

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other agreed departures	Total number of exit packages
<£10,000	-	16	**16**
£10,001 - £25,000	4	9	**13**
£25,001 - 50,000	5	9	**14**
£50,001 - £100,000	1	1	**2**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	12	35	**47**
Total resource cost (£000)	647	635	**1,282**

Reporting of compensation schemes - exit packages year ended 2014/15

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other agreed departures	Total number of exit packages
<£10,000	-	7	**7**
£10,001 - £25,000	-	6	**6**
£25,001 - 50,000	-	5	**5**
£50,001 - £100,000	-	4	**4**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	1	**1**
Total number of exit packages by type	-	23	**23**
Total resource cost (£000)	-	763	**763**

Exit packages: other (non-compulsory) departure payments

	Year ended 31 March 2016		**Year ended 31 March 2015**	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies	4	40	-	-
Mutually agreed resignations (MARS) contractual costs	14	273	17	408
Early retirements	1	2	-	-
Contractual payments in lieu of notice	14	259	5	134
Contractual payments in lieu of notice	2	45	-	-
Non-contractual payments requiring HMT approval	1	16	1	221
Total	**35**	**635**	**23**	**763**

The non-contractual payment did not receive Treasury approval, although Trust executives were of the firm opinion that the cost of this payment would be substantially lower than that of an employment tribunal process.

Average numbers of employees (WTE basis)

	Year Ended 31 March 2016			Year Ended 31 March 2015
	Permanent Number	Other Number	Total Number	Total Number
Medical	468	26	**494**	487
Administration and estates	743	57	**800**	779
Healthcare assistants and other support staff	97	31	**128**	130
Nursing, midwifery and health visiting staff	1,345	163	**1,508**	1,449
Scientific, therapeutic and technical staff	572	23	**595**	571
Total average numbers	**3,225**	**300**	**3,525**	**3,416**

This Remuneration Report has been prepared having regard to the requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16.

R. Bell.

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Robert J Bell
Chief Executive
On behalf of the Board of Directors

25th May 2016

2.3 Staff Report

Introduction

The 2015 Staff Survey was conducted in the months of October and November and the results were published by the Care Quality Commission in February 2016.

The Trust recognises that staff engagement and motivation is key to productivity, job satisfaction and service quality. For this reason there are several methods in place to enhance communication, to provide opportunities for information sharing, and for rewarding staff. These are established across both hospital sites.

The Trust has again performed extremely highly on overall staff engagement, above the average for the country across all acute specialist Trusts, with a score of 4.02 out of 5.

Existing Initiatives

The Trust's Chief Executive holds regular Staff Forums. These are valued opportunities, not just to update staff on recent news and developments from a strategic perspective, but also to take questions and comments from staff. Questions can be submitted beforehand if staff would like to remain anonymous or will be taken directly at the meeting. The contents of the forums are published on the intranet to inform those who were unable to attend.

The Trust also has a staff magazine, 'intouch', which is complemented by the monthly 'What's New?' news bulletin, both of which are distributed throughout the Trust. The 'Trust News' and 'Trust Matters' pages on the intranet are also available to all staff.

The Trust has continued the popular Staff Recognition Scheme which takes nominations for individuals or teams from colleagues or customers who feel they have made an outstanding contribution to for example, their team, service improvement, or delivering efficiencies. A ceremony is held twice a year where stories are shared, awards are given and successes are celebrated. The results are published for everyone in the Trust to see and these often inspire others.

In the past three years a new appraisal process has been implemented to help employees understand behavioural expectations and these are assessed against the Core Behaviours and Trust Values which embed principles of fairness and respect.

New Staff Well-being and Stress management policies have been put in place and the Trust has introduced Schwartz Rounds which are open and confidential multidisciplinary forums where caregivers discuss challenging social and emotional issues that arise when caring for patients. Their aim is to help reduce staff stress whilst supporting our staff to provide compassionate care.

A new Induction programme for consultants has been implemented to ensure that senior clinical leaders are fully integrated into the Trust and are supported by senior management.

The survey score for bullying and harrassment has increased by 2% since last year and is now 5% above the national average. An initiative entitled 'Working Together Better for Patients' will continue to be delivered through 2016/17 in order to maintain the drive for improvement.

Initiatives recently implemented

Programmes such as stress and conflict handling, team building, and mediation have been run regularly, and are tailored for each departmental or individual need. We are also currently making a concerted effort with staff and managers to improve Appraisal completion rates. The staff forums, Champions awards, Communications programmes and other employee focussed initiatives will also continue, and we anticipate these will contribute to achieving further high scores for employee engagement and motivation.

Tailored reports from the staff survey by department, showing more details results for individual areas are being circulated to managers and teams following this year's survey to encourage staff to look at areas that may need improvement. Working Together better for Patients courses may become mandatory for areas showing high levels of bullying and harrassment. Leadership management courses may also be refreshed on a 3 year rotation.

Summary of performance - NHS staff survey

The Trust participates in the annual NHS Staff Survey and the results from the 2015 survey are summarised below.

Response Rate:

At the time of sampling, 3,365 staff were eligible to receive the survey. Questionnaires were sent to all fixed term and permanent staff. This includes staff directly employed by the Trust; it excludes staff working for external contractors. It also excludes bank staff unless they are employed directly elsewhere in the Trust.

1,072 staff at the Trust took part in this survey. This is a response rate of 32% which has risen slightly from the 2014 survey.

	2014 (Acute Trusts)		2015 (Acute Trusts)		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	30%	42%	32%	37%	+2%

Areas of improvement and deterioration from the prior year:

The Trust has shown improvement in many Key Findings in the 2015 survey, some of the most notable being the percentage of staff reporting errors, near misses or incidents witnessed in the last month and the percentage of staff having been appraised in the last year, which has risen by 6%.

The survey has also shown a decline in some areas, such as the percentage of staff believing the Trust provides equal opportunities for career progression, although the overall percentage still remains very positive, and the number of staff witnessing potential errors or near misses in the month immediately preceding the survey. These are areas that the Trust is striving to improve on.

Improvements

Key Finding	Change since 2014	2015 survey result	Acute Specialist Trusts National Average 2015
% of staff reporting errors, near misses or incidents witnessed in the last month	+11%	93%	92%
% of staff appraised in last 12 months	+6%	74%	88%
Staff motivation at work (score out of 5)	+0.04	4.02	3.98
Staff satisfaction with level of responsibility and involvement (score out of 5)	+0.03	3.99	3.96

Deteriorations

Key Finding	Change since 2014	2015 survey result	Acute Specialist Trusts National Average 2015
% believing the Trust provides equal opportunities for career progression/promotion	-7%	85%	88%
% witnessing potentially harmful errors, near misses or incidents in last month (lower = better)	+10%	37%	29%
% of staff working extra hours (lower = better)	+4%	77%	75%
% of staff feeling pressure in the last 3 months to attend work when feeling unwell (lower = better)	+4%	50%	59%

Top 5 Ranking Scores:

**where NA is noted due to updated questions the data from 2014 is not directly comparable to 2015, or was not included in the 2014 survey at all.*

	2014 (Acute Specialist Trusts)		2015 (Acute Specialist Trusts)		Trust Improvement/ Deterioration
Top 5 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF12. Quality of appraisals	NA	NA	3.36	3.23	NA
KF18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	NA	NA	50%	59%	NA
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.28	4.14	4.21	4.17	-0.07
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	NA	NA	3.89	3.85	NA
KF14. Staff satisfaction with resourcing and support	NA	NA	3.54	3.48	NA

Bottom 5 Ranking Scores:

	2014 (Acute Specialist Trusts)		2015 (Acute Specialist Trusts)		Trust Improvement/ Deterioration
Bottom 5 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF11. Percentage of staff appraised in last 12 months	68%	84%	74%	88%	+6%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26%	23%	28%	23%	+2%
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	1%	1%	2%	1%	+1%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	NA	NA	49%	53%	NA
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	29%	37%	29%	+10%

Recommendations for addressing areas requiring improvement

From the results we see a very positive picture, showing that staff are extremely engaged and motived, reporting excellent team work and communication throughout the Trust.

The areas requiring improvement will be worked on closely with the HR leads and managers.

This year departements/areas that the results of the survey are broken down by will be given specific reports showing a summary of their data. This will enable managers to focus on areas that require improvement within their teams.

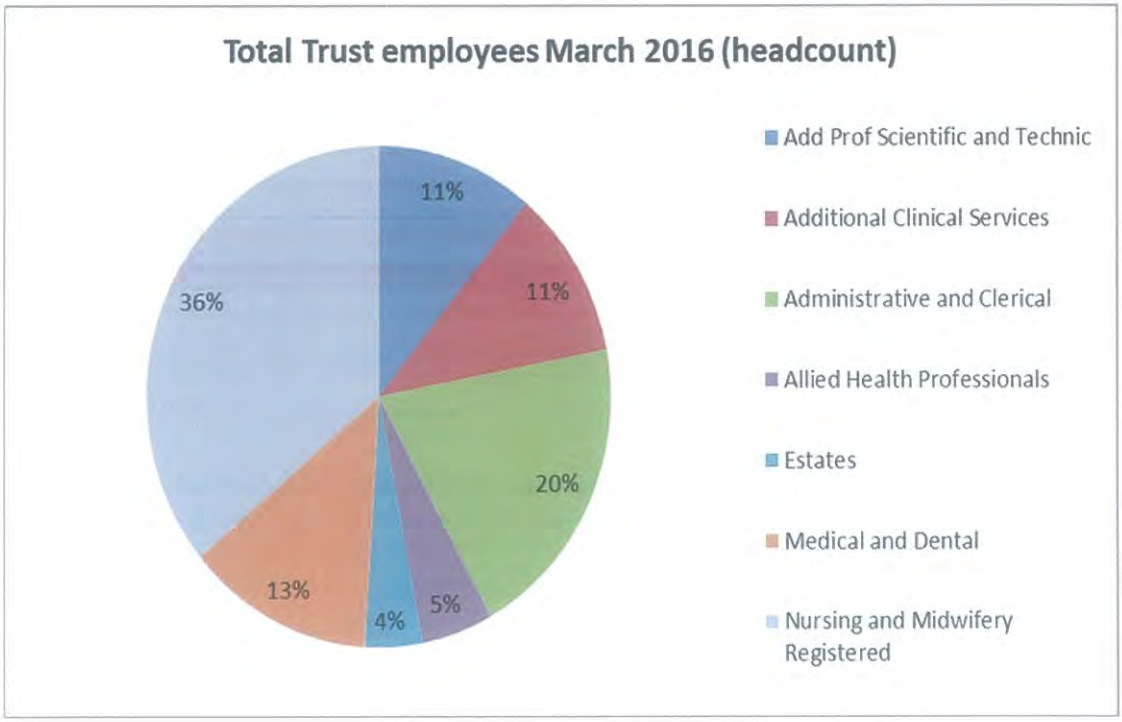
Bullying and harrassment remains an ongoing area of focus, as with many Trusts. The Learning and Development team run a variety of personal development courses such as 'Communication and Assertiveness' and 'Working Together Better for Patients', which may become mandatory for departments reporting higher levels of bullying and harassment. There is also a possibility of running refresher 'leadership and management' courses, particularly in departments reporting higher levels of bullying by managers, to ensure that teams are being managed and communicated to in the correct way, to enusre a healthy work environment.

The Trust's Employees

As at 31st March 2016, the Electronic Staff Record showed that the Trust employed 3,545 people; expressed as head count.

Of these 1,273 were registered as nurses and a further 472 were doctors. There were 182 allied health professionals and 384 people employed to provide additional clinical services (mostly health care assistants). Scientific and professional staff numbered 371. There were 150 estates and ancillary staff. The administrative and clerical staff numbered 713; this group includes ward clerks, medical secretaries, clinic receptionists as well as corporate teams such as Finance, Human Resources, Information Technology and members of the operational management team.

The chart below shows the composition of the work force by staff group:



The following table shows a breakdown at year end of the number of female and male members of staff in each of the specified groups:

	Female	Male
Directors (Trust Board)	3	12
Senior Managers (grade 8c or above)	32	22
All employees	2569	976

Occupational Health Service

The occupational health service is an in house service provided by a team of three occupational health nurse advisors and two administrators. A five day per week service is provided at both Harefield and the Royal Brompton Hospital sites. We also provide occupational health services to the staff working onsite who are employed by ISS Facilities Health Care.

