A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

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Annual Report and Accounts 2016/17

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Royal Brompton & Harefield NHS Foundation Trust

Annual Report 2016-17

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1.1 Overview of Performance

Introduction

The following pages constitute the Annual Report of Royal Brompton & Harefield NHS Foundation Trust for its seventh full year as a Foundation Trust, for the period 1st April 2016 to 31st March 2017. The information contained in this Report is presented and prepared in accordance with the requirements set out by NHS Improvement in the "*NHS Foundation Trust Annual Reporting Manual 2016-17*".

Mr Neil Lerner was Acting Chairman at the Trust from 1st April 2016 to 31st December 2016. Baroness Sally Morgan of Huyton came into post as the new substantive Chair of the Trust on 1st January 2017.

Overall Performance

The Trust is committed to the provision of high quality services for patients of all ages. During 2016/17 the Trust cared for over 200,000 patients at our out-patient clinics and over 39,000 patients of all ages on our wards. During the year, NHS Improvement introduced the new Single Oversight Framework (SOF) under which the Trust has been categorised within Segment 2 (i.e. offered non-mandatory 'targeted' support by NHS Improvement). More detailed information about this can be found on page 76 of this Annual Report. There follows a brief overview of the main areas of focus for the year.

Congenital Heart Disease Services Review Recommendations

A joint review of adult and children's congenital heart services followed the demise of the Safe and Sustainable Review of Children's Congenital Cardiac Services in England, in 2013. When a set of new standards for congenital heart disease (CHD) services was endorsed by the NHS England Board on 23 July 2015, it was on the basis that "major reconfiguration of specialist services, with associated risk and upheaval, can probably be avoided".

It was with surprise and regret therefore, that in July 2016 the Trust was informed that on the basis of not meeting a number of new standards, its congenital heart disease service, which cares for around 12,500 patients, was at risk of being dismantled. A public announcement made on 8 July stated that NHS England planned to 'safely transfer CHD surgical and interventional cardiology services [at Royal Brompton] to appropriate alternative hospitals'. The Trust provides the largest CHD service in the country with 14,000 outpatient appointments and 1,300 surgical procedures a year. It records among the best outcomes in the country, with a 30-day survival rate of 98.3% (national average 98%).

Subsequently, NHS England identified just one standard that the Trust did not meet to its satisfaction – a standard relating to co-location of children's facilities, which required all units to provide certain other paediatric services (gastroenterology and general surgery) from the site where CHD services are based.

To ensure all children's services are readily available, the Trust works closely with neighbouring Chelsea and Westminster Hospital NHS Foundation Trust, operating joint contracts with a number of its consultants under a formal Service-Level Agreement (SLA). These specialists deliver care cross-site and their job plans reflect this, and the service is audited to ensure all clinical targets are met. The Trust has never had any material problems or adverse incidents attributed to not having all children's services on one site. Indeed, both commissioners and regulators acknowledge that there are no concerns about the quality of Royal Brompton's congenital heart disease services, which remain among the best performing in the country.

The authors of the CHD review acknowledged that the idea that all paediatric services need to be based on the same site has been opposed by a number of doctors and has no basis in evidence.

The Trust Board firmly rejects the proposals from NHS England for a number of reasons.

i) No account has been taken of the serious knock-on effects they would have on other world leading specialist services at the hospital, including paediatric intensive care and paediatric respiratory care. Royal Brompton is the national centre for treating babies and children from around the UK with some of the most severe forms of cystic fibrosis, asthma, muscular dystrophies and other respiratory illnesses. Without the back-up of intensive care, which will also be closed as part of NHS England's plans, it will be unsafe to undertake the more complex specialist treatments and they will have to stop. NHSE admits that its plan will impact on these specialist services but has publicly stated that no risk assessment has been carried out for these patients and the knock-on effects will only be looked at in detail once plans for CHD services are finalised.

ii) Royal Brompton has the largest and best resourced adult CHD team in the country, and as a result is also the leading centre of research into adult congenital heart disease in the world. Four of the top 10 publishers of this research internationally are based at the hospital and its teams currently publish more research into ACHD than any other centre internationally. Experts estimate that dispersing this team to a number of other centres could set ACHD research back ten years. There is no reference made to the impact on research in the public consultation documentation on NHSE's plans, nor is there recognition of the damage that would occur to the Trust's work in genetics and high risk pregnancy, and to the services conducting research into inherited cardiac and respiratory conditions.

iii) Royal Brompton's teams have developed an international reputation for tailoring the transition from paediatric to adult care in a seamless, coordinated process. International data shows that there are now more adults than children with CHD – a testament to the success of these services. The best prospect of improving care is to focus on the whole pathway, a continuum from foetal diagnosis, infancy and childhood through adolescence and into the adult service. This approach, mirrored by several other centres internationally, will be lost if Royal Brompton's service is closed. NHSE's final report on the review acknowledged that some clinicians felt that *"the link between paediatric CHD and adult CHD services is more important than the link between paediatric CHD and other specialist paediatric services".* This advice was rejected against the recommendation of the expert clinician group, and without any evidence supporting the view that co-location of different paediatric services was crucial, but that co-location of adult and child services was not.

iv) Over 400 whole time equivalent staff at Royal Brompton will be affected by the plan - the potential cost of redundancies could be in the region of £13.5m.

The Trust is of the firm view that this is an unnecessary re-structuring of CHD provision, for which no evidence has been produced to show any resulting improvement in patient care. Implementation of the plans will involve considerable risk to current services and lead to the break-up of internationally renowned care and research teams.

The Trust's executives continue to liaise with NHS England on this issue and will participate fully in the public consultation on the plans, published in February 2017. The revised closing date of the consultation is 17 July after which NHS England will review responses and publish its findings.

Re-developments
Future plans and strategy revolve around the development of the Trust's infrastructure to ensure that our patients are cared for in an environment that is aligned with the expectations for healthcare in the 21st century. The Trust remains committed to improving its clinical facilities and is advancing plans for redevelopment at both Royal Brompton and Harefield campuses.

Royal Brompton Hospital
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 that facilities are not as good as patients have a right to expect in the twenty-first century

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 site, which could house respiratory inpatient care and be located on existing Trust land. This is intended to be a state-of-the-art facility, designed with help from 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 in progress but at least 80 beds will be available for the re-provision of respiratory inpatient and day patient 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 state-of-the art imaging centre will also be constructed to replace the current Imatron Unit, and will house 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 by the Trust 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 has been undertaken. It is anticipated that the Trust's related planning applications will be heard by the RBKC planning committee on 1 June.

However, Transport for London has safeguarded the land identified for this sale, pending a decision on the construction of a Crossrail 2 station in Chelsea. TfL is currently preparing a revised business case for Crossrail 2 which is expected to be publicly consulted on this summer. Subject to the results of that consultation a final decision on a Chelsea station is expected later in this calendar year.

In case a decision is taken in favour of a Chelsea Crossrail 2 station discussions are in progress with Transport for London to agree how both parties can nonetheless achieve their respective objectives.

Harefield Hospital
Redevelopment at Harefield Hospital continues to progress. An extension to the Critical Care Unit and a new Imaging Centre are under construction and expected to come into service before the end of 2017.

Wimpole Street
A new outpatient and diagnostic facility opened at Wimpole Street in July 2016. This offers private outpatient appointments, as well as state of the art imaging and scanning services. The diagnostic services are shared with NHS teams.

Financial landscape
A continuing major challenge has been financial performance against tariff prices offered by NHS England for NHS services to patients provided by the Trust. The Trust provides highly specialised services that have not been adequately recompensed through these tariff arrangements. In years prior to 1 April 2015, financial balance was achieved through a combination of income from non-NHS sources and 'Project Diamond' top up funding received from the Department of Health / NHS England in recognition of case complexity.

The Trust had been advised that a new tariff system, HRG 4+, would be introduced to compensate for some or all the shortfall resulting from the withdrawal of Project Diamond funding. However that introduction was postponed until 1 April 2017; moreover, although HRG 4+ is beneficial to cardiac inpatient tariffs that benefit is almost wholly negated by reductions in specialist top ups and outpatient tariffs.