The main causes of sickness absence across the Trust can be attributed to stress/anxiety and musculoskeletal conditions. To help address these problems, and to reduce the time lost from work for these reasons, Physiotherapy, Pilates and Counselling services are available to staff members.

Staff members are referred to Occupational Health either in line with the Trust Sickness Absence Management policy or when managers are concerned regarding staff members' health and wellbeing or fitness to be at work. We also provide new entrant health screening, workplace immunisations and management of needle stick / splash incidences.

The Occupational Health Department has applied for accreditation for Safe Effective Quality Occupational Health Services (SEQOHS). The data submitted is being reviewed and we are awaiting confirmation of an on-site inspection.

The Seasonal flu campaign for 2015/16

The seasonal flu vaccination campaign for staff members commenced on both sites in the week beginning 3rd October 2015. Due to negative press regarding the efficacy of the seasonal flu vaccination during 2014/2015 we were concerned regarding the uptake of the flu vaccination this season. Indeed there had been evidence of a reduced uptake of the flu vaccination last season so additional education resources, the use of screen savers, all user emails and support from the communication team in advertising our campaign were utilised to promote the uptake of the flu vaccination.

During October 2015, 1,164 flu vaccinations were administered to frontline health care workers during site visits to clinical areas; this amounted to 76.3% of the flu vaccinations provided by Occupational Health during this season. Despite a positive start and continued drive to deliver flu vaccinations on site, uptake was reduced.

The uptake for the flu vaccination amongst front line health care workers this season was 45.9% across both sites. The flu vaccination uptake amongst medical staff was 28.5% and 37% of qualified nurses. Additional strategies need to be considered to encourage flu vaccination uptake within front line health care workers in particular medical and nursing staff. The national uptake for flu vaccination amongst frontline health care workers nationally was 53.9%.

During the flu campaign workplace vaccination clinics were established in various departments. Walk in clinics were offered in the Occupational Health Departments of both the Royal Brompton and Harefield Hospital from October 2015 to December 2015. If staff could not attend the walk in clinics, individual appointments were offered. A screen saver was used to encourage flu vaccination uptake and to advertise the flu campaign.

Health and Safety

The Trust recognises that providing a safe environment for its patients and staff underpins all its other activities. The Trust therefore provides Health and Safety training to all staff when they join the organisation and ongoing training throughout their employment to ensure safety awareness and good practice is maintained. This may be supplemented by additional specialist training dependent on the specifics of the staff member's role. Site-based Committees have been established to ensure that safety concerns can be raised through local Safety Representatives. The Trust also supports staff well-being in their work through a comprehensive Occupational Health service to ensure that they, members of the public, and of course, our patients enjoy a safe environment where occupational and safety risks are minimised. Health and safety is supported from the Chief Executive down to all levels.

Staff Sickness

The following data has been supplied from the Trust Electronic Staff Record system:

Total Staff Years	Total Days Lost	Average Sick Days per FTE
3,239	20,029	6

Policies in relation to disabled employees and equal opportunities

The Trust has an Equality and Diversity Policy which was reviewed in May 2015.

The Trust is committed to delivering equality of opportunity for all patients and staff, to maintain a culture in which all forms of discrimination are considered unacceptable. People are at the very heart of our Trust and the services we provide. Our patients, their carers and our staff deserve to feel respected, valued and empowered. We are committed to eliminating all forms of discrimination on the grounds of age, disability, gender, racial group, religion or belief and sexual orientation, in line with current legislation.

In particular, the Trust takes steps to ensure that in respect of people with a disability, no discrimination takes place during the recruitment process, and that both for people with a disability, and those who become disabled during our employment, reasonable adjustments are made as required. The Trust Diversity Policy contains clear guidance for managers in respect of training, career development and promotion of people with a disability.

Since 2011/12 the Trust has met its obligations, under the public sector equality duty, to publish annual equality information in the form required by the regulations.

Information on Policies and Procedures with Respect to Countering Fraud and Corruption

Staff are provided with information on policies and procedures with respect to countering fraud and corruption through the Trust's Anti-Bribery Policy, Gifts Hospitality and Sponsorship Policy and the Conflicts of Interest Policy. The Trust's provider of counter fraud services, TIAA, carries out awareness raising activities and provides counter fraud training on a regular basis.

2.4 Disclosures FT Code of Governance

Compliance with the NHS Foundation Trust Code of Governance

Royal Brompton & Harefield NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code which was reissued during 2014.

The Trust is compliant with the majority of the requirements of the NHS Foundation Trust Code of Governance. Areas where explanation is required include:

B.6.2 'Evaluation of the Boards of NHS foundation trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor[1].

An externally facilitated evaluation of the Trust Board was undertaken in 2012. Monitor guidance on the subject of governance reviews, published on 20th May 2014, stated that Trusts need to consider whether an external governance review should be undertaken before May 2017 (i.e. within 3 years of the guidance being issued).

During 2015/16, the Trust conducted a self-assessment against Monitor's Quality Governance Framework. This was presented to the Audit Committee on 22nd February 2016. This self-assessment also provided assurance to underpin the Corporate Governance Statement, and the associated Monitor certification process.

Further information on Performance Evaluation of the Board of Directors can be found on page 39 of this Annual Report.

Membership Report

New members of the Trust are assigned to a constituency and geographical catchment in line with the criteria for membership set out in the constitution. There are three constituencies: patient, public and staff. The patient constituency has a sub category for carers. As the Trust is a national provider of specialist cardiac and respiratory services, the geographical catchments for the patient and public constituencies span the whole of the United Kingdom (UK). They consist of: North West London, Bedfordshire & Hertfordshire, South of England and the Rest of England & Wales (public members) and for the patients' constituency 'Elsewhere' which includes both Wales and Scotland. The eligibility requirements for the membership constituencies are as follows:

Patients' Constituency – an individual who has attended the Trust's hospitals, in the last three years immediately preceding the date of an application to become a member, as either a patient or as the carer of a patient and who has reached a minimum age of 16 years.

Public constituency – an individual must reside in one of the four geographical constituencies and have reached the minimum age of 16 years.

Staff constituency – the trust has employed an `opt out' system for staff membership. Staff who are eligible for membership are those who are employed by the Trust under a contract which has no fixed term, or has a fixed term of at least 12 months or has been continuously employed by the Trust under a contract of employment for at least 12 months. Individuals who exercise functions for the Trust but do not hold a contract of employment e.g. those

[1] The NHS Foundation Trust Code of Governance, Monitor July 2014

employed by a university or who hold an honorary contact, a contractor or those employed by contractors may also become members of the staff Constituency. Volunteers to the Trust do not qualify for membership under the Staff Constituency but are invited to become public members.

Members of staff who are eligible to be members are informed about the Trust's status as a Foundation Trust and membership at monthly induction sessions for new staff. Members of the staff constituency may opt out of staff membership by notifying the Membership Manger. When members of staff leave the Trust they are invited to become public members.

Membership Strategy and Engagement

The Membership Steering Committee was established in June 2011. It is currently chaired by a patient governor and includes representation from both public and staff governors. Its remit includes development and implementation of the membership and communication strategy that details the Trust's plan for recruitment, engagement and communication with members. The Committee reports to the Council of Governors. The Membership Strategy for 2015-2017 was formulated by the Membership Steering Committee then ratified by the full Council of Governors.

The Trust is mindful of its duties to ensure a representative membership, in both patient and public constituencies. These are enshrined in the Health and Social Care Act 2012. During 2015/16, the Membership Manager, in conjunction with the Membership Steering Committee, has been exploring a number of methods to recruit members with a view to ensuring that the membership is representative of the communities served by the Trust. The database, hosted by Membership Engagement Services, has functionality which enables comparisons to be made between the general population of the UK and the membership of the Foundation Trust.

Engaging Members

The Trust held its sixth Annual Members' Meeting on 22nd July 2015 and approximately 60 members attended. The next Annual Members Meeting is scheduled for 20th July 2016 and once again all members will be invited. The Trust has engaged its members in a number of ways during 2015-2016. A series of member's events were held, these included talks entitled 'Pacemakers in 2015 and what the future holds held at Harefield Hospital, 'Skeletal Muscle in COPD – why bother' held at the Royal Brompton Hospital and a tour of the children's Sleep and Ventilation Unit at the Royal Brompton Hospital. These events have proved very popular with our members with over 20 members attending each event. Further events are planned for later in 2016. Members have also been invited to a number of patient open days organised by clinical teams and our research departments. Others have been engaged via volunteering, participating in national and local patient surveys and voting for governors in elections and putting themselves forward as governor. Members were invited to join a patient advisory group. The advisory group began meeting in January 2016 and plans to meet on a quarterly basis to provide valuable input into a variety of initiatives to improve the patient experience. Examples include supporting the set-up of a peer support group for families of patients in our adult intensive care unit.

Analysis of Membership at 31 March 2015: Membership Size and Movements

Public			2014-2015	2015-2016
	At year start (April 1)	+ve	2,291	2,838
	New members	+ve	623	51
	Members leaving	+ve	(77)	(39)
	At year end (31 March)		***2,838**	**2,850**
Staff	At year start (April 1)	+ve	3,433	3,464
	New members	+ve	467	516
	Members leaving	+ve	(225)	(472)
	At year end (31 March)		**3,675**	****3,508**
Patient	At year start (April 1)	+ve	4,617	4,599
	New members	+ve	161	241
	Members leaving	+ve	(179)	(160)
	At year end (31 March)		**4,599**	**4,680**
	TOTAL		**11,111**	**11,038**

*This includes one member added in April 2015 who joined in March 2015.

**Please note that for the staff member category 363 members were removed in October 2015. These members had left during the course of 2014/2015 but had remained on the staff membership database as members of the staff base. These duplicate entries were deleted in October 2015

In Year Movements

	Members Leaving	Members Joining	Net
Public	39	51	12
Patient	160	241	81
Staff	472	516	44
Total	671	808	**137**

Growing the Membership

The membership profile of the Trust is different compared to most other trusts because as a specialist trust there is no `local community.' Instead our community is our patients. As we are unable to focus on a local community defined by geography, our main strategy for recruitment of new members is to seek to recruit our current patients before they are discharged. We also encourage our patient members to recruit public members such as family members and friends. Work to recruit current in-patients and day-case patients is mainly undertaken by hospital volunteers and the membership manager. Several methods of recruitment are in use. These include:

- use of hospital volunteers to recruit new patient members on wards and out patients
- mail-outs to ex-members of staff to encourage them to become public members
- mail outs to patients recently discharged from the Trust
- publication of articles setting out the advantages of Foundation Trust membership in local newspapers, charity newsletters and hospital newsletters
- Membership stands have been positioned in the reception areas

Ensuring a Representative Membership

Analysis of the membership database by age, gender and ethnicity is undertaken to help the Trust work towards developing a membership that is representative of the communities the Trust serves. The membership ethnic groups are fairly balanced when we compare to the representation with our local populations, however it is recognised that membership recruitment should focus on increasing the number of the ethnic groups Arab, Chinese and mixed white and Asian.

Communication with Members

The Trust's Human Resources Department send out a `welcome letter,' in their correspondence, to new staff. During monthly induction training for new staff, the Membership Manager, covers the role of a Foundation Trust and the `opt-out' system for staff members. For new patient and public members, a welcome letter is sent to new members.

The Trust maintains contact with its members through a newsletter that is sent out twice a year. Members are sent this in the post and by email to those members who have indicated a preference to receive the newsletter by email. It is also available through accessing the trust website. A function of the MES database allows the newsletter to be distributed to members 'households' rather than individuals living at the same address. This has reduced the number of newsletters sent by 1,000 making the process more cost effective. Members' events are advertised on the Trusts internet and intranet as well as in the member's newsletters.

Contact details for people who wish to become members, or members who would like to communicate with governors and the Membership Manager:

There is a generic email address available for members to communicate with governors: governors@rbht.nhs.uk

There is also an e mail address for members who wish to contact the Membership Manager:

members@rbht.nhs.uk

2.5 Regulatory Ratings

Table of Analysis

2015/16	Annual Plan	Q1	Q2	Q3	Q4
Financial Sustainability Risk Rating			2*	2	To be confirmed by Monitor
Continuity of Service Rating	3	2*			
Governance Rating	Green	Green	Green	Green	To be confirmed by Monitor

Table of Analysis

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Service Rating	3	4	4	3	4
Governance Rating	Green	Green	Green	Green	Green

Details of performance against governance indicators are given in the Quality Report, Annex 1 of this document and details of financial performance are given within the section of this report covering Performance Analysis (page 12).