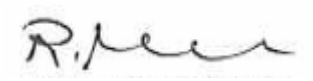
For 2016/17 NHS Improvement introduced the concept of financial 'control totals' and Sustainability & Transformation Funding (STF) for Trusts that achieved their control totals (and less significantly met certain operational performance targets). The Trust was initially allocated a maximum of £4.8m of STF for 2016/17. Towards the end of the financial year under review, NHSI offered additional 'incentive' STF to those Trusts exceeding their control totals on a £ for £ basis plus a so called 'bonus' STF allocation. As the Trust exceeded its 2016/17 control total it has earned a total of £15.5m of STF most of which will be received in cash in June 2017 once final audited accounts for 2016/17 have been submitted. More details of financial performance are given on page 14 of this report.

Sustainability & Transformation Planning
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 'place based' to reflect geographical planning footprints. As a specialist tertiary provider we, along with a limited number of other specialist Trusts, do not fit naturally into a geographic footprint. However, after further consideration NHS England has assigned the Trust to the NW London STP although only some 8% of our NHS-commissioned income derives from the eight NW London CCGs.

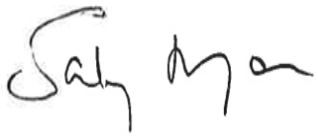
STPs have been tasked with delivering clinical improvement as well as financial discipline within their geographic footprint: member bodies, comprising providers, commissioners and, ideally, local authorities, are expected to work together to these ends. The Trust has played its full part in these discussions and plans notwithstanding its limited direct interest in the financial performance of the NW London STP as a whole.

Care Quality Commission (CQC)
The Trust was inspected by the CQC in June 2016 and the inspection report was published on 10 January 2017. The majority of the Trust's services were rated as 'Good', with a number being identified as 'Outstanding'. In particular, Services for Children and Young People were rated 'Outstanding' for the Well-led domain and 'Good' overall. The overall rating for the Trust was 'Requires Improvement'. Within this rating Harefield Hospital was rated as 'Good' and the Royal Brompton Hospital as 'Requires Improvement'.

An action plan has been developed and is currently being implemented prior to re-inspection by the CQC.



..... **Robert J Bell** **26th May 2017**
Chief Executive



..... **Baroness (Sally) Morgan of Huyton** **26th May 2017**
Chair

For queries regarding this Annual Report please contact, in the first instance:
Mr Richard Connett
Director of Performance and Trust Secretary
Royal Brompton & Harefield NHS Foundation Trust
Sydney Street, London, SW3 6NP T: 0207 349 7713 W: www.rbht.nhs.uk

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. During 2016/17, 26.8% of our nursing staff came from the European Union, excluding the UK.

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. As part of ante natal care, our foetal cardiologists can perform scans (at 12 weeks gestation) when the 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.

In May 2016, our teams implanted the youngest patient in Europe, and the first child in Britain, with an artificial heart. The child, who was twelve years old at the time of the surgery, had the device installed in a nine-hour operation that involved 30 staff at Royal Brompton Hospital. The artificial heart kept her alive until a human heart became available, which was then transplanted at Harefield Hospital. She was diagnosed with dilated cardiomyopathy when four weeks old, leading to heart failure when she was just 11. She has since restarted school, and has visited both Harefield and Royal Brompton hospitals to thank the staff who cared for her.

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 through 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.

We are committed to our specialist approach which we believe 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 partnership with Liverpool Heart and Chest NHS FT, through the Institute for Cardiovascular Medicine & Science, is an existing example of such joint working. As described on page 2 of this Annual Report, the Trust works closely with Chelsea and Westminster Hospital NHS Foundation Trust operating under a formal service level agreement.

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 2017/18-19 which has been submitted to NHS Improvement.

❖ 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. Long term survival has improved and more patients are being seen by our adult congenital heart disease service. The adoption of new technologies also makes possible the treatment of patients who may previously have been too unwell for surgery.

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 NHS Improvement.

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).

2016/17 was a more challenging year than 2015/16, whilst overall activity was up on the previous year we saw a decrease in the number of sponsored patients coming from international markets, particularly from the Gulf countries. This is partly due to the continuing low oil prices putting pressure on their treatment abroad budgets. We saw a growth in our self-funding markets which helped to offset the drop in Middle Eastern Embassy paid business and a flat UK insurance business.

Even in this difficult environment the Trust's private patient income saw a small increase of £0.6m over the £39m reported in 2015/16.

New Facilities and services

The Trust opened its new outpatient and diagnostic facility at 77/78 Wimpole Street in July 2016 offering private outpatient appointments in the prestigious Harley Street Medical Area, as well as state of the art imaging and scanning services

The facility is the only private centre in the UK that will offer Rubidium Cardiac PET scans, which provides a faster imaging protocol and less radiation burden to patients. In addition, the diagnostic facilities include CT, MRI, echocardiography, lung function, non-invasive cardiology services, and x-ray. As well as private patients the CT-PET and MRI are used for NHS patients and some research studies.

We will open new Private Patient facilities at Harefield Hospital towards the end of 2017. A new ward will be opened in October 2017 providing 16 ensuite rooms, 4 HDU beds, a patient lounge and admin offices. At present private patients share a ward on the ground floor with NHS patients. Opening the new Private Patient facility will provide an overall increase in inpatient capacity which will benefit both NHS and Private Patients. In September 2017 a new Outpatient area will also be opening at Harefield Hospital. This will provide 2 consulting rooms, 1 ECHO/consulting room, treatment room and waiting area.

The Trust had expected to commence a hospital management contract in Kuwait from 1st October 2016. However, circumstances in Kuwait have changed and as a result the prospects of signing this contract with the Kuwaiti Ministry of Health are no longer assured.

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 2016/17, research income to the Trust, £13.3m (£12.6m 2015/16), continued to rise in line with the Research Strategy to grow the business. Over 1,800 patients were recruited into NIHR portfolio research studies, 900 patients consented to donate their tissue for retention within the Trust's ethically approved NIHR Biomedical Research Unit Biobanks with many more participating in the full range of our research endeavours.

In addition the Trust is part of West London NHS Genomic Medicine Centre and to date 94 Trust patients have consented to participation in this National 100k Genome project for rare diseases.

Other highlights include:

- Over £3m of funding awarded to Trust academics and their collaborators, from a wide variety of funding bodies including the NIHR, Wellcome Trust, British Lung Foundation, independent charities and the Health Foundation. Commercial research income including collaborative research, contract research, consultancy and service agreements contributed around £2m to research activity at the Trust.
- Over £1m of research funding specifically to research projects led by allied health professionals, nurses and healthcare scientists including physiotherapists, dieticians and pharmacists.
- Over £500k of British Heart Foundation funding awarded to two early career researchers in cardiology and advanced imaging, to undertake prestigious research training fellowships.
- Nine current NIHR Senior Investigators, with Professor Eric Alton awarded NIHR Senior Investigator status to commence in April 2017. 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
- With its academic partner, Imperial College London, the Trust is the leading centre for cardiovascular, critical care and respiratory research. The third RAND analysis (2016) of influential biomedical and health research highlighted that the Trust produces more highly cited publications about respiratory and critical care medicine than any other hospital trust in England. During 2016-17, Trust researchers produced 790 peer-reviewed publications (750; 2015-16).

Having joined the Imperial College Academic Health Science Centre in June 2016, the Trust is actively participating in collaborative research and education activities with Imperial College, Imperial College Healthcare Trust and the Royal Marsden Hospital. This includes contributing to the National Health Informatics Collaborative project by sharing lung cancer data and re-launching the Trust's successful Research Development Programme across the AHSC during 2017/18. The Trust also continues to develop its research relationship with Liverpool Heart and Chest Hospital, through the Institute of Cardiovascular Medicine and Science running collaborative clinical trials and developing shared education and clinical services.

From 1st April 2017, the Trust no longer benefits from £4.0m per annum of NIHR funding for its cardiovascular and respiratory Biomedical Research Units. Accordingly, the Trust is currently refining its research strategy, which includes taking the opportunity to fully integrate research with clinical activity, supported by the newly funded NIHR Clinical Research Facility.

Education

The Trust's vision is to be the UK's leading specialist centre for heart and lung disease in the UK. For this vision to be fulfilled the Trust recognises the value of high quality education and training and is committed to developing its workforce so that we can provide excellent patient care and meet future challenges through quality improvement, service development and innovation.

Over the last year, the Trust's Education Board has met and considered a draft multi-professional education strategy for the next three years, supporting planning for and development of a highly skilled workforce. The strategy supports the core values of the Trust and is flexible and adaptable to meet the challenges of providing high quality clinical care in a financially accountable environment. It recognises that an effective education strategy embeds a culture of learning which, through collaboration, supports the retention of a motivated, knowledgeable and skilled workforce. In addition, by working together across disciplines, existing activities can be co-ordinated, which will facilitate the development of income generating opportunities including Trust delivered online education, short courses and training fellowships as part of the 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:

- Recently agreed two year tariffs and specialist top up arrangements under the new HRG 4+ regime
- Anticipated levels of clinical activity
- 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 availability of borrowings, including the continuation of the Trust's revolving credit facility
- The threat by NHS England to decommission from April 2019 the Trust's congenital heart disease services and the collateral impact thereof

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 2016/17

The Trust has reported a surplus for the year of £11.3m (2015/16 – deficit of £9.7m) after paying a dividend of £6.1m (2015/16 - £6.7m) on Public Dividend Capital. This reflected essentially flat year on year income from patient care activities, including private patient activities. The Trust's plan for the year was to achieve a (post-STF) deficit of £6.8m, sufficient to earn £4.8m of STF (Sustainability & Transformation Funding) from NHS Improvement subject to achieving that financial result (and to meeting certain clinical targets).

The great majority of NHS-commissioned activities generate a financial deficit owing to the poor tariffs associated with this work. Private patient activities provide some compensation as they command better prices. Accordingly, in July 2016 the Trust opened new private outpatient and diagnostic facilities in London's Wimpole Street to expand the private patient revenue base although, to date, the new facility is running behind plan. The Trust was also hoping to secure from October 2016 a substantial hospital management contract in Kuwait: however, as a result of local political developments the hoped for agreement has yet to be signed and currently there appears to be no immediate prospect of this situation changing.

The planned 2016/17 £6.8m deficit took into account the intended sale of one of the Trust's (non-clinical) investment properties to generate a gain of some £10m. This property was sold on 30 September 2016 to the Trust's linked but independent Charity, generating an additional gain relative to plan of £4m. Finally, another Trust investment property, Chelsea Farmers Market (CFM), was revalued by some £14m during the year by an independent firm of valuers to reflect progress on obtaining planning applications and the resulting prospect of an open market sale of CFM during 2017/18.

These investment property gains more than outweighed the Trust's underlying operating deficit, thereby achieving a better financial outcome than the Trust's 'control total' financial target set by NHS Improvement. As a result, the Trust was able to take advantage of an NHS Improvement incentive scheme to secure a further £10.7m of STF monies, thereby permitting it to report a significant surplus for the year. Nevertheless, it is important to note that the Trust had an operating deficit (i.e. before investment property gains) of £16m even taking into account the additional STF earned.

The Trust invested £21.6m (2015/16 – £24.7m) in fixed assets during the year under review of which £0.9m (2015/16 – £2.9m) was funded by donations from the Trust's linked Charity. These investments in the Trust's future reflect the continuing need 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 were drawn down over three years and are now repayable over the coming 12 years. In July 2015 the Trust secured a further £20m facility from the ITFF to be drawn down over the ensuing two years and repayable over the following 12. Both ITFF 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 2017 £47.5m 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 the new private patient diagnostic and outpatient facility in Wimpole Street. This facility had been fully drawn by April 2017 in line with the associated capital expenditure payment profile and will be repayable over the coming five years. At 31 March 2017 £9.6m was outstanding against this facility.

During the year the Trust's cash position was aided by the investment property sale and the continuing drawdowns against ITFF loan facilities, as well as cash management activities. As a result, at 31 March 2017 net cash balances amounted to £32.1m (2016 - £13.0m). The current cash position will be boosted by a further £11.9m of STF monies due and payable once the audited 2016/17 accounts have been filed.

Note: the accounts have been prepared under a direction issue by NHS Improvement pursuant to paragraph 24(1) of Schedule 7 to the National Health Service Act 2006.

Trust Performance Against Key Healthcare Targets 2016/17

There are national healthcare targets that enable the regulators and other institutions to compare and benchmark the performance of organisations. Trusts are required to report against the targets that are relevant to them. The table below shows the key healthcare targets that this Trust reports to the Trust board and also externally.

Risk Assessment Framework - Performance for Quarter 1 & 2

Indicator	Target/ threshold	2016-17 Q1		2016-17 Q2	
		Score	Indicator Met	Score	Indicator Met
Clostridium difficile - Cases due to lapses of care	12 (de minimis)	0	Met	1	Met
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	94.0%	100%	Met	97.78%	Met
Cancer - 62 day Urgent GP referral to first definitive treatment – including breach allocations	85.0%	69.64%	Not Met	75.0%	Not Met
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93.0%	100%	Met	100%	Met
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96.0%	98.33%	Met	97.93%	Met
Percentage of patients on an incomplete pathway waiting less than 18 weeks	92.0%	88.90%	Not Met	89.06%	Not Met

The Risk Assessment Framework was operated by NHS Improvement from 1st April 2016 to 30th September 2016, when it was replaced by the Single Oversight Framework.

During this period:

- There was one lapse of care relating to *Clostridium difficile* during Quarter 2. This related to a case where patient to patient transmission could not be definitely excluded.
- The 31 day Cancer target for subsequent treatment was met in both quarters
- The 62 day cancer target (for the time from GP consultation to first definitive treatment) did not meet the national standard set out in the Risk Assessment Framework. However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF)
- The two week cancer target (for the time waiting to first out-patient appointment) was met in both quarters
- The 31 day cancer target (from diagnosis to first treatment) was met in both quarters
- The 18 week waiting time target (from GP consultation to first definitive treatment) did not meet the national standard of 92% in quarter one and quarter 2. However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF).

Single Oversight Framework - Performance for Quarter 3 and Quarter 4

Indicator	Target/ threshold	Oct		Nov		Dec		Jan		Feb		Mar	
		Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met
Clostridium difficile - Cases due to lapses of care	23	0	Met	0	Met	0	Met	0	Met	0	Met	0	Met
MRSA Bacteraemias	0	1	Met	0	Met	0	Met	0	Met	0	Met	0	Met
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92.0%	92.40%	Met	92.85%	Met	91.98%	Not Met	93.12%	Met	93.52%	Met	92.67%	Met
Cancer - 62 day Urgent GP referral to first definitive treatment – including breach allocation	85.0%	100.00%	Met	60.87%	Not Met	92.86%	Met	20.00%	Not Met	88.89%	Met	61.54%	Not Met
Maximum 6 – week wait for diagnostic procedures	1%	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met
Never Events	0	0		0		0		0		0		0	

The Single Oversight Framework was operated by NHS Improvement from 30th September 2016 to 31st March 2017.

During this period:

- there were no lapses of care relating to *Clostridium difficile* during Quarter 3 or Quarter 4
- One sample tested positive for MRSA in October 2016. This result was reported to Public Health England. The sample was determined to be contaminated with MRSA rather than a true case of MRSA bacteraemia. The Trust is currently (5th May 2017) appealing against attribution of this case to the organisation. Please note that as the patient did not have a bacteraemia, this test result does not count against the target.
- The 18 week waiting time target (from GP consultation to first definitive treatment) did not meet the national standard of 92% in month 9 (December). However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF).