2.6 Statement of Accounting Officer's Responsibilities

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed Royal Brompton & Harefield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal Brompton & Harefield NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual 2015-16* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the *NHS Foundation Trust Financial Reporting Manual 2015/16* have been followed, and disclose and explain any material departures in the financial statements;

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and

- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Robert J Bell
Chief Executive and Accounting Officer **25th May 2016**

2.7 Annual Governance Statement

Annual Governance Statement 2015-16

1. **Scope of responsibility**

   As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's polices, 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 Foundation 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 Foundation Trust Accounting Officer Memorandum*.

2. **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 polices, aims, objectives; it can therefore only provide a reasonable and not absolute assurance of effectiveness. The system of internal control, is based on an ongoing process designed to identify and prioritise the risk to the achievement of the policies, aims and objectives of Royal Brompton & Harefield NHS Foundation 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 Royal Brompton & Harefield NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

3. **Capacity to handle risk**

   To ensure that the Board is able to provide the appropriate levels of assurance on effective internal control to the Trust's patients, its Council of Governors and stakeholders, a committee of the Board, the Risk and Safety Committee, has been established. This committee, with membership of the Trust's Non-Executive Directors and attended by the Executive Directors, is accountable for seeking assurance that systems, processes and outcomes contribute to the Trust's aims and values and objectives relating to patient safety and quality, a safe and clean hospital environment and staff satisfaction and to ensure that there is evidence of robust governance and assurance processes in these areas. The Governance & Quality Committee reports into the Risk & Safety Committee.

   The Governance and Quality Committee, chaired by the Medical Director & Responsible Officer, provides management scrutiny of the Trust's risk management issues against an integrated governance and patient safety agenda. It receives reports on clinical and non-clinical issues from each of the clinical divisions, to ensure that it has the opportunity to identify examples of both good and poor practice so as to ensure that these areas are operating to the highest clinical and quality standards. With representation from each of the clinical and non-clinical divisions present the Trust is able to share best practice and respond to identified weaknesses.

   All Directors across all areas of the Trusts take responsibility for risk identification, management and mitigation within their areas of work and practice. The Divisions are responsible for their own areas, and this is supported by Divisional Quality & Safety reports which contain a wide-range of information including risks, incidents, complaints, clinical outcomes, clinical audits, compliance with best practice.

Training is available for all staff both an induction, and throughout their careers with regard to risk management. In addition, there are detailed guidance and support resources available through the intranet and a team of staff trained in risk management to provide additional support to staff across the organisation.

To ensure that the Trust undertakes its activities within a safe environment, the Trust has appointed an external specialist contractor to monitor compliance with its health and safety obligations. Additionally this contractor provides specialist advice and training in fire, health, safety and manual handling issues.

4. The risk and control framework

As the Trust provides specialist, innovative, tertiary cardiorespiratory services there are risks to patients and the organisation inherent in the healthcare delivery, clinical innovation and research undertaken. The Trust recognises that not all risk can be eliminated or avoided but specific risks can be effectively mitigated and managed. The level of risk deemed acceptable / tolerable is kept under review by the Trust Board.

The Trust is committed to doing everything possible to reduce risk (avoidable harm and death) to patients and to deliver high quality, safe and cost-effective care. Our aim is to develop the characteristics of a high reliability organisation, consistently delivering high quality evidence–based care whilst recognising that for many patients there are risks associated with treatment which cannot be eliminated, but can be controlled. The Trust commits to working with patients and their families to ensure that they understand fully the options for treatment including the potential risks, intended benefits, alternatives and effects of no treatment and are assisted in balancing the risks to come to a decision to give fully informed consent for treatment and/or research.

Governance structures have been established to ensure that a detailed assessment of all identified risks (clinical, research, operational, financial and infrastructure) is performed and managed through the risk register where responsibility for mitigation or management of each risk is identified.

Serious risks are identified as a significant risk to the fulfillment of the organisation's strategic objectives; or may present as a risk to compliance with the requirements of the NHS Provider Licence granted by Monitor. Therefore serious risks are included on the Risk Register and are summarised as the Trust's top risks subject to review by the Risk and Safety Committee of the Trust Board in order to assess mitigating actions, the adequacy of resources directed towards managing the risk and the level of assurance that the controls are effective. Lower scoring risks are managed within the division /department where they originate and held on the risk register.

The aim is not to remove all risk but to identify, assess and manage factors internal and external to the Trust which can threaten achievement of our objectives. Risk taking then occurs in an appropriate, balanced and sustainable way across the full breadth of the Trust's portfolio. The Trust recognises that controlled risk taking within defined parameters (policies, procedures, objectives, risk assessment, review and management and control processes) and agreed by the Trust Board encourages creativity, optimises financial rewards and improves performance, thereby benefiting the patients in our care.

The Top Trust Risks are kept under review by the Trust Board, via the Risk and Safety Committee.
For 2015/16 the Top Risks and their mitigating actions have included:

Top Risks	Mitigation
Service Excellence: Failure to achieve expected standards of clinical care	• Clear lines of accountability; Medical director appointed as Responsible Officer, Divisional Directors/Care Groups Chairs responsible for clinical services • Clinical structure based around care groups which focus on disease pathway and needs of patients, rather than professions of staff • Service Level Agreements in place with other trusts to provide specialist input for patients with clinical needs which fall outside the heart and lung specialty areas. • Robust annual appraisal and revalidation process for medical staff in place • Lead clinicians for Clinical Risk appointed on each site • Clear reporting from regular Governance & Quality Committee, attended by Divisional Directors (clinical) and Executive Directors to discuss clinical issues affecting trust; underpinned by the divisional Quality & Safety meetings, as well as groups with a more specialised focus such as the Clinical Practice Committee, Medicines Management Board, Tissue Governance Oversight Board, Research Committee and the Medical Devices Safety Group. • Regular governance updates / training supplied through the Monthly Governance Day, where non-essential clinical activity is suspended to allow governance activities to occur. Includes peer review of all patients who die in hospital • Participation in all relevant national clinical audits and registries • Routine review, implementation and audit of practice against (inter)national guidelines and standards e.g. National Institute for Health and Care Excellence, Society for Cardiothoracic Surgery, British Thoracic Society • Programme of internal audits performed by KPMG, the Trust's internal auditor, to review our governance arrangements across all aspects of care • Proactive engagement with all external stakeholders and monitoring organisations such as Care Quality Commission and Monitor, commissioners, professional societies, Royal Colleges, Dr Foster, etc. • Proactive approach to tackling any areas where expected standards are not being achieved, from local reviews to involvement of external/national agencies e.g. review of Lung

	Cancer Service and involvement of the elective care intensive support team in formulating an action plan to address performance against the 18 week referral to treatment time pathway.
Organisational Excellence: Estates – out of date areas unsuitable for patients / staff	• Planned, preventative maintenance (PPM) programme focused on high-risk areas and issues. • Increased investment in estates requirements overseen by Capital Working Group. • Long-term redevelopment plans for both sites overseen by the Redevelopment Advisory Steering Group, with professional advisors in place
Estates – general maintenance backlog	• A 3 year programme of works (including costs) has been developed to reduce the maintenance backlog and has been presented to the Trust Board. • Progress against this plan is being monitored by the Chief Operating Officer through the Capital Working Group and the Head of Estates and Facilities has reported progress to the Trust Risk and Safety Committee • All maintenance risks are individually listed on the Risk Register
Reputation & Relationships: Failure to maintain effective designation for specialist clinical services	• Compliance demonstrated with service standards and specifications wherever possible (e.g. in Congenital Heart Disease, Transplantation and VAD, Lung Cancer, Pulmonary Hypertension, Primary Ciliary Dyskinesia and Cystic Fibrosis) • High quality and volume of service provided and monitored: Clinical outcomes reported quarterly to divisions, and to clinicians. Participation in all national audits. Clinical outcomes are monitored via Governance & Quality and (Board) Quality & Safety Committees. • Engagement with commissioners via regular Clinical Quality Review (CQR) meetings to discuss compliance and current issues, attended by Director of Service Development, Director of Nursing & Clinical Governance and Director of Performance • Engagement with relevant regional and national bodies/processes: Many clinicians chairing/members of national CRGs.

Failure to maintain effective influence with key external stakeholders	• Some of the Trust's care groups and teams (e.g. adult and paediatric Cystic fibrosis teams) have for several years engaged effectively with commissioners, medical charities and fellow clinicians from other peer centres in activities such as defining standards of care and planning of pathways. • This level of on-going engagement is not however replicated consistently across all care groups within the Trust. • A small internal project team is interviewing all care group chairs and senior clinicians - doctors, nurses, allied health professionals and technicians - in order to compile an inventory of all the external stakeholders / bodies with whom one or more of our clinicians a) have influence or membership, b) do NOT have influence or membership. The team will then identify common gaps, as well as identify key stakeholders at a Trust-wide level, prioritise gaps to be filled / areas where influence needs to be built, then revert to the care-group leads to agree the actions / campaign required.
Failure to comply with external regulations	• All key targets are monitored and reported to the Trust Board, either routinely or by exception through the Clinical Quality Report. • Monitor was informed of 3 Risk Assessment Framework Targets were at risk during 2015/16; 62 day cancer target / admitted RTT / incomplete RTT – Note; the admitted RTT Target was discontinued as a metric from 1st October 2015 • Robust bottom-up process of internal control through review of performance information at meetings of the Operational Management Team (OMT), Management Committee, Governance and Quality Committee, Risk and Safety Committee and the Trust Board. • Clinical Quality Report presented to Trust Board at every meeting to ensure regular tracking of performance - includes untoward incidents • Review of CQC Intelligent Monitoring which is reported to G&Q Committee and the Risk & Safety Committee • Quarterly Trust Board declarations made against the standards set out in the Risk Assessment Framework published by Monitor • Regular meetings of the CQC Steering Group • Regular oversight of key performance indicators by commissioners through the Clinical Quality Review Group. • A Trust lead has been appointed in order to assist with preparation for CQC inspection during 2016

Financial Risk: Failure to maintain adequate liquidity, ensuring availability of cash	• Trust has made representations to NHS England and Monitor in relation to tariff proposals • Trust has processes in place to monitor and forecast liquidity levels and to arrange appropriate borrowing facilities • Trust has well defined process for planning and managing capital spend in line with available internal and external funding • Stock is managed; bulk purchases need to be agreed by Finance • The Trust has in place a revolving credit facility to meet short term cash requirements that occur. • Suitable internal monitoring processes are in place for accurate reporting to the Trust Board and its Committees to determine timely remedial action.

Productivity & Investment: Information and technology unable to adequately support newly introduced Trust systems/services	• All projects are subject to the standard I&T project controls with monitoring from I&T PMO, CIO, I&T SMT and then ultimately approval from the project sponsor(s). This process includes an 'Acceptance into Service' and Change Control process, which ensures that the support requirements from I&T are clearly understood and agreed prior to system Go-Live. • The I&T Committee, scheduled monthly, is made up of a cross section of senior clinical & operational stakeholders, and determines, prioritises and monitors all I&T projects through scheduled monthly sessions with standard agendas, packs and minuted decisions.
Failure to execute property re-development effectively and within budget	• Existence of the Redevelopment Advisory Steering Group which meets regularly to review progress • Continuous involvement of CEO, and Associate Chief Executive – Finance • Appointment of leading property, financial, tax and legal advisers to the project team • Application of and compliance with the Trust's SFIs for major capital projects • Application of and compliance with Monitor's requirements for major capital projects • Phasing of redevelopment such that capital expenditure wherever possible is funded from earlier disposals

The risks detailed within the risk register are aligned to the Trust's Objectives through the Forward Planning process. The risk register is designed to reflect risks from all aspects of the organisation and provide details of the controls in place to mitigate the risks and identify where assurance can be located. The risk register provides, through ongoing review, assurance to the Board that these risks are being adequately controlled and informs the collation of the Annual Governance Statement.