- The 62 day cancer target (for the time from GP consultation to first definitive treatment) did not meet the national standard of 85% for 3 out of the 6 months of quarters 3 and 4. It should be noted that this national standard is designed for use in hospitals delivering a broad range of cancer services involving both long and short pathways. The 85% standard is intended to be an average set across both long and short pathways. The Trust is a specialist centre providing surgical treatment for lung cancer patients. This is an inherently long pathway, the diagnostic portion of which is carried out in secondary care. Although the national standard was not met, the requirements of the improvement trajectory agreed with NHS Improvement were met. This enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF.)
- 6 week wait for diagnostic procedures. The Trust met the standard for 6 week diagnostic waits throughout the period
- Never Events, these are clinical incidents that should never occur, such as wrong site surgery and retained foreign body after surgery. There were none during the whole of 2016/17.

Further details of non-financial performance, and on data quality with respect to the 18 week referral to treatment time target and the 62 day cancer target, are given in the Quality Report 2016/17 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 £134.1m and a contribution of £14.9m in 2016/17, £2.3m behind plan. This is a decrease in overall income from 2015/16, when the division generated £137.3m, and a fall in the level of contribution, which was £19.7m in 2015/16.

Total NHS income was £111.4m in 2016/17, compared to £114.1m of income generated in 2015/16 in part driven by lower tariffs for inpatient activity. Adult cardiac surgery generated income of £19.3m, a decrease compared to £22.6m in 2015/16 and £2.7m below plan. The shortfall was partly within inpatient spell volumes but largely related to critical care, as a result of change in practice to a more efficient recovery model which resulting in fewer level 3 critical care bed days per patient.

Adult cardiology income was behind plan in 2016/17 by £1.5m, predominantly within outpatient clinic activity. As in 2015/16, there was more elective activity than planned offset by a reduction in emergency activity.

Children's services income was behind plan by £1.5m and 211 spells; a shortfall in surgical activity was partly offset by cardiology activity being more than planned. Despite efforts towards the recruitment of permanent paediatric nurses, the vacancy rate for nursing staff across the children's wards was 20% during the year (this vacancy factor remains higher than in other areas of the Trust).

The adult ECMO service continued to grow during 2016/17, resulting in an end of year position of £0.3m ahead of plan. Patient retrievals from Scotland and Northern Ireland in addition to the Trust's designated zone continued in 2016/17.

Private patient income at £21.1m was both below plan by £3.2m (13%) and a fall compared to 2015/16 when private patient income was £21.7m. Planned inpatient referrals from the Wimpole Street diagnostic and imaging centre, which opened in year, did not materialise at the anticipated trajectory. Existing baseline activity was also behind plan particularly within paediatrics.

Pay costs increased from £72.7m in 2015/16 to £76.1m in 2016/17, an underspend against budget of £1.7m (2%) as reflected in lower activity levels overall than planned. Planned nursing expenditure on increased private patient activity (as noted above) was not incurred, resulting in a £0.7m underspend. Paediatric ward nursing was £0.6m underspent; permanent nursing vacancies were only partly offset by the use of agency staffing cover. As a result of the change in practice to a more efficient recovery model, nursing in the adult intensive care unit resulted in an underspend of £0.9m. As a result of steadily increasing ECMO activity levels and the partnership with Guys and St Thomas' Foundation Trust for the training and provision of a collaborative ECMO retrieval service, consultant costs were overspent in 2016/17 by £0.6m.

Divisional non-pay costs were £43.2m, a decrease from £44.9m in 2015/16 and representing an underspend against budget of £4.1m. This is due to the shortfalls in activity described above and the impact of the initial rollout of a national initiative to move to a 'zero-cost' procurement model for high cost devices which sees the costs borne directly by NHS England and resulted in underspends against budget with a corresponding reduction to income.

Harefield Heart Division

Harefield Heart division was £2.3m below its contribution target for 2016/17, ending the year with a contribution of £13.0m. This compares to a contribution of £15.8m in 2015/16. Total income for the year was £94.1m, £2.3m behind plan, driven by lower tariffs for NHS activity and lower volumes of cardiac surgery activity. This is a decrease in total income of £1.4m from 2015/16. Inpatient and day-case spell volumes were 13 behind plan for the year at 6,669 and this represents an increase of 46 spells from 2015/16.

NHS cardiac surgery activity was 151 spells below the plan set for the year, leading to an unfavourable financial position of £2.6m against an income target of £11.5m. Total cardiac surgery spells of 1,014 are a decrease of 112 spells compared to 2015/16. In contrast NHS cardiology activity ended the year 175 spells ahead of plan; this represents an increase of 195 spells from 2015/16. Cardiology income at £20.6m exceeded its target by £1.0m, an increase of £1.1m from 2015/16. 22 heart and 41 lung transplants were undertaken in 2016/17 and 31 Ventricular Assist Device (VAD) implants, compared with 25 heart, 49 lung transplants and 39 VAD implants in 2015/16.

Private patient income at £5.5m was £0.5m above plan (2015/16: £5.1m). This position was driven by an over-performance in both cardiac surgery and cardiology.

There have been higher pay costs than budgeted, predominantly within nursing, consultant and scientific and technical (STT) posts. The nursing overspend of £1.1m was driven by the high levels of vacancies, supernumerary costs due to new starters at times during the year and patient acuity, filled using bank and agency staffing. Additional STT and consultant costs were largely due to the additional costs associated with covering vacancies, as well as sessional payments in addition to job plans to meet RTT trajectory activity. Total pay costs in 2016/17 at £50.1m increased by £3.1m from 2015/16.

The division experienced lower non-pay costs through the year, as a direct consequence of the lower volumes of surgical patients treated and number of VADs implanted. Growth was seen, however, in the volumes of high cost cardiology devices used, such as implantable cardioverter defibrillators (ICDs) and trans-catheter aortic valves (TAVI), which grew from 287 and 99 respectively in 2015/16 to 336 and 117 in 2016/17. Total non-pay costs in 2016/17 at £31.0m reduced by £1.7m from 2015/16.

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 2015/16 and plan. The division generated total income of £85.1m in 2016/17, an increase of £0.8m on 2015/16 (£84.3m), spending £60.0m (2015/16: £56.8m); resulting in a contribution of £25.1m. Of total income, NHS services accounted for £79.7m (2015/16: £78.3m), and private practice £4.8m (2016/17: £5.7m).

Spell volumes in respiratory medicine at Royal Brompton were 499 below target in the year; although they exceeded 2015/16 activity levels by 1%. Service developments, which started later than planned in the year, are now due to make a beneficial impact in 2017/18. The retirement of one thoracic surgeon contributed to thoracic surgery on the Royal Brompton site falling below activity and income targets by 16% and 21% respectively albeit income and activity were both 6% higher than the levels of 2016/17.

Respiratory activity at Harefield continues to grow and ended the year ahead of plan by 209 spells. Thoracic surgery at Harefield declined in terms of activity and income compared to 2015/16 levels by 3% and 4% respectively, and was behind the 2016/17 target, by 2% in activity and 1% in income. This was mainly due to the sickness absence of one thoracic surgeon and is expected to recover in 2017/18.

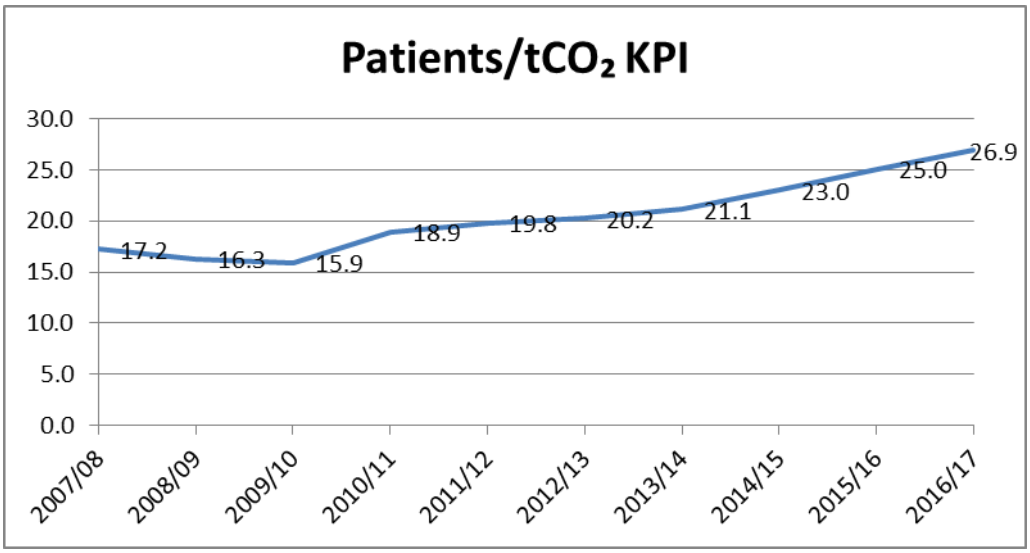
Environmental Matters

Carbon Management

The Trust recognises its responsibility to minimise its environmental impact and 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). Taking a sustainability approach provides both financial benefits in terms of reduced resources (i.e. electricity, natural gas and water) and delivers long term resilience. A Carbon Management Plan (CMP) 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 CMP was formally approved by the Operational Management Team in March 2014. The CMP is currently focuses on its core responsibilities over which it has direct control; reducing emissions associated with the estate, i.e. natural gas and electricity. The table and chart in the CRC Section below shows that over recent years, progress has been made in reducing emissions; savings of around 9% have been achieved since 2010/11. This is predominately due to improved management of the estate's facilities and the implementation of energy efficient measures such as upgrading heating, ventilation and air conditioning plant, improved Building Energy Management System (BEMS) control and the installation of low energy lighting. Although progress has been made, it has not been possible to meet the NHS 10% reduction target against the 2007/08 baseline of 14,378tCO_{2e}; the emissions for 2016/17 are approximately 1.9% below the baseline value.

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 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 has adopted energy performance KPI's of patients treated/tonnes CO_2 to demonstrate progress of the CMP and improving the sustainability of the organisation. The chart below shows that since 2007/08 the KPI performance has significantly increased with 26.9 patients/tCO_2 in 2016/17, a 56% increase. Note analysis includes all patient bed days for NHS and private patients and NHS outpatients attendances (excludes private outpatient).



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 73 projects identified although it should be noted that most savings can only be achieved through capital investment with a payback period of several years.

A range of energy saving projects have been implemented in 2016/17 including various LED lighting upgrades across both sites, LED external lighting at Harefield Hospital, various IT initiatives, together with refurbishment of the heat exchangers in Sydney Wing boiler plant room.

The Green Committee is now in its second year, it 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. Green Champions have been nominated in many departments to promote recycling and other green initiatives in their area. Green Committee initiatives have focused on waste management and include:

- Increased recycling bins and greater recycling across both sites
- Introduction of recycling to theatres
- Trial to use reusable sharp bins to avoid incineration of disposable bins
- Improved confidential waste service which is added to the recycle waste stream
- Increased the use of the offensive waste stream in theatres across both sites and in the ITU at Harefield Hospital

This work by the Green Committee has led to a reduction in the environmental impact of waste by eliminating waste to landfill, increasing recycling and reducing waste to incineration.

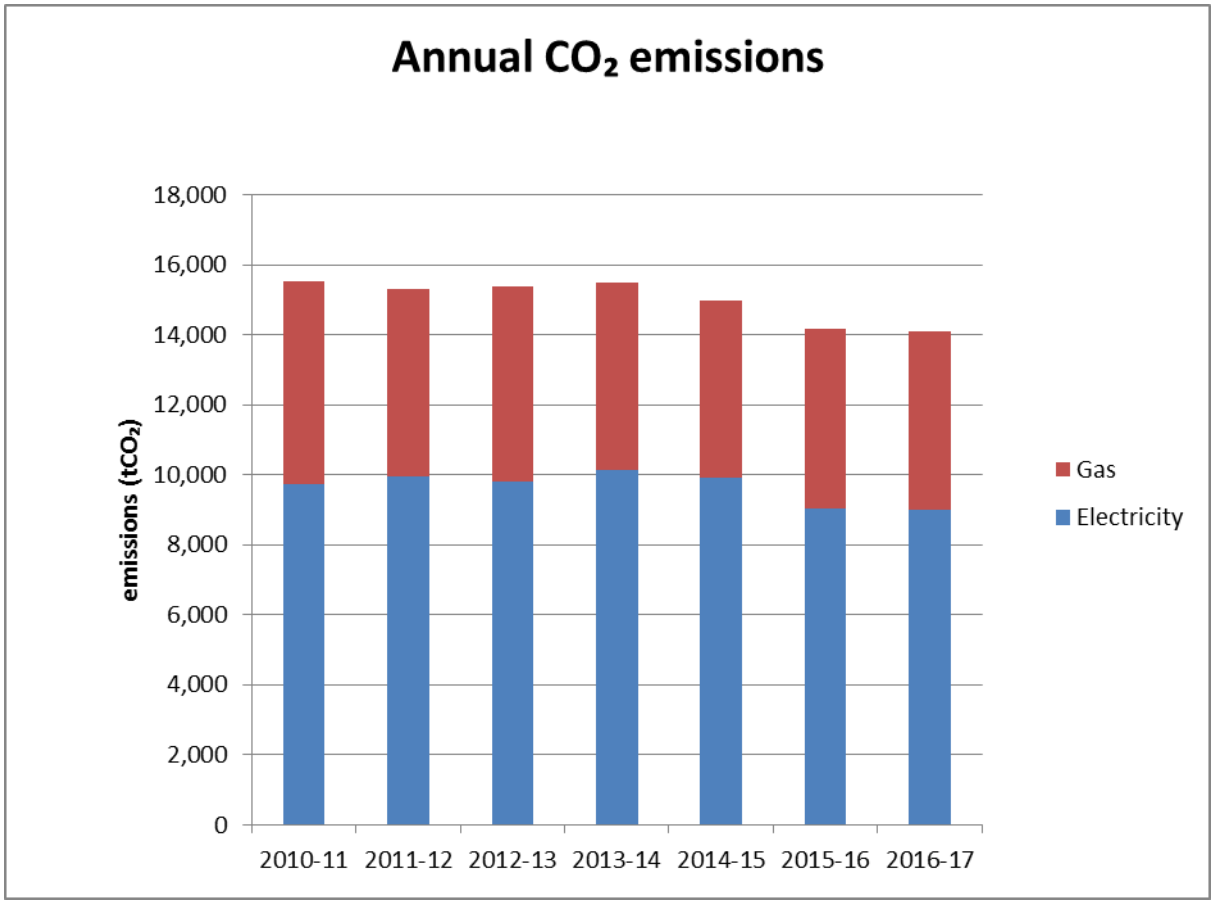
Carbon Reduction Commitment

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 2016/17 are currently projected to be 14,100 tCO_2 which represents a small reduction on the previous year.

The table and chart below show annual reported CRC CO_2 emissions for the Scheme to date which are provided for comparison purposes. It can be seen that emissions have reduced by around 9% with both emissions due to fossil fuels and electricity falling.

	Emissions (tCO_{2e})			
CRC Report	Electricity	Gas	Oil	Total
2010-11	9,727	5,787	1728	15,514
2011-12	9960	5343	-	15,303
2012-13	9820	5570	-	15,390
2013-14	10,132	5,353	-	15,484
2014-15	9,902	5,082	-	14,984
2015-16	9,053	5,127	-	14,180
2016-17	9,010	5,090	-	14,100



Under the CRC Scheme, participants are charged for each tonne of CO_2 emitted. The total cost of emissions in 2016/17 was in the region of £242k. The cost has risen sharply over the last two years owing to the cost per tonne of CO_2 rising from £12 to around £17.20 for 2016/17 (depending on when allowances are paid for). The charge is levied by the government. The rate is set by the Department of Business, Energy & Industrial Strategy (BEIS) (formally Department of Energy and Climate Change (DECC)) and the amount collected goes into central government funds. The rate will increase in further increments over the next two years. It should also be noted that it was announced in the 2016 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 which 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 2016/17 through 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 2016/17, as updated by NHS Improvement in January 2017.