The risk register recognises and is informed by the Trust's wider role and risk profile, especially as a leading centre for research and development, innovation, translational research and training and the part played by the Trust's stakeholders in its delivery of world class healthcare:

- Monitor, the Foundation Trust regulator, assesses the Trust's risk profile throughout the year and its ratings inform the risk register and Quality Governance Framework.
- Relationships with the Care Quality Commission for ongoing monitoring of compliance with registration requirements.
- Monthly monitoring meetings are held with the Trust's coordinating commissioner, NHS England to assess performance against the NHS Standard Contract – reported through the Clinical Quality Review Group (CQRG).
- The External Services Scrutiny Committee of London Borough of Hillingdon reviews Trust performance.
- Healthwatch in Hillingdon and Central West London. The Healthwatch groups have established a management board and a number of sub-groups focusing on particular health areas. In particular, Healthwatch groups are involved with the development of the Trust's Quality Report.
- The Care Quality Commission undertakes a range of monitoring to identify potential risk issues. The CQC has registered Royal Brompton and Harefield NHS Foundation Trust without restriction and is due to undertake a comprehensive inspection in June 2016.
- Relationships with our health partners and stakeholders in relation to key objectives and future referral patterns.
- The Trust's continued relationship with the National Heart and Lung Institute of Imperial College London.
- The Trust's participation in the Academic Health Science Network for North West London
- The Trust's membership of the Institute of Cardiovascular Science and Medicine, a joint venture with Liverpool Heart and Chest NHS Foundation Trust.

NHS Provider Licence Condition 4; (FT Governance).
Compliance with Condition FT4 of the NHS Provider Licence was reviewed by the Trust's internal auditors during 2014/15. The overall report rating was that of adequate assurance, this being the highest rating that can be achieved on the scale used by KPMG. Further information on enhanced quality governance reporting is provided within the Accountability Report page 45 of this document.

Care Quality Commission
The Trust is fully compliant with the registration requirements of the Care Quality Commission. Ongoing compliance with registration requirements is managed through the Fundamental Standards Leads Group. There are registration leads for each of the registration requirements. During 2015/16 this group was reconstituted in line with the 2014 Regulations and the Fundamental Standards which came into force on 1st April 2015.

The CQC has not undertaken an inspection since its inspection of Harefield Hospital in February 2014, at which time they reported that the Trust was meeting all of the essential standards of quality and safety that were inspected. The CQC also undertook a routine inspection of Royal Brompton Hospital in August 2013 and again found no concerns for the standards inspected. The Trust is compliant with the registration requirements of the Care Quality Commission. The next inspection by the CQC will take place between 14th and 17th June 2016.

NHS Employer
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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Environment
The Trust has undertaken risk assessments 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 this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Managing Public Money
There are a number of required disclosures which have been covered elsewhere in the Annual Report 2015/16. These include:

- Governance framework, to include the Board's committee structure, attendance records and the coverage of its work; please see section the Accountability Report.
- Board Committee reports; please see the Accountability Report
- An account of corporate governance; please see the Accountability report and in particular the section dealing with Compliance with the NHS Foundation Trust Code of Governance on page 67 of this Annual Report.

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

The development and reporting of patient level costing and service level reporting continues, to ensure that the Board is aware of relative profitability and efficiency. Monthly finance and performance reports are provided to the Board and this information is used to identify opportunities for improving efficiency and profitability for each Division. This has been achieved through the introduction of contribution reporting at Divisional level.

Information Governance

The Trust manages its risks related to data security through a number of different approaches. The Trust has a Board level Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data we hold and the evidence base to support the Trust's assessment against the information governance toolkit has been extensively reviewed during 2015/16. The internal auditors have reviewed the evidence and have made recommendations to strengthen the evidence base supporting compliance. All of the toolkit indicators are being met at level 2 or 3. There have been no serious incidents classified as level 2 involving data loss during 2015-16. During 2015/16, data quality has been managed through the Performance and Information Team and kept under review through the Quality Indicator Assurance Framework.

Annual Quality Report

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. Monitor has issued guidance to NHS foundation trust boards on the form and content of the Annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The involvement of stakeholders regarding how our priorities were consulted on and decided is described in more detail in the Quality Report. Quality data is reported to the Board each time it meets and the Governance and Quality Committee receives regular updates covering performance against quality and safety metrics at divisional level.

The external audit review of referral to treatment time (RTT) data for the incomplete patient pathway indicator conducted by Deloitte LLP has led to a qualified audit conclusion with regard to the Quality Report. As a result of the 2014/15 audit findings and recommendations, the Trust has been pursuing remedial actions, engaging the Elective Care Intensive Support Team during 2015/6 in a review of RTT pathway management and data quality. The actions include adoption of a new Waiting-List Policy to reflect latest (October 2015) DH guidance; regular sample audits; investigation of data anomalies; development of new Standard Operating Procedures (SOPs) and associated staff training programmes. Importantly, this is directly linked to implementation of a new Patient Administration System (PAS) from July 2016 as part of the Trust's Digital Care Transformation Programme, which will combine enhanced data validation checks and data entry processes. The ongoing actions have also been reviewed by and agreed with our commissioners, NHS England. Finally, the Trust is considering 3rd party evaluation in late 2016/7 of the PAS implementation and its impact on RTT pathway and data management.

The RTT indicator is included within the Trust's Quality Indicator Assurance Framework and will be the subject of particular scrutiny during 2016/17 in order to ensure that the risks to the quality and accuracy of this data are managed effectively.

Review of effectiveness

As Accounting 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to 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 Board, the Audit Committee and the Risk & Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process which has been applied in maintaining and reviewing the effectiveness of the system of internal control has included the involvement of the following bodies:

The Board has exercised its role of oversight of the system of internal control through regular reports made by the Chairman of the Audit Committee to the Board. Reports have been provided to the next meeting of the Trust Board following every meeting of the Audit Committee. At its meeting on 25th May 2016, the Board concluded that an effective system of internal control had been in place during 2015/16.

The Audit Committee provides the Trust Board with an independent and objective evaluation of the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that support the achievement of the organisation's objectives. The conclusion of this Committee is that it has discharged its duties appropriately during 2015/16.

The Risk & Safety Committee provides the Trust Board with independent and objective evaluation of whether the systems and processes in place in the Trust to manage risks, especially patient safety risks, are complete, appropriate, and working as intended. The conclusion of this Committee is that is has discharged its duties appropriately during 2015/16.

Clinical audits are regularly conducted across all clinical services of the Trust. Details of participation in the national clinical audit programme are detailed in the Quality Report, at Annex 1 of the Annual Report. The clinical audit team can confirm that it has fulfilled its duties throughout 2015/16.

Internal audit services are outsourced to KPMG, who have provided an objective and independent opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management; control and governance support the achievement of the objectives of the organisation. KPMG's conclusion as set out in its formal Head of Internal Audit Opinion is that 'significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control'.

Deloitte LLP provides the Trust with its external audit assurance and reports on annual accounts.

The Quality Governance Framework and Risk Register Assessments have to date identified no significant control issues.

6. Conclusion

Based on the information set out in this Statement, I consider that appropriate governance structures and internal control measures are in place and have operated throughout 2015/16, during which time, no significant control issues have been identified.

Signed: **Date: 25th May 2016**

.....

Robert J Bell
Chief Executive

Annex 1

Quality Report

Independent auditor's report to the council of governors of Royal Brompton & Harefield NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Royal Brompton & Harefield NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Brompton & Harefield NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Royal Brompton & Harefield NHS Foundation Trust as a body, to assist the council of governors in reporting Royal Brompton & Harefield NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Brompton & Harefield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the quality report is not consistent in all material respects with the sources specified below; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from NHS England, dated 25 May 2016;
- feedback from governors, dated 17 May 2016;
- feedback from local Healthwatch organisations, dated 19 May 2016 and 20 May 2016;
- feedback from Local Authority Scrutiny Committees dated 16 May 2016 and 21 May 2016;
- the national inpatient survey 2015;
- the national staff survey 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 24 April 2016; and
- the CQC Intelligent Report Monitoring dated May 2015

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- reviewing the process flow of the indicator with management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.
The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion
The "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

Our procedures included testing a risk based sample of items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We found that:

- for 36% of our sample of patients' records tested, the pathway was incorrectly recorded (including start or end date of treatment not accurately recorded, or inclusion of patients not on 18 week pathways), affecting the calculation of the published indicator; and
- for 20% of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator; and
- for 2.99% of completed patient pathways for the year, the Trust had recorded an "unknown" clock start date, meaning that the patient could not be included in the reported indicator.

The "Performance against key healthcare targets 2015-16" section on page 34 of the Trust's Quality Report details the actions that the Trust is taking to resolve the issues identified in its processes.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2016. We are unable to quantify the effect of these errors on the reported indicator.

Qualified conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual'.

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom
25 May 2016

Annex 2

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2015 TO 31st MARCH 2016

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2015 TO 31st MARCH 2016

Accounts for the year 1st April 2015 to 31st March 2016

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INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

Opinion on financial statements of Royal Brompton & Harefield NHS Foundation Trust	**In our opinion the financial statements:** • **give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;** • **have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and** • **have been prepared in accordance with the requirements of the National Health Service Act 2006.** The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and the related notes 1 to 26. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.
Certificate	We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and Code of Audit Practice.
Going concern	We have reviewed the Accounting Officer's statement contained in the Performance Report that the Trust is a going concern. We confirm that: • we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and • we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.
Independence	We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.
Our assessment of risks of material misstatement	The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team:

Risk	How the scope of our audit responded to the risk
NHS revenue and provisions	
As described in note 1.21, Critical Accounting Estimates and Judgements, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: the introduction of a new "block" contract with NHS England for the year, covering the majority of the Trust's clinical income; the complexity of the Payment by Results regime, in particular in determining the level of over performance revenue to recognise; and the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters three and four. Details of the Trust's income, including £277.5m from NHS England and Clinical Commissioning Groups (2014/15: £285.0m), are shown in note 3 to the financial statements. NHS debtors are shown in note 17 and related disputes provisions in note 21 to the financial statements The majority of the Trust's income is commissioned by NHS England under a "block" contractual arrangement for 2015/16. The remainder of income is from a wide range of commissioners, increasing the complexity of agreeing a final year-end position	We reviewed the terms of the contract with NHS England, and of the variation signed in the year, considered the accounting implications and evaluated whether revenue was being recognised in line with the contract. We evaluated the design and implementation of controls over recognition of Payment by Results income, with IT specialists performing the testing of the systems controls. We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners,

Risk	How the scope of our audit responded to the risk
Property valuations	
The Trust holds property assets within Property, Plant and Equipment at a valuation of £158.8m and Investment Properties of £34.1m (2014/15: £151.2m and £30.6m respectively). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. As detailed in notes 1.21 and 12, the Trust has reassessed a number of valuation assumptions in the current year, including the use of an "alternative site" valuation basis for one property and a reduced land area for another. The net valuation movement on the Trust's estate shown in note 12 is an impairment of £17.6m to land, and revaluation gains of £24.8m on buildings and £3.5m on investment properties (2014/15: land gain of £0.2m, buildings gain of £1.1m, and investment property loss of £0.6m).	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2016. We challenged the Trust's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by considering the Trust's previous plans and critically evaluating whether the alternatives considered would be viable given the nature of the Trust's activities. We assessed the reduced land value assumption by comparison to the overall land area of the site and the potential for reduction in landscaping and open space. We have reviewed the disclosures in notes 1.21 and 12 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

Risk	How the scope of our audit responded to the risk
Accounting for Capital Expenditure	
The Trust has an extensive capital programme with expenditure of £20.0m in 2015/16 on Property, Plant and Equipment and £4.7m on Intangible Assets (2014/15: additions of £27.6m)	We tested the design and implementation of controls around the capitalisation of costs, and tested expenditure on a sample basis to confirm that it complies with the relevant accounting requirements.
Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards, and when to commence depreciation. In addition, adjustments may be required to the carrying value of previously capitalised works that are being replaced or refurbished.	We obtained an understanding of key projects and challenged management's assessment of whether any impairment arises in respect of newly capitalised expenditure, and that adjustments to the value of old assets were dealt with as part of the revaluation process.
Where existing properties are being modernised, the "modern equivalent use" valuation rules can lead to a "day one" impairment where the accumulated cost of the asset exceeds the cost of a newly built facility.	
Further details of the associated estimates and balances are included in notes 1.21, 12 and 13 to the financial statements.	