..... Robert J Bell **26th May 2017**
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. There were no changes to the Constitution during 2016/17.

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 Chair 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 have not been formal committees of the Trust Board during 2016/17.

Council of Governors, Trust Board and Committees

Council of Governors

The role of the Council of Governors is to appoint or remove the Chair 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 2016/17. Details of attendance, including that of Board members, are given in the table on the following pages of this report.

Nominations & Remuneration Committee of the Council of Governors

Members of the Committee during 2016/17 have included:

- Mr Ray Puddifoot (stepped down 31st December 2016)
- Dr Andrew Morley-Smith (stepped down October 2016)
- Mr George Doughty
- Mrs Chhaya Rajpal
- Mr Anthony Archer
- Dr Ejikeme Uzoalor
- Mr Tim Mack
- Ms Jennifer Sano
- Mr Neil Lerner (1st April 2016 – 31st December 2016)
- Baroness (Sally) Morgan (from 1st January 2017)

An additional appointment to the Committee, of a staff governor, was ratified by the Council of Governors on 11th May 2017.

Please see the Remuneration Report (pages 49 to 53 of this document) for further information about the work of this Committee during 2016/17.

The Council of Governors

Name	Date of Appointment / Election	Term of Appointment	Constituency	Attendance Record Council of Governors
Governors				
Mr George Doughty	1.6.15	3 years	public	5/5
Mr Anthony Archer	1.4.16	3 years	public	5/5
Mr Robert Parker	1.1.16	3 years	public	5/5
Ms Jennifer Sano	1.1.16	3 years	public	5/5
Mrs Chhaya Rajpal	1.7.15	3 years	patient	3/5
Mr Tim Mack	1.1.16	3 years	patient	5/5
Mrs Brenda Davies	1.12.13	3 years (2nd term)	patient	4/5
Mr Peter Kircher (Term ended 30.11.16)	1.12.13	3 years (2nd term)	patient	3/3
Mr Edward Waite	1.7.15	3 years (2nd term)	patient	4/5
Mr Stuart Baldock	1.12.16	3 years (2nd year)	patient	4/5
Dr Ejikeme Uzoalor	1.12.13	3 years	patient	4/5
Ms Caroline Karlsen	1.7.15	3 years	patient-carer	4/5
Dr Andrew Morley-Smith (Resigned 5.10.16)	1.6.15	3 years (2nd term)	staff	1/2
Dr Claire Hogg	1.6.15	3 years	staff	5/5
Mrs Anne McDermott	1.6.15	3 years (2nd term)	staff	3/5
Mrs Elizabeth Henderson	1.12.16	3 years	staff	4/5
Dr Charles Butcher	1.6.15	3 years	staff	3/5
Councillor Lady Victoria Borwick, MP	1.6.16	1 year (Re-appointment)	L.B. Kensington & Chelsea	2/5
Mr Ray Puddifoot MBE (Resigned 31.12.16)	1.6.16	1 year (Re-appointment)	L.B. of Hillingdon	4/4
Professor Mary Morrell	1.6.16	3 years (2nd term)	Imperial College, London	4/5

Other Attendees including **Board Members:**				
Chair *Commenced 8/12/16*				1/1
Chief Executive				5/5
Medical Director				3/5
Associate Chief Executive - Finance				4/5
Chief Operating Officer				5/5
Director of Nursing & Governance				3/5
Director of Performance & Trust Secretary				5/5
Director of Service Development				3/5
NED N Lerner (Deputy Chairman)				2/5
NED: P Dodd				4/5
NED: K Owen				3/5
NED: A Vallance-Owen				4/5
NED: Lesley – Anne Alexander				0/5
NED: R Jones				3/5
NED: L Bardin				1/5
Non-independent NED: Prof K Fox				0/5

Governors' Interests

PUBLIC CONSTITUENCY: North West London	
DOUGHTY, George	None
PUBLIC CONSTITUENCY: Bedfordshire & Hertfordshire	
ARCHER, Anthony	Partner: JWA Governance Services LLP Managing Partner: Bridgewater Leadership Advisory Senior Adviser: Steele Solutions Limited (trading as nCube Home)

PUBLIC CONSTITUENCY: South of England	
PARKER, Robert	None
PUBLIC CONSTITUENCY: Rest of England & Wales	
SANO, Jennifer	Member Lay Governance Group Royal College of Pathologists Member of the Conservative Party
PATIENT CONSTITUENCY: North West London	
RAJPAL, Chhaya	None
MACK, Tim	Trustee and Non executive board member: Children's Food Trust Volunteer: Guide Dogs for the Blind, London Engagement Team, Richmond and Chiswick Fundraising Member: Dukes Meadows Trust Member of the Conservative Party
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 Member of the Liberal Democrats
PATIENT CONSTITUENCY: Elsewhere	
BALDOCK, Stuart	Member of the Conservative Party Associate Member of the Conservative Medical Society
UZOALOR, Ejikeme	Member of the Labour Party
PATIENT CONSTITUENCY: Carer	
KARLSEN, Caroline	Director, C-Squared Consulting Ltd Trustee of the Cystic Fibrosis Trust

STAFF CONSTITUENCY	
BUTCHER, Charles	Chelsea and Westminster Hospital: On call only registrar role Chase Farm Hospital: Occasional bank work
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	Director, Friends of Royal Brompton (Charity)

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 Member: 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
MORRELL, Professor Mary (Imperial College London)	Trustee and President: British Sleep Society Trustee: Porter Progress UK (Charity)

Governors' Expenses

Dr Ejikeme Uzoalor	£127.58
Mr Peter Kircher	£303.80
Mrs Chhaya Rajpal	£59.68
Mr Robert Parker	£164.65
Mrs Brenda Davis	£537.88
Mr Stuart Baldock	£457.00
Mr George Doughty	£80.64
Mr Anthony Archer	£171.15
Mr Tim Mack	£320.88

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 Chair 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 2016 and 31 March 2017, the Trust Board convened on 8 occasions.

Composition and Committee Duties

Name	**Roles**	**Attendance Record**			
		Trust Board	**Audit Committee**	**Risk & Safety Committee**	**Nominations & Remuneration Committee of the Trust Board**
Baroness (Sally) Morgan of Huyton (From 1 Jan 2017)	Chairman	2/2	-	-	1/1
Robert Bell	Chief Executive	8/8	-	-	
Executive Directors					
Robert Craig	Chief Operating Officer	8/8	-	-	
Joy Godden	Director of Nursing & Clinical Governance	8/8	-	-	
Dr Richard Grocott-Mason	Medical Director	8/8	-	-	
Nicholas Hunt	Director of Service Development	8/8	-	-	
Richard Paterson	Associate Chief Executive – Finance	8/8	-	-	

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	7/8	-	2/4	1/1
Luc Bardin	Audit Committee	8/8	4/4	1/2	-
Philip Dodd	Risk & Safety Committee	8/8	-	3/4	-
Prof Kim Fox		8/8	-	-	-
Richard Jones		8/8	-	-	-
Neil Lerner	Deputy Chairman Chair of Audit Committee, Risk & Safety Committee	7/8	4/4	2/4	-
Kate Owen	Chair - Nomination and Remuneration Committee, Audit Committee	8/8	3/4	-	1/1
Dr Andrew Vallance - Owen	Chair - Risk & Safety Committee Audit Committee Nomination and Remuneration Committee	7/8	4/4	4/4	1/1
Other Attendees					
Richard Connett	Director of Performance & Trust Secretary	8/8	4/4	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:

Chair, 1st January – 31st March 2017

Baroness (Sally) Morgan of Huyton
Member - House of Lords Science & Technology Committee
Vice Chair - Council King's College London (KCL)
Chair - Ambition School Leadership (Charity)
Chair - Frontline (Charity)
Board Adviser - Ark
Non-executive Director - Dixons Carphone plc
Non-executive Director - Countryside Properties plc
Trustee, NHLI Foundation