Risk	How the scope of our audit responded to the risk
Going concern As described in the going concern section in the Performance Report, the Trust's Annual Plan and forecasts considered in evaluating the going concern assumption include a number of key assumptions. The assessment of the reasonableness of these assumptions, their potential interaction and other potential downsides, and the availability of mitigating actions, represent key judgements in the preparation of the financial statements.	We evaluated management's going concern assessment by challenging the key judgements within the Trust's forecasts and annual plan including assumptions over disposals, financing avialability, income and activity levels, cost improvement programme savings, planned capital expenditure and working capital levels. We have reviewed the Trust's historical accuracy in forecasting its cash position. We have reviewed management's paper to the Audit Committee, and observed the discussion and challenge of key assumptions at Audit Committee. We have reviewed the calculations included in the underlying analysis, including base and sensitised plan, and evaluated the adequacy of management's downside sensitivity, and the feasibility of the mitigating actions available to management. We sighted documentation in respect of the status of negotiations in respect of the planned sale of an investment property and in respect of the continuation of the Trust's revolving credit facility.

Our report includes an additional risk, going concern, which was not included in our report last year. This was identified as a risk in 2014/15, but has had an increased effect upon the conduct of our audit this year due to the increased judgements in the current year described in management's statement on going concern in the Performance Report.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page [x].

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality	**We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.** **We determined materiality for the Trust to be £3.35m (2014/15: £3.30m), which is below 1% of operating income and below 1.6% of equity (2014/15: below 1% of operating income and below 1.6% of equity). Operating income was chosen as a benchmark as the Trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements. This is an increase on 2014/15 due to the increased operating income for the year.** **We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £167,500 (2014/15: £150,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.**
An overview of the scope of our audit	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's sites in Chelsea and in Harefield directly by the audit engagement team, led by the audit partner. The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems. Data analytic techniques were used as part of audit testing, in particular to support profiling of populations to identify items of audit interest. Key areas where analytics were used included journal testing.
Opinion on other matters prescribed by the National Health Service Act 2006	In our opinion: • the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and • the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor	As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team. This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal Brompton & Harefield NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.
Scope of the audit of the financial statements	An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Susan Barratt, BA, ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom
25 May 2016

Accounts of Royal Brompton & Harefield NHS Foundation Trust
for the Year ended 31 March 2016

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2016 have been prepared by Royal Brompton & Harefield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

.....

Robert J Bell
Chief Executive

25th May 2016

Royal Brompton and Harefield NHS Foundation Trust

Annual Report and Financial Statements for the year ended 31 March 2016

Foreword to the financial statements

Royal Brompton and Harefield NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Royal Brompton and Harefield NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name **Robert J Bell**
Job title **Chief Executive**
Date **25 May 2016**

Statement of Comprehensive Income

	Note	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Operating income from patient care activities	3	328,957	337,979
Other operating income	4	34,895	32,413
Total operating income from continuing operations		**363,852**	**370,392**
Operating expenses	5	(369,849)	(366,301)
Operating (deficit)/ surplus from continuing operations		**(5,997)**	**4,091**
Finance income	10	47	36
Finance expense - financial liabilities	11	(564)	(160)
Finance expense - unwinding of discount on provisions	21	(11)	(11)
PDC dividends payable		(6,671)	(6,681)
Net finance costs		**(7,199)**	**(6,816)**
Movement in the fair value of investment property	14	3,476	(593)
Deficit for the year		**(9,720)**	**(3,318)**
Other comprehensive income (will not subsequently be reclassified to I&E)			
Revaluations of operational properties and other non-current assets	12, 13	7,148	1,320
Other reserve movements		(3)	1
Total comprehensive expense for the year		**(2,575)**	**(1,997)**

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Property, plant and equipment	12	195,510	189,224
Intangibles	13	12,054	-
Investment properties	14	34,088	30,612
Total non-current assets		**241,652**	**219,836**
Current assets			
Inventories	16	9,043	11,186
Trade and other receivables	17	32,512	46,828
Cash and cash equivalents	18	13,777	9,476
Total current assets		**55,332**	**67,490**
Current liabilities			
Trade and other payables	19	(49,597)	(46,724)
Borrowings	20	(3,070)	(10,039)
Provisions and liabilities	21	(1,019)	(856)
Total current liabilities		**(53,686)**	**(57,619)**
Total assets less current liabilities		**243,298**	**229,707**
Non-current liabilities			
Borrowings	20	(27,500)	(10,000)
Provisions and liabilities	21	(690)	(2,234)
Total non-current liabilities		**(28,190)**	**(12,234)**
Total assets employed		**215,108**	**217,473**
Financed by			
Public dividend capital		108,362	108,152
Revaluation reserve		57,070	49,924
Income and expenditure reserve		49,676	59,397
Total taxpayers' equity		**215,108**	**217,473**

The financial statements on pages 1 to 37 were approved by the Trust Board and authorised for issue on, and signed on its behalf by:

Signed .....

Name **Robert J Bell**
Job title **Chief Executive**
Date **25 May 2016**

Statement of Changes in Equity for the year ended 31 March 2016

	Note	Public Dividend Capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2015 - brought forward		**108,152**	**49,924**	**59,397**	**217,473**
Deficit for the year		-	-	(9,720)	**(9,720)**
Impairments		-	-	-	**-**
Revaluations	12, 13	-	7,148	-	**7,148**
Public Dividend Capital received		210	-	-	**210**
Other reserve movements		-	(3)	-	**(3)**
Taxpayers' equity at 31 March 2016		**108,362**	**57,070**	**49,676**	**215,108**

Statement of Changes in Equity for the year ended 31 March 2015

		Public Dividend Capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2014 - brought forward		**105,304**	**48,603**	**62,715**	**216,622**
Deficit for the year		-	-	(3,318)	**(3,318)**
Impairments		-	-	-	**-**
Revaluations	12, 13	-	1,320	-	**1,320**
Public Dividend Capital received		2,848	-	-	**2,848**
Other reserve movements		-	1	-	**1**
Taxpayers' equity at 31 March 2015		**108,152**	**49,924**	**59,397**	**217,473**

Information on reserves

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 Trust. Additional PDC may be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health 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 income. 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 represents the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Cash flows from operating activities			
Operating (deficit)/ surplus		(5,997)	4,091
Non-cash income and expense:			
Depreciation and amortisation	5	14,577	16,011
Impairments charged to operating expenses	5	412	3,480
Reversals of impairments credited to other operating income	4	(1,553)	-
Loss/ (gain) on disposal of non-current assets	4, 5	17	(52)
Income recognised in respect of capital donations		(2,838)	(2,829)
Decrease/ (increase) in receivables and other assets		14,316	(19,444)
Decrease/ (increase) in inventories		2,143	(1,510)
Increase in payables and other liabilities		3,229	4,687
Decrease in provisions		(1,392)	(1,177)
Other movements in operating cash flows		(2)	1
Net cash generated from operating activities		**22,912**	**3,258**
Cash flows from investing activities			
Interest received	10	47	36
Purchase of property, plant, equipment and intangibles		(25,242)	(27,174)
Receipt of cash donations to purchase capital assets		2,838	2,829
Net cash used in investing activities		**(22,357)**	**(24,309)**
Cash flows from financing activities			
Public dividend capital received		210	2,848
Capital loans received from the Department of Health	20	17,500	10,000
Movement on other loans	20	2,275	39
Other interest expense	11	(564)	(160)
PDC dividend paid		(6,431)	(6,705)
Net cash generated from financing activities		**12,990**	**6,022**
Increase/ (decrease) in cash and cash equivalents		**13,545**	**(15,029)**
Cash and cash equivalents at 1 April		**(524)**	**14,506**
Cash and cash equivalents at 31 March	18	**13,021**	**(524)**

Note 18.1 reconciles cash and cash equivalents as presented in the Statement of Cash Flows and the Statement of Finanial Position, in the case of the latter it is reported gross of drawdown in committed facility and/ or overdrafts where applicable.

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *FT ARM* which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the *FT ARM 2015/16* issued by Monitor. The accounting policies contained therein follow IFRS and HM Treasury's *FReM* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going concern

The Directors have carefully considered the financial position of the Trust and its expected future performance given the demanding financial context in which it is operating.
Key factors have included:

- The planned sale of an investment property, including its probability, quantum of sale proceeds and timing;
- The availability of borrowings, including the continuation of the Trust's revolving credit facility
- The intended expansion of private patient activities both in the UK and overseas to subsidise loss-making NHS work
- Likely future developments in tariffs and specialist top ups
- Achievement of planned savings targets
- The level of planned capital expenditures

These factors have been the subject of sensitivity analysis against which the Trust's capacity to mitigate downside risks has been assessed.

Having made appropriate enquiries, the Directors have concluded that there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. Accordingly, they continue to adopt the going concern basis in preparing the accounts.

Note 1.1 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 NHS commissioners for health care services.
Where income is received for a specific activity which is to be delivered in the subsequent financial year, that income is deferred.
Income is recognised on partially completed patient episodes at 31 March based on estimated costs at the balance sheet date insofar as NHS commissioning bodies agree to recognise the corresponding expenditure.
Government grants are grants from Government bodies other than income from commissioners or NHS 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.
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.

Note 1.2 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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. It is not possible for the Trust to identify its share of the underlying Scheme liabilities. Therefore, the Scheme is accounted for as 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 1.3 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received and is measured at their fair value. 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 1.4 Property, plant and equipment

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;

and

- the item has a cost of at least £5,000;
- collectively, items have a cost of at least £5,000 and, individually, a cost of more than £250, where they are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- the items form part of the initial equipping and set-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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 property, plant and equipment assets are measured subsequently at fair value.

Note 1.4 cont...

Valuation of Operating Properties
Land and buildings used for the Trust's services or for administrative purposes are stated in the balance sheet at their revalued amounts. Under IAS 16 this is the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Fair values are determined as follows:

Land and non-specialised buildings - market value for existing use
Specialised buildings - depreciated replacement cost.

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. Since then, HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. As at 31 March 2016 the specialised buildings at the Chelsea campus have been valued on an alternate site basis using the locational weighing and BCIS index of an adjacent Borough. As at 31 March 2016 the land area valued at the Harefield campus was reduced to reflect a notional adjustment to exclude space that would not be required in the reprovision of a modern equivalent asset.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. As allowed by IAS 23 for assets held at fair value, cost includes professional fees and any direct borrowing cost charged by third parties as part of financing arrangements associated with construction of the asset, but not borrowing costs attributable to the provision of the asset, which are expensed immediately. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, all fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation on assets of low value ceased and the carrying value of existing assets from that date could be written off over their remaining useful lives and new fixtures and equipment carried at depreciated historic cost, as this is not considered to be materially different from fair value.

Any increase arising on revaluation is taken to the revaluation reserve except where it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the amount previously charged. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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 will result 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. Assets under construction are not depreciated except where there is doubt over the completion of the construction project.

Revaluation gains and losses
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.

Note 1.4 cont...

Impairments
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 income 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 and their reversals as revaluation gains.

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 ceases to be charged. Assets are derecognised when all material sale contract conditions have been met.

The profit or loss on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve, if any, is transferred to retained earnings.

Property, plant and equipment which is to 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.

Donated, government and other grant funded assets
Donated and grant funded property, plant and equipment 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.

Assets are valued, depreciated and impaired as described above for purchased assets.

Note 1.4 cont...

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The ranges of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, including dwellings	25	60
Plant & machinery	4	7
Transport equipment	2	7
Information technology	2	5
Furniture & fittings	4	7

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.5 Intangible assets

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, where the cost of the asset can be measured reliably and is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- the asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the costs attributable to the asset during development.

Software

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.

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 fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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

Note 1.5 cont...

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

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The ranges of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Development expenditure	2	12
Software	2	5
Licences & trademarks	2	5

Note 1.6 Government and other revenue grants

There are two types of government grants: revenue (to fund revenue expenditure for example research) and capital (to fund the acquisition of non-current assets by the Trust). Both types are commonly granted on condition that the funding should be applied in accordance with the intentions of the granting body. Non-current assets purchased using government grant funding are valued, depreciated and impaired as described above for purchased assets.

Revenue grants are taken to the Statement of Comprehensive Income to match the related expenditure and the value of granted non-current assets is recognised in full in the Statement of Comprehensive Income at the date of receipt.

Note 1.7 Inventories

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

Work-in-progress comprises goods in intermediate stages of production. Partially completed patient episodes are not accounted for as work-in-progress but as receivables. This is because partially completed patient episodes are verified with NHS providers and commissioners as part of the intra-NHS debtor/creditor balances agreement exercise.

Note 1.8 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities which arise from the sale and purchase of goods or services are recognised when delivery or receipt of the goods or services is made.

Financial assets or 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 below.

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

Note 1.8 cont...