Deputy Chair; and Acting Chair 1st April 2016 – 31st December 2016

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
Governor, Royal Medical Foundation of Epsom College
Chair, Medical Advisory Board, Medicover (Poland)
Board Member, Institute of Cardiovascular Medicine & Science
Chair, Association of Independent Healthcare Organisations, Cosmetic Surgery Forum

Non-Executive Directors

Mrs Lesley-Anne Alexander CBE
Chair – Red Door Ventures
Non-Executive Director, Metropolitan Housing Association
Member, National Council for Voluntary Organisation (NCVO)
Member, Association of Chief Executives of Voluntary Organisations (ACEVO)
Trustee, MicroLoan Foundation
Fellow, Royal Society of Arts (RSA)
Freeman, Guild of Entrepreneurs
Ambassador, Alzheimer's Society
Owner, Alexander Original Cakes
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
Non-Executive Director, Albion Healthcare (Oxford) Holdings Limited
Non-Executive Director, Albion Healthcare (Oxford) Limited
Non-Executive Director, Albion Healthcare (Doncaster) Holdings Limited
Non-Executive Director, Albion Healthcare (Doncaster) Limited
Non-Executive Director, Mercia Healthcare Holdings Limited
Non-Executive Director, Mercia Healthcare Limited
Non-Executive Director, The Hospital Company (Dartford) 2005 Limited
Non-Executive Director, The Hospital Company (Dartford) Group Limited
Non-Executive Director, The Hospital Company (Dartford) Holdings 2005 Limited
Non-Executive Director, The Hospital Company (Dartford) Holdings Limited
Non-Executive Director, The Hospital Company (Dartford) Issuer PLC
Non-Executive Director, The Hospital Company (Dartford) Limited

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

Mr Richard Jones
Director, RJ Real Estate Consulting Ltd
NED, Commercial Development Advisory Group at TfL
Special Director - Ribston (General Partner) Limited.

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

Executive Directors

Mr Robert J .Bell
Board Member, Imperial College Health Partners
Board Member, Institute of Cardiovascular Medicine and Science
Visiting Professor, Imperial College

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

Mr Richard Paterson
Chairman Elect – Hurlingham Court Ltd

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

Chairman

Baroness Sally Morgan was appointed by the Council of Governors' as the Trust's chair for a term of three years, effective 1st January 2017.

Baroness Morgan was made a life peer in 2001. She has served as minister of state in the Cabinet Office, political secretary to the prime minister and director of government relations at 10 Downing Street, Chair of OFSTED and board member of the Olympic Delivery Authority.

After serving as a local councillor and working as a secondary school teacher, Baroness Morgan worked for Tony Blair when he was leader of the opposition. Following the 1997 general election she was appointed as political secretary to the Prime Minister and head of the Prime Minister's political office. She then served as minister of state in the Cabinet Office before returning to Downing Street as director of government relations.

Since leaving government in 2005, Baroness Morgan has held a number of appointments in the public and private sector. She was the Chair of OFSTED, the Office for Standards in Education, from 2011 – 2014 and sat on the board of the Olympic Delivery Authority for its six-year duration. She is currently a member of the House of Lords Science & Technology Select Committee.

Baroness Morgan has been a lay member of the Council of King's College London, since 2013, and was appointed vice-chair in September 2016. She is also a member of the Council's Estates Strategy Committee and the Fellowships and Honorary Degrees Committee.

Currently she is Chair of Ambition School Leadership (a UK education charity) and board adviser to Ark, which runs academies in the UK and works internationally in education. She is a non-executive director of Dixons Carphone PLC and Countryside Properties PLC.

Deputy Chair

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. He stepped in as Acting Chair of the Trust on 1st April 2016 and held this office until 31st December 2016.

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 held the post of chief executive of the Royal National Institute of Blind People (RNIB) from 2004-2016. Prior to this 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 the 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 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 Board Member 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 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 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.

The Nomination and Remuneration Committee of the Trust Board recommended that Dr Grocott-Mason be appointed as Medical Director/Responsible Officer at its meeting on 27th July 2016. The appointment was ratified by the Trust Board on 27th July 2016.

Ms Joy Godden, 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.

Mr Nicholas Hunt, director of service development and also site director for Harefield Hospital, a role he took on in 2006. He has worked at Royal Brompton & Harefield NHS Foundation Trust since its inception. Mr Hunt began his career at Regional HQ, the forerunner of strategic health authorities. His subsequent career in NHS management has included both operational and strategic roles at a number of London hospitals.

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 maintenance 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.

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.

Composition of the Committee

The members of the Committee who served during the period under review are disclosed on page [ ] 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 chairs the Audit Committee, is also a member of the Risk & Safety Committee. While he was Acting Chairman of the Trust Mr Lerner was not permitted to chair the Audit Committee. Accordingly, during that period Mr Lerner stepped down from the Audit Committee and the role of Chair was assumed by Mr Luc Bardin.

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:

- October 2016
    - Reports from internal audit and counter-fraud services
    - Updates in relation to earlier reports on nurse validation and referral to treatment (RTT) waiting times
    - External audit plan for 2016/17

- February 2017
    - Reports from internal audit and counter-fraud services
    - Health sector developments
    - Counter fraud work plan for 2017/18

- April 2017
    - Progress report from internal audit
    - Health sector developments
    - Draft 2016/17 annual reports from internal audit (including draft Head of Internal Audit Opinion) and counter-fraud services
    - 2017/18 work plan for internal audit
    - External audit status report

- May 2017
    - Final draft of 2016/17 Report and Accounts
    - External audit reports on financial and quality accounts
    - Trust going concern assessment
    - Self-assessment of the effectiveness of the Audit Committee
    - Private session with external auditors

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

- In light of continuing pressures on NHS revenues and the Trust's operating and other costs, the organisation's ability to continue in operation as a going concern. The Committee considered cash flow projections for both 2017/18 and 2018/19 in both 'base case' and sensitised versions, following which it recommended that the Trust Board make the statement made on page 13 of this Annual Report.

- The impact on the financial statements of the independent revaluation of the Trust's operational and investment properties as at 31 December 2016 (considered to be an adequate proxy for their valuation as at 31 March 2017 and providing adequate time for the results of this exercise to be incorporated into the Annual Accounts).

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

- The continuing capitalisation of consultancy costs associated with the Trust's proposed redevelopment of Royal Brompton Hospital

- 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 and 62 day cancer. See the section in the Quality Report 2016/17 dealing with Performance against key healthcare targets for further information.

All these matters, in relation to the annual accounts, were resolved to the satisfaction of the Committee and the Trust's external auditors without requiring adjustments. Where adjustments are proposed by the auditors, the Committee considers both their nature and their materiality in deciding whether the Trust should 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 although liquidity risk is becoming more significant based on forward projections of the Trust's financial performance.

Of the internal audit reports issued by KPMG LLP during the year under review there was none badged as either 'no assurance' or 'partial assurance with improvements required', nor were there any high priority recommendations.

There were a number of less significant ('low' and 'medium' priority) recommendations made by the Trust's external and internal auditors for improvements in systems and processes: the Committee monitors the implementation by executive management of all auditor recommendations. All recommendations have been accepted by management, or are under consideration, and the necessary actions have been agreed and are underway There were no overdue responses to recommendations at the end of the year under review.

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 is also a private session 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. The committee also undertakes an annual self-evaluation process with input from members and other Trust attendees. During 2016/17 £5k of fees were earned by the external auditors in respect of other assurance work.

Internal audit
Each year the Committee reviews and approves the internal audit plan, and reviews internal audit reports 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.

Counter fraud service
Each year the Committee reviews and, where appropriate, approves the counter fraud annual risk assessment and work plan, progress reports and annual report. Details of individual referrals are considered and actions by executive management are noted.