Derecognition

Financial assets are derecognised 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 derecognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised between 'at fair value through income and expenditure'; 'held to maturity investments'; 'loans and receivables' and 'available-for-sale'.

Financial liabilities are classified between 'at fair value through income and expenditure' and 'other financial liabilities'.

Financial assets and liabilities 'at fair value through income and expenditure'

Financial assets and liabilities at 'fair value through income and expenditure' are financial assets or liabilities held for trading. A financial asset or 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.

These financial assets and liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in fair value are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust has not entered into contracts that have different risks and characteristics to their host contract.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The Trust does not hold any held to maturity investments.

Loans and receivables

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

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

Loans and receivables are recognised initially at fair value, net of transaction costs, and 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.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Note 1.8 cont...

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 non-current 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.

The Trust does not hold any 'available for sale' financial assets.

Other financial liabilities
All other financial liabilities including borrowings 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 twelve months after the Statement of Financial Position date, which are classified as non-current 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 by the Trust 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 liabilities carried at fair value, carrying amounts are determined from quoted market prices where possible, otherwise by discounted cash flow analysis.

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 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 have an impact on the estimated future cash flows for 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.

Note 1.9 Leases

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 as an item of property plant and equipment.

The annual rental cost 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 the Statement of Comprehensive Income. The lease liability is derecognised when the liability is discharged, cancelled or expires.

Note 1.9 cont...

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses/ credited to other operating income on a straight-line basis over the term of the lease. Operating lease incentives received and initial direct costs incurred in negotiating and arranging a lease are recognised on a straight-line basis over the lease term.

The Trust leases investment properties under operating leases as a lessor.

Note 1.10 Investment properties

Investment property is defined in IAS 40 as property (land or a building or part of a building, or both) held (by the owner or by the lessee under a finance lease) to earn rentals or for capital appreciation or both, rather than for:
(a) use in the production or supply of goods or services or for administrative purposes; or
(b) sale in the ordinary course of business.

The elements of properties rented out for the purpose of relatives' accommodation are classified as investment property.

Investment property is initially valued at cost and thereafter stated at fair value. Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

Under IAS 40 revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date.

Gains and losses arising from the revaluation of Investment properties are recognised in the Statement of Comprehensive Income.

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 within 3 months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.12 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 rates published and mandated by HM Treasury.

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations exceed the economic benefits expected to be received under it.

A restructuring charge is recognised when the Trust has developed a detailed formal plan for restructuring at the Statement of Financial Position date and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Note 1.12 cont...

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 21.2 but is not recognised as a liability in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the NHSLA's Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution 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 1.13 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 Trust's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, 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 Trust's control; or
- 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 1.14 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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

Note 1.15 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 1.16 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the year in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.17 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 1.18 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 expenditure headings on an accruals basis.

The losses and special payments note (Note 24) is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in the 2015/16 accounts.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the NHS Foundation Trust Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but first effective at a subsequent reporting period:

IFRS 11 (amendment) – acquisition of an interest in a joint operation (not yet EU adopted)
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation (not yet EU adopted)
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants (not yet EU adopted)
IAS 27 (amendment) – equity method in separate financial statements (not yet EU adopted)
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets (not yet EU adopted)
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception (not yet EU adopted)
IAS 1 (amendment) – disclosure initiative (not yet EU adopted)
IFRS 15 Revenue from contracts with customers (not yet EU adopted)
Annual improvements to IFRS: 2012-15 cycle (not yet EU adopted)
IFRS 9 Financial Instruments (not yet EU adoptded)

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have a significant impact or potential impact on the Trust.

Note 1.21 Critical accounting estimates and judgements

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, considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an ongoing 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.

Critical judgements in applying accounting policies

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

Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities.

Provision for impairment of receivables

Management will use their judgement to decide when to write off revenue or to provide against the probability of not being able to collect debt.

Impairments, estimated asset lives and revaluations

The Trust is required to review property, plant and equipment and investment properties for impairment. Between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives. Estimates are used to assess the fair value of land and buildings assets at each year end, in comparison to the carrying values, which may result in revaluation surpluses or deficits being recognised.

Redevelopment fees

The Trust has reversed an impairment on fees incurred in relation to the redevelopment of the Chelsea campus following an assessment of ongoing benefit.

Key sources of estimation uncertainty

Management has made the following critical judgements in the process of applying the entity's accounting policies where this has had a significant effect on the amounts recognised in the accounts:

1) The use of estimated asset lives in calculating depreciation (see Note 12 and 13) and professional valuations that can result in increases and decreases to property values.

2) Provisions covering items for contractual disputes, impairment of receivables, early voluntary retirement pension contributions and injury benefit obligations (which are estimated using expected life tables and discounted at the pensions rate of 1.37%, see Note 1.12).

Note 1.22 Prior year disclosures

Prior year disclosures are presented on a comparable basis to current year equivalent items.

Note 2 Operating segments

The segmental analysis below reflects the format of contribution reporting by the three clinical divisions of the Trust that is made monthly to the Trust Board.

	£000			
Full Year 2015/16	**RBH Heart**	**HH Heart**	**Lung**	**Total**
NHS clinical income	114,092	90,019	78,256	282,367
Non NHS income	21,677	5,068	5,686	32,431
Non clinical income	1,562	447	366	2,375
Total income	**137,331**	**95,534**	**84,308**	**317,173**
Pay	(72,726)	(46,985)	(32,137)	(151,848)
Non pay	(44,935)	(32,745)	(24,629)	(102,309)
Total expenditure	**(117,661)**	**(79,730)**	**(56,766)**	**(254,157)**
Contribution	**19,670**	**15,804**	**27,542**	**63,016**
Contribution %	14%	17%	33%	20%
Other income & costs				(57,212)
EBITDA				**5,804**
Capital charges/ other				(15,524)
Deficit for the year				**(9,720)**

	£000			
Full Year 2014/15	**RBH Heart**	**HH Heart**	**Lung**	**Total**
NHS clinical income	113,930	91,266	76,067	281,263
Non NHS income	19,994	5,032	5,607	30,632
Non clinical income	1,131	597	250	1,978
Total income	**135,055**	**96,895**	**81,924**	**313,874**
Pay	(70,029)	(46,055)	(31,147)	(147,231)
Non pay	(42,795)	(34,758)	(25,255)	(102,807)
Total expenditure	**(112,824)**	**(80,813)**	**(56,402)**	**(250,038)**
Contribution	**22,231**	**16,082**	**25,523**	**63,836**
Contribution %	16%	17%	31%	20%
Other income & costs				(42,589)
EBITDA				**21,246**
Capital charges/ other				(24,564)
Deficit for the year				**(3,318)**

The accounting policies of the reportable segments are the same as the Trust's accounting policies as described in Note 1.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Acute services		
Elective income	69,410	68,766
Non elective income	30,071	31,630
Outpatient income	24,928	23,237
Other NHS clinical income	163,499	175,250
Other services		
Private patient income	39,287	37,463
Other clinical income	1,762	1,633
Total	**328,957**	**337,979**

Note 3.2 Income from patient care activities (by source)

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
NHS England & CCGs*	277,465	284,972
Other NHS Foundation Trusts	2,682	2,595
NHS Trusts	1,624	1,504
NHS other	6,129	7,612
Department of Health other	8	2,200
Non-NHS: private patients	39,287	37,463
Non-NHS: overseas patients (chargeable to patient)	1,092	494
NHS injury scheme	52	107
Other	618	1,032
Total	**328,957**	**337,979**

All income related to continuing operations.

*Income from NHS England & CCGs includes £5,002k at 31 March 2016 (£5,534k at 31 March 2015) for partially completed patient episodes.

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

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Income recognised this year	1,092	494
Cash payments received in-year	440	159
Amounts added to provision for impairment of receivables	546	494
Amounts written off in-year	144	157

Note 4 Other operating income and income from commissioner requested services

Note 4.1 Other operating income

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Research and development	11,946	11,045
Education and training	6,033	6,240
Receipt of capital grants and donations	2,926	2,829
Charitable and other contributions to expenditure	2,426	2,225
Non-patient care services to other bodies	544	338
Profit on disposal of non-current assets	-	52
Reversal of impairments of non-current assets	1,553	-
Rental revenue from operating leases	1,198	1,565
Income in respect of staff costs where accounted on gross basis	1,457	1,233
Other income:		
Clinical excellence awards	2,916	2,689
Staff accommodation rentals	1,215	1,217
Catering	1,408	1,520
Childcare services	673	801
Car parking	194	190
Other	406	469
Total other operating income	**34,895**	**32,413**

All income related to continuing operations.

Note 4.2 Income from activities arising from commissioner requested services

Under the terms of its Provider Licence, the Trust is required to analyse the level of income from activities that has arisen from NHS commissioner requested and non-commissioner requested services. NHS commissioner requested services are defined in the Provider Licence as services that NHS commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Income from services designated (or grandfathered) as NHS commissioner requested services	287,908	298,883
Income from services not designated as NHS commissioner requested services	75,944	71,509
Total	**363,852**	**370,392**

Note 5 Operating expenses

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Employee expenses - executive directors	1,111	1,048
Employee expenses - non-executive directors	200	207
Employee expenses - staff	206,429	200,604
Supplies and services - clinical	106,825	104,584
Supplies and services - general	9,900	10,092
Establishment	8,518	9,800
Transport	1,949	1,980
Premises	8,767	9,697
Increase in provision for impairment of receivables	2,680	1,720
Increase/ (decrease) in other provisions	126	(557)
Depreciation on property, plant and equipment	14,333	16,011
Loss on disposal of non-current assets	17	-
Amortisation on intangible assets	244	-
Impairments	412	3,480
Fees payable to the external auditor	123	123
Internal audit costs	95	123
Clinical negligence contributions to NHSLA	3,645	2,409
Professional services	2,310	2,623
Training, courses and conferences	840	1,077
Other	1,325	1,280
Total	**369,849**	**366,301**

All expenses related to continuing operations.

Staff costs include £273k (2014/15: £408k) incurred under the Mutually Agreed Resignation Scheme (MARS) to enable restructuring of the Trust.

Fees payable to the external auditor include £112k (2014/15: £116k) for statutory audit and £11k (2014/15: £7k) for audit of the Quality Accounts.

The external audit engagement is under a procurement framework, which states that the liability of Deloitte LLP, its members, partners and staff (whether in contract, negligence or otherwise) towards the Trust shall in no circumstances exceed £2m.

Note 6 Impairment of assets

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Impairments charged to operating expenses: redevelopment fees	412	3,480
Reversals of impairments credited to other operating income: redevelopment fees	(1,553)	-
Total net impairments	**(1,141)**	**3,480**

Note 7 Employee benefits

Note 7.1 Employee benefits

	Year Ended 31 March 2016			Year Ended 31 March 2015
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	147,452	2,926	**150,378**	146,577
Social security costs	14,645	-	**14,645**	14,245
Employer's contributions to NHS pensions	17,611	-	**17,611**	16,743
Termination benefits	1,282	-	**1,282**	763
Agency/ contract staff	-	23,624	**23,624**	23,324
Total staff costs	**180,990**	**26,550**	**207,540**	**201,652**

Note 7.2 Retirements due to ill-health

In the year ended 31 March 2016 there was 1 early retirement from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £55k (£214k in 2014/15). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Directors' remuneration

The aggregate amounts payable to directors were:

	Year Ended 31 March 2016	Year Ended 31 March 2015
	£000	£000
Salary	1,201	1,139
Performance related bonuses	12	44
Employer's pension contributions	98	72
Total	**1,311**	**1,255**

Further details of directors' remuneration can be found in the remuneration report.

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.

The expected contributions to the plan for the next annual reported period will increase from the 2015/16 levels (as per Note 7) in line with the overall net growth in the number of employees and the impact of the 2016/17 1% pay award. The employer contribution percentages remains 14.3% so will not be a cause in itself for any increase.

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Note 9 Operating leases

Note 9.1 Royal Brompton and Harefield NHS Foundation Trust as a lessor

The Trust owns six investment properties that are leased out under operating leases. From 1 April 2011, new operating leases were agreed, involving a minimum occupancy period of two years, thereafter either party being able to provide six months' notice to terminate.

Each lease is subject to the Landlord and Tenant Act 1954 and the 1995 Landlord and Tenant (Covenants) Act and will be renegotiated at market rate at the end of the lease term. None of the lease agreements provides for an option to purchase.

The related income is shown within Note 4 - Other operating income.

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Rental revenues	1,198	1,565
Total	**1,198**	**1,565**

	31 March 2016 £000	31 March 2015 £000
Future minimum lease receipts due within one year:	599	783
Total	**599**	**783**

Note 9.2 Royal Brompton and Harefield NHS Foundation Trust as a lessee

The Trust was a party to six operating leases with a total expenditure of £52,000 during the year to 31 March 2016 (£44,000 to 31 March 2015).

Terms of renewal or extension to leases are agreed towards the end of the contract terms at market rents.

Purchase options are not included in operating lease contracts. Any decision to purchase the asset at the end of the lease period would be based on market prices at the time.

In the case of any dispute between the Trust and the lessor regarding the condition of the assets when returned to the lessor, a jointly appointed expert will be used to arbitrate and to deliver a binding decision. Early termination sums are generally payable in respect of the period up to the end of the full contract, for the full contract price discounted at 4% per annum, and in the event of total loss of the asset, the discounted residual value of the asset.

There were no contingent rents or sub leases payable.

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Minimum lease payments	52	44
Total	**52**	**44**

	31 March 2016 £000	31 March 2015 £000
Future minimum lease payments due:		
- not later than one year	27	7
- between one and five years	10	-
- later than five years	-	-
Total	**37**	**7**

Note 10 Finance income

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Interest received on bank accounts	47	36
Total	**47**	**36**

Note 11 Finance expense - financial liabilities and late payments

Note 11.1 Finance expense - financial liabilities

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Interest expense:		
Capital loans from the Department of Health	456	160
Commercial loans	4	-
Overdrafts - revolving credit facility	104	-
Total interest expense	**564**	**160**

Note 11.2 The Late Payment of Commercial Debts (Interest) Act 1998

There was no interest paid for late payments of debts in the year to 31 March 2016 (year to 31 March 2015: nil).

Note 12 Property, plant and equipment

Note 12.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2015	**49,320**	**96,133**	**5,702**	**8,166**	**67,098**	**31,616**	**258,035**
Additions	-	-	-	19,972	-	-	**19,972**
Impairments to operating expenses	-	-	-	(412)	-	-	**(412)**
Reversal of impairments credited to operating income	-	-	-	1,553	-	-	**1,553**
Reclassifications							
- to intangible assets	-	-	-	(2,574)	-	(8,658)	**(11,232)**
- from AuC	-	7,379	531	(14,435)	6,116	410	**-**
Revaluations	(17,648)	16,643	727	-	17	7	**(254)**
Disposals/ derecognition	-	-	-	-	(16,987)	(9,837)	**(26,824)**
Valuation/ gross cost at 31 March 2016	**31,672**	**120,155**	**6,960**	**12,270**	**56,243**	**13,538**	**240,839**
Accumulated depreciation at 1 April 2015	**-**	**-**	**-**	**-**	**48,703**	**20,108**	**68,811**
Provided during the year	-	7,097	302	-	4,871	2,063	**14,333**
Reclassifications							
- to intangible assets	-	-	-	-	-	(3,610)	**(3,610)**
Revaluations	-	(7,097)	(302)	-	-	-	**(7,399)**
Disposals/ derecognition	-	-	-	-	(16,970)	(9,837)	**(26,807)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**36,604**	**8,724**	**45,328**
Net book value at 31 March 2016	**31,672**	**120,155**	**6,960**	**12,270**	**19,639**	**4,814**	**195,510**
Financed by:							
Owned	31,672	113,323	6,766	12,230	14,105	4,814	**182,910**
Donated	-	6,832	194	40	5,534	-	**12,600**
Net book value at 31 March 2016	**31,672**	**120,155**	**6,960**	**12,270**	**19,639**	**4,814**	**195,510**

Land and buildings were valued by Montagu Evans as at 31 March 2016 in accordance with International Financial Reporting requirements. The assets were valued by reference to the market conditions prevailing at the valuation date. The Trust's Chelsea campus (land and buildings) were valued on an alternative site basis and the land area valued at the Harefield campus was reduced to reflect a notional adjustment to exclude space that would not be required in the reprovision of a modern equivalent asset.

The revaluation resulted in a net gain of £7,145k (which is a shown above as the net of the revaluations adjustment to cost/ valuation of £254k and to accumulated depreciation of £7,399k). This net gain is reported within Other comprehensive income on the Statement of Comprehensive Income.

Costs of assets under construction are shown net of impairments to operating expenses against the value of professional fees in relation to the intended redevelopment of the Trust's Chelsea campus totalling £9,543k at 31 March 2016 (31 March 2015: £7,464k). An impairment of £412k was placed on the £2,079k costs incurred during 2015/16 and £1,553k of impairment was reversed during 2015/16. The cumulative impairment against the these costs stands at £6,323k as at 31 March 2016.

During 2015/16 the Trust reviewed and reclassified a number of IT assets from PPE to intangible with a net book value of £7,622k (opening assets under construction of £2,574k and capitalised cost of £8,658k net of accumulated depreciation of £3,610k).

Donated assets have been mainly funded by Royal Brompton and Harefield Hospitals Charity.

Note 12.2 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2014	**49,104**	**98,919**	**5,483**	**3,229**	**69,320**	**22,493**	**248,548**
Additions	-	-	-	27,578	-	-	**27,578**
Impairments to operating expenses	-	-	-	(3,480)	-	-	**(3,480)**
Reclassifications	-	3,360	110	(19,161)	5,391	10,300	**0**
Revaluations	216	(6,146)	109	-	-	-	**(5,821)**
Disposals/ derecognition	-	-	-	-	(7,613)	(1,177)	**(8,790)**
Valuation/ gross cost at 31 March 2015	**49,320**	**96,133**	**5,702**	**8,166**	**67,098**	**31,616**	**258,036**
Accumulated depreciation at 1 April 2014	**-**	**-**	**-**	**-**	**50,258**	**18,525**	**68,783**
Provided during the year	-	6,868	273	-	6,110	2,760	**16,011**
Revaluations	-	(6,868)	(273)	-	-	-	**(7,141)**
Disposals/derecognition	-	-	-	-	(7,665)	(1,177)	**(8,842)**
Accumulated depreciation at 31 March 2015	**-**	**-**	**-**	**-**	**48,703**	**20,108**	**68,811**
Net book value at 31 March 2015	**49,320**	**96,133**	**5,702**	**8,166**	**18,395**	**11,508**	**189,224**
Financed by:							
Owned	49,320	92,150	5,632	6,322	13,596	11,508	**178,528**
Donated	-	3,983	70	1,844	4,799	-	**10,696**
Net book value at 31 March 2015	**49,320**	**96,133**	**5,702**	**8,166**	**18,395**	**11,508**	**189,224**

Note 13 Intangibles

Note 13.1 Intangible assets - 2015/16

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2015	-	-	-	-
Additions	-	-	4,674	**4,674**
Reclassifications:				
- from PPE	2,707	5,951	2,574	**11,232**
- from AuC	-	2,993	(2,993)	-
Revaluations	2	1	-	**3**
Disposals/ derecognition	-	-	-	-
Valuation/ gross cost at 31 March 2016	**2,708**	**8,945**	**4,255**	**15,909**
Amortisation at 1 April 2015	-	-	-	-
Provided during the year	67	177	-	**244**
Reclassifications				
- from PPE	1,269	2,341	-	**3,610**
Disposals/ derecognition	-	-	-	-
Amortisation at 31 March 2016	**1,336**	**2,519**	-	**3,855**
Net book value at 31 March 2016	**1,372**	**6,427**	**4,255**	**12,054**
Financed by:				
Owned	1,372	6,427	4,255	**12,054**
Donated	-	-	-	-
Net book value at 31 March 2016	**1,372**	**6,427**	**4,255**	**12,054**

During 2015/16 the Trust reviewed and reclassified a number of IT assets from PPE to intangible with a net book value of £7,622k (opening assets under construction of £2,574k and capitalised cost of £8,658k net of accumulated depreciation of £3,610k).

Note 13.2 Intangible assets - 2014/15

There were no intangible assets in 2014/15.

Note 14 Investment properties

	31 March 2016 £000	31 March 2015 £000
Carrying value at 1 April	**30,612**	**31,205**
Movement in fair value	3,476	(593)
Carrying value at 31 March	**34,088**	**30,612**

Investment properties were valued as at 31 March 2016 by Montagu Evans (an independent valuer) in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and in accordance with International Financial Reporting requirements. The assets were valued by reference to the market conditions prevailing at the valuation date.

The rental terms are typically for 5 years.

Most properties are leased out on tenant repairing leases (meaning that the lessee retains responsibility for repairs and maintenance). The Trust incurs only minor costs in this respect, which are not considered material.

The elements of properties rented out for the purpose of relatives' accommodation are classified as investment property.

Note 15 Disclosure of interests in other entities

The Trust owns 100 per cent of the ordinary share capital of The Chelsea Private Hospital Ltd. The cost of this investment is £100. The Chelsea Private Hospital Ltd is a dormant company.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

With effect from November 2011 the Trust has had a 50:50 joint venture in The Institute of Cardiovascular Medicine and Science Limited ('ICMS'), a company limited by guarantee, with Liverpool Heart and Chest Hospital NHS Foundation Trust. The founding partners have each contributed £100,000 in total to the funding of ICMS.

Using the equity accounting method, the investment would be recognised initially at cost in the Trust's Statement of Financial Position and increased or decreased each year to reflect the Trust's share of the surplus or deficit, with the gain or loss being recognised in the Statement of Comprehensive Income.

However, the Trust has decided not to reflect any surplus or deficit from ICMS's activities in the accounts as it deems the impact to be immaterial. The Trust has made nil contribution to ICMS's operating costs in 2015/16 (2014/15: £50,000, 2013/14: nil and the original £50,000 contribution in 2012/13).

The Trust has established, in collaboration with Imperial College and other nearby Trusts, Imperial College Healthcare Partners Limited ('ICHP'), a Company limited by guarantee. This company provides central services to the Imperial Academic Health Science Partnership, in which the Trust participates.

Using the equity accounting method, the investment would be recognised initially at cost in the Trust's Statement of Financial Position and increased or decreased each year to reflect the Trust's share of the surplus or deficit, with the gain or loss being recognised in the Statement of Comprehensive Income.

However, the Trust has decided not to reflect any surplus or deficit from ICHP's activities in the accounts as it deems the impact to be immaterial. The Trust has made nil contribution to this company during the year (2014/15 £41,250).

Note 16 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	1,458	1,322
Consumables	7,585	9,864
Total inventories	**9,043**	**11,186**

Inventories expensed for the year amounted to £104,040k (2014/15: £101,686k).

Note 17 Trade and other receivables

Note 17.1 Trade and other receivables*

	31 March 2016 £000	31 March 2015 £000
Receivables due from related parties	6,467	19,536
Other receivables	21,363	17,125
Prepayments	4,891	2,430
Accrued income	6,714	12,844
VAT receivable	395	460
Provision for impaired receivables	(7,318)	(5,567)
Total	**32,512**	**46,828**

*Trade and other receivables include £5,002k at 31 March 2016 (£5,534k at 31 March 2015) for partially completed patient episodes.

Note 17.2 Provision for impairment of receivables

	31 March 2016 £000	31 March 2015 £000
At 1 April	**5,567**	**4,263**
Increase in provision	3,232	1,809
Amounts utilised	(929)	(416)
Unused amounts reversed	(552)	(89)
At 31 March	**7,318**	**5,567**

Receivables written off during the year represent debts where management has determined that all appropriate means and methods of recovery have been exhausted.

Note 17.3 Aged analysis of receivables

	31 March 2016 £000	31 March 2015 £000
Ageing of impaired receivables		
0 - 30 days	117	1,361
30 - 60 Days	414	322
60 - 90 days	60	70
90 - 180 days	460	248
Over 180 days	6,267	3,566
Total	**7,318**	**5,567**
Ageing of non-impaired receivables but past their due date		
0 - 30 days	5,001	11,402
30 - 60 Days	3,495	6,555
60 - 90 days	3,071	2,167
90 - 180 days	4,295	6,635
Over 180 days	2,120	2,175
Total	**17,982**	**28,934**

Note 18 Cash and cash equivalents

Note 18.1 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2015/16	2014/15
	£000	£000
At 1 April	**9,476**	**19,146**
Net change in year	4,301	(9,670)
At 31 March	**13,777**	**9,476**
Analysed as follows:		
Cash at commercial banks and in hand	93	1,190
Cash with the Government Banking Service	13,684	8,286
Total cash and cash equivalents as in SoFP	**13,777**	**9,476**
Bank overdraft	(756)	-
Drawdown in committed facility	-	(10,000)
Total cash and cash equivalents as in SoCF	**13,021**	**(524)**

Note 18.2 Third party assets held by the Trust

Under the Tenancy Deposits Scheme, at 31 March 2016 the Trust held £169k (31 March 2015: £114k) in a deposit account for tenants renting accommodation owned by the Trust. These arrangements are not recognised in the cash and cash equivalents figure reported in the accounts as the Trust has no beneficial interest in them.

Note 19 Trade and other payables

	31 March 2016	31 March 2015
	£000	£000
Receipts in advance	6,152	5,607
Payables to related parties	3,507	5,543
Non NHS trade payables	10,496	11,692
Social security costs	2,131	2,115
Other taxes payable	2,313	2,388
Other payables	2,533	3,129
Accruals	22,195	16,220
PDC dividend payable	270	30
Total	**49,597**	**46,724**

Note 20 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Bank overdraft	756	-
Drawdown in revolving credit facility	-	10,000
Other loans	2,314	39
Total	**3,070**	**10,039**
Non-current		
Capital loans from the Department of Health	27,500	10,000
Total	**27,500**	**10,000**
Total borrowings	**30,570**	**20,039**

Current

Bank overdraft borrowing of £756k (31 March 2015: nil) represented a temporary negative cash balance in the Trust's books of acccount (but not in its bank account) for payables processed on 31 March 2016 that cleared in April 2016.

The Trust has a £10m Revolving Credit Facility, from Barclays Bank PLC which was repaid in full during 2015/16 and has a nil balance at 31 March 2016 (31 March 2015: £10m).

A £10m loan facility has been granted by Barclays Bank PLC to fund the costs associated with the fitting out and equipping of a leased suite of private patient consulting and diagnostic scanning rooms. During the period of the Progress Payment (PP) agreement interest only is payable, at 1.95%pa above base rate. At the conclusion of the PP period the capital balance will be rolled into a 5 year amortising 'mortgage-style' loan facility, at an interest margin of 1.95% above the then prevailing 5 year fixed rate swap. At 31 March 2016 the balance is £2.3m (31 March 2015: £39k). Equipment assets are pledged as security against the PP agreement with a net book value at 31 March 2016 of £4,593k with further assets to be pledged during 2016/17 to provide full security against the £10m loan.

Non-current

A £30m loan facility from the Independent Trust Financing Facility to support the capital expenditure programme from 2014/15 to 2016/17 is set at a fixed rate of 2.54%. Interest is calculated on any outstanding balance being £20m at 31 March 2016 (2014/15: £10m).

A further £20m loan facility from the Independent Trust Financing Facility to support the capital expenditure programme from 2015/16 to 2017/18 is set at a fixed rate of 2.06%. Interest is calculated on any outstanding balance being £7.5m at 31 March 2016 (2014/15: nil).

Note 21 Provisions & liabilities

Note 21.1 Provisions for liabilities and charges analysis

	Staff pensions	Other legal claims	NHS Contractual Disputes	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2015	**816**	**28**	**486**	**1,760**	**3,090**
Arising during the year	24	57	612	-	**693**
Utilised during the year	(79)	-	-	-	**(79)**
Reversed unused	(3)	(28)	(486)	(1,489)	**(2,006)**
Unwinding of discount on provisions	11	-	-	-	**11**
At 31 March 2016	**769**	**57**	**612**	**271**	**1,709**
Expected timing of cash flows:					
- not later than one year;	79	57	612	271	**1,019**
- later than one year and not later than five years;	316	-	-	-	**316**
- later than five years.	374	-	-	-	**374**
Total	**769**	**57**	**612**	**271**	**1,709**

The provision for pensions is calculated using expected life tables and is discounted over the estimated period of the pension.

Note 21.2 Clinical negligence liabilities

At 31 March 2016, £66,325k was included in provisions of the NHSLA for clinical negligence liabilities of the Trust (31 March 2015: £35,300k).

Note 22 Contractual capital commitments

	31 March 2016	31 March 2015
	£000	£000
Property, plant and equipment	5,263	6,318
Intangible assets	2,436	-
Total	**7,699**	**6,318**

Note 23 Financial instruments

Note 23.1 Financial risk management

International Financial Reporting Standard (IFRS) 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS commissioners and the way those commissioners are financed, the 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 this Standard mainly applies. The NHS Foundation 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 it faces 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. Treasury activity is subject to review by the Trust's internal auditor.

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 minimal exposure to currency rate fluctuations.

Interest-rate risk

Where appropriate, the Trust may borrow from Government and commercial sources, as disclosed in Note 20. The Trust therefore has minimal exposure to interest rate fluctuations, although the year interest rate fixed to the facility with Barclays Bank PLC disclosed in Note 20 will not be confirmed until the current Progress Payment agreement is converted to a five year loan (expected during 2016/17).

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposure as at 31 March 2016 is in receivables from other customers, as disclosed in Note 17 and adequate consideration of impairment of receivables is made for such debtors on an annual basis.

Liquidity risk

Most of the Trust's operating costs are incurred under contracts with NHS commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital programme from donations and its own resources and where necessary by accessing loans from government and commercial bodies.

Note 23.2 Financial assets

	31 March 2016 £000	31 March 2015 £000
Assets as per SoFP as at 31 March 2016		
Trade and other receivables	27,621	44,398
Cash and cash equivalents at bank and in hand	13,777	9,476
Total at 31 March 2016	**41,398**	**53,874**

Note 23.3 Financial liabilities

	31 March 2016 £000	31 March 2015 £000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance leases	30,570	20,039
Trade and other payables	27,402	30,504
Total at 31 March 2016	**57,972**	**50,543**

Note 23.4 Maturity of financial liabilities

	31 March 2016 £000	31 March 2015 £000
In one year or less	30,472	40,543
In more than one year but not more than two years	2,155	-
In more than two years but not more than five years	6,467	2,400
In more than five years	18,878	7,600
Total	**57,972**	**50,543**

Management considers that the carrying values of financial assets and liabilities reported above are equal to their fair values.

Note 24 Losses and special payments

The table below outlines 75 cases of losses and special payments totalling £284k during the year to 31 March 2016 (year to 31 March 2015: 138 cases, £748k). These amounts are reported on an accruals basis when identified but exclude provisions for future losses.

	Year Ended 31 March 2016		Year Ended 31 March 2015	
	Number of cases	Total value	Number of cases	Total value
	Number	£000	Number	£000
Losses				
Cash losses	9	-	6	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	44	212	110	483
Stores losses and damage to property	12	53	12	40
Total losses	**65**	**265**	**128**	**523**
Special payments				
Compensation under legal obligation	-	-	-	-
Extra contractual to contractors	-	-	-	-
Ex-gratia payments	9	3	9	4
Special severance payments	1	16	1	221
Extra statutory and regulatory	-	-	-	-
Total special payments	**10**	**19**	**10**	**225**
Total losses and special payments	**75**	**284**	**138**	**748**

Note 25 Events after the reporting date

There were no disclosable events after the reporting date.

Note 26 Related parties

The Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions, other than in respect of remuneration, with the Trust.

The Department of Health is regarded as a related party. During the year Royal Brompton and Harefield NHS Foundation Trust has had numerous material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities include NHS England, Clinical Commissioning Groups, NHS Foundation Trusts, NHS Trusts, the NHS Litigation Authority and NHS Supply Chain.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these latter transactions have been with Imperial College of Science, Technology and Medicine (relating to research projects) and the London Borough of Hillingdon and the Royal Borough of Kensington and Chelsea (relating to National Non-Domestic Rates). The Trust operates in close collaboration with the National Heart and Lung Institute of Imperial College of Science, Technology and Medicine to deliver education, research and medical care.

Transactions with the principal Related Parties are summarised:

Note 26.1 Related party balances

	Receivables		Payables	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Department of Health Group				
Department of Health	54	2,200	270	30
NHS England and CCGs	6,962	24,785	904	931
of which >£250k:				
NHS England	*497*	*19,217*	-	-
NHS West London CCG	*502*	*716*	-	-
NHS Hillingdon CCG	*700*	-	-	*18*
NHS Wandsworth CCG	*387*	*67*	-	-
NHS Surrey Heath CCG	*252*	*142*	-	-
NHS Coastal West Sussex CCG	*371*	*444*	-	-
NHS Herts Valleys CCG	*14*	-	*291*	-
Sub-total	*2,723*	*20,586*	*291*	*18*
%	*39%*	*83%*	*32%*	*2%*
Foundation Trusts	1,636	956	1,549	1,510
NHS Trusts	1,130	857	417	376
Other DH Bodies	78	377	8	4
Total DH Group	**9,860**	**29,175**	**3,148**	**2,851**
Other Whole of Government (WGA)				
Central Government Departments	725	2,013	7,026	7,225
of which:				
HMRC	*395*	*460*	*2,313*	*2,388*
National Insurance Fund	-	-	*2,131*	*2,115*
NHS Pension Scheme	-	-	*2,540*	*2,482*
Sub-total	*395*	*460*	*6,984*	*6,985*
%	*54%*	*23%*	*99%*	*97%*
Local Government	-	-	-	-
TOTAL Other WGA	**725**	**2,013**	**7,026**	**7,225**
Other (non-WGA) Related Parties				
Royal Brompton & Harefield Hospitals Charity	377	628	-	-
Total Non-WGA	**377**	**628**	-	-
Total Related Parties Balances	**10,962**	**31,816**	**10,174**	**10,076**
Total Non-Related Party Balances	*21,550*	*15,012*	*39,423*	*36,648*
Total Balances	***32,512***	***46,828***	***49,597***	***46,724***

Note 26.2 Related party transactions

	Income		Expenditure	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Department of Health Group				
Department of Health	7,643	9,100	4	15
NHS England and CCGs	280,159	287,595	-	-
of which >£2,000k:				
NHS England	*227,636*	*237,975*	-	-
NHS Hillingdon CCG	*6,626*	*6,184*	-	-
NHS Herts Valleys CCG	*4,050*	*3,987*	-	-
NHS Ealing CCG	*2,137*	*1,996*	-	-
NHS Harrow CCG	*2,062*	*1,905*	-	-
NHS West London CCG	*2,013*	*2,485*	-	-
Sub-total	*244,524*	*254,532*	-	-
%	*87%*	*87%*	*0%*	*0%*
Foundation Trusts	3,436	3,216	4,327	4,263
NHS Trusts	2,965	2,926	2,167	2,395
Other DH Bodies	5,864	6,351	3,809	2,551
Total NHS	**300,067**	**309,188**	**10,307**	**9,224**
Other Whole of Government (WGA)				
Central Government Departments	6,204	7,640	35,206	34,152
of which:				
Welsh Assembly Government	*3,865*	*5,418*		-
NHS Blood & Transplant	*1,927*	*1,908*	*2,905*	*3,013*
National Insurance Fund	-	-	*14,645*	*14,245*
NHS Pension Scheme	-	-	*17,611*	*16,850*
Sub-total	*5,792*	*7,326*	*35,161*	*34,108*
%	*93%*	*96%*	*100%*	*100%*
Local Government	-	-	1,070	1,019
TOTAL Other WGA	**6,204**	**7,640**	**36,276**	**35,171**
Other (non-WGA) Related Parties				
Royal Brompton & Harefield Hospitals Charity	5,352	5,054	-	-
Total Non-WGA	**5,352**	**5,054**	-	-
Total Related Parties Transactions	**311,623**	**321,882**	**46,583**	**44,395**
Total Non-Related Party Transactions	*52,229*	*48,510*	*323,266*	*321,906*
Total Transactions	***363,852***	***370,392***	***369,849***	***366,301***

Note 26.3 Department of Health related parties

The Annual Reporting Manual specifies that the key management of the Department of Health and their related parties should be treated as related parties of the Trust. The transactions in year and year end balances are as follows:

	Receivables 31 March 2016 £000	Payables 31 March 2016 £000	Income Year Ended 31 March 2016 £000	Expenditure Year Ended 31 March 2015 £000
British Telecom	-	-	-	340
Cumberland Lodge	-	-	-	1
London School of Economics	-	-	-	23
Medical Research Council	-	-	-	22
Medicines and Healthcare Products Regulatory Agency	-	-	-	3
Total	-	-	-	***389***