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 32 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 2016
    - Emerging Issues from the CQC visit
    - Quality Improvement: lung cancer patient experience
    - Trust Insurance Update
    - Serious Incidents
    - Infection Prevention and Control
    - Skin integrity
    - Complaints Annual Report
    - Preliminary PLACE results
    - Controlled Drugs
- October 2016
    - ECMO Service
    - Candida auris
    - Wimpole Street Governance
    - Human Tissue Governance
    - Risk Register
    - Quality Priorities
    - Cancer Review – action plan
    - Serious Incidents
    - Pharmacy and Medicines Optimisation
    - Falls
    - Controlled Drugs
- February 2017
    - ECMO Service
    - CQC Update
    - Serious Incidents
    - Trust Risk Register
    - Quality Priorities 2016/17 and 2017/18
    - Quality Indicator Assurance Framework
    - Cancer Services- update on action plan
- April 2017
    - ECMO Service
    - Cancer Service – update on action plan
    - Falls
    - Laboratory Medicine Reporting
    - Freedom to Speak Up Guardian
    - CQC Action Plan
    - Quality Priorities 2016/17 and 2017/18
    - Learning from Deaths
    - Radiation safety
    - Serious Incidents
    - Controlled Drugs

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 2016-17

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, and commended the implementation of a clear action plan drawn up following the latest Trust-instigated Cancer Service Review, which focusses in particular, on further strengthening the links to referrers, other providers and community services.

- Provision of ECMO services. In 2016-17, The Trust was required by NHS England to go through a re-tender process for the ECMO service. In the meantime the ECMO service has been running efficiently and effectively, with no Serious Incidents or concerns with regards to clinical care. The results of the re-tender process were due in April 2017, but have been postponed by NHS England and are still awaited.

- The Trust was inspected by the CQC in June 2016, with the report published in January 2017. The inspection highlighted many excellent practices and services across the Trust with Harefield Hospital achieving a rating of 'good' overall. The results at Brompton were more varied, and overall the Trust rated as 'requires improvement'. Since then, the Trust has worked hard to make improvements in the areas where the CQC felt practice was not meeting the required standard; as has implemented a new tool for assessing deteriorating patients; improved the approach to briefing and debriefing in theatres.

- Candida auris outbreak. In April 2016, and in consultation with Public Health England, the Trust formally declared an outbreak of a new and unusual organism that had initially been identified in a group of patients cared for in the Adult Intensive Care unit at the Brompton Hospital. In total, between April 2015 and December 2016, 72 patients treated at the hospital were identified as positive for this organism. The majority of patients carried the organism on their skin, although 8 of these were diagnosed with a candidaemia (blood stream infection with candida) and required drug treatment. Multiple interventions to manage the outbreak were required, including enhanced infection control precautions, specific skin and equipment cleaning regimes, environmental refurbishment and on-going tight management of infection control practices within the clinical areas. The outbreak was finally closed in December 2016. As it was the first outbreak of this organism in the UK, knowledge and expertise associated with its management was developed in conjunction with other agencies as the situation evolved. This expertise is now being shared nationally as other hospitals identify and manage similar outbreaks.

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.

One new major risk was identified during the year: the risk of Mycobacterial infections associated with Heater Cooler Units used in Cardiothoracic Surgery. In 2016-17, the Medicines and Healthcare Products Regulatory Agency (MHRA) issued a medical device alert MDA/2015/022 - 2015 regarding the risk of infection with Mycobacterium species linked with the use of Heater Cooler Units. This required all NHS organisations to undertake a notification exercise of patients who had undergone surgery since January 2013, and may be at risk of this infection. This exercise was completed within the timescale set by NHS England and work is now underway to ensure the small number of patients requiring follow-up are seen in the most appropriate setting.

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. In 2016-17, a new Patient Administration System has been implemented, and work is progressing on delivering Electronic Prescribing and Medicines Administration (EPMA), Electronic Document Management (EDM).

- ***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. The latest project has been an update to the water risk assessment and water safety plan.

- ***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 2016/17, reviewed progress against the Quality Priorities for 2016/17, and approved the selection of Quality Priorities for 2017/18. The Quality Report for 2016/17 can be found in Annex 1 of this document.

Performance Evaluation of the Board of Directors

Monitor, published guidance on the well led framework for governance reviews in April 2015 and NHS Improvement has continued to maintain the requirement to carry out these reviews since its inception on 1st April 2016.

During 2016/17, the Trust commissioned PricewaterhouseCoopers (PwC) to facilitate and evaluation of the Board of Directors. PwC were appointed following a competitive tending process. PwC does not have any other connection to the Trust.

The review was carried out between September and December 2016 and the findings were reported to the Trust Board at a Board Seminar held on 25th January 2017.

No material governance concerns were identified and this finding was communicated to NHS Improvement in early February 2017 as required.

An action plan has been developed following the well led governance review and is in the process of being implemented.

Board of Directors

Board of Directors

The Board of Directors brings a wide range of experience to the Trust and during 2016/17 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.

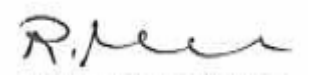
During 2016/17 the Board comprised:

Non-Executive Directors	Executive Directors
Chair Baroness (Sally) Morgan of Huyton	Chief Executive Robert J Bell
Deputy Chair Neil Lerner	Associate Chief Executive – Finance; Richard Paterson
Senior Independent Director Mr Andrew Valance-Owen	Medical Director Richard Grocott- Mason
Kate Owen	Chief Operating Officer; Robert Craig
Lesley-Anne Alexander	Director of Nursing & Clinical Governance; Joy Godden
Philip Dodd	Director of Service Development; Nick Hunt
Richard Jones	
Professor Kim Fox	
Luc Bardin	

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.



..... Robert J Bell **26th May 2017**
Chief Executive

On behalf of the Board of Directors

Disclosures in the public interest

NHS Improvement guidance indicates that a set of key disclosures should be incorporated within 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 2016/17, 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 2016/17 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 55-58 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 2016/17 The Trust has concluded the following formal consultation / organisational changes:

- Heart Division Harefield Hospital, changes to shift structures in the cardiac catheter laboratory
- Lung Division, restructuring within the Interstitial Lung Disease (ILD) Research Unit following reduced workload
- Corporate Services, reconfiguration of the video conferencing services, improvements to Imaging Services and implementation of the Electronic Document Management (EDM) project.

Public Consultations

Details of consultations with stakeholder groups engaging with the Trust around selection of quality priorities for 2017/18 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 7.2 of the Accounts.

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

Data Loss/Confidentiality Breach
Two level 2 incidents were reported to the Information Commissioner's Office during 2016/17. More information relating to these incidents is given in the Annual Governance Statement (Section 2.7 of this Annual Report).

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 2016/17, the Trust's land and buildings were revalued as at 31st December 2016 by independent valuers.

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

Events since 31 March 2017
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 24 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.

During the course of 2016/17 the Trust sold an investment property to the Royal Brompton & Harefield Hospitals Charity.

These related party transactions are set out in note 27 to the Accounts.

2.2 Remuneration Report

Annual Statement of Remuneration

The Chief Executive has confirmed, in line with the Foundation Trust Annual Reporting Manual 2016/17 (s2.48), that the definition of senior managers to be used for this Remuneration Report 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 2nd March 2016 in order to decide the remuneration of the Chief Executive and the other executive directors for the 2016/17 financial year. The remuneration of the Chief Executive, Medical Director, Chief Operating Officer and Director of Nursing and Clinical Governance all increased as shown in the table on page 55 of this report. It should be noted when comparing salaries with the prior year, that 2016/17 was the first full year during which the Medical Director and the Director of Nursing and Clinical Governance were in post. In fact the appointment of Dr Richard Grocott-Mason as Medical Director was made substantive following interview during June 2016, the recommendation for this appointment being ratified by the Trust Board on 7th July 2016.

The Committee met again on 8th March 2017 in order to agree remuneration for the executive directors during 2017/18.

…… **Date 26th May 2017**

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

Annual Statement of Remuneration Continued

During 2016/17, the Nominations and Remuneration Committee of the Council of Governors met on 4th, 18th and 31st May 2016, 26th September 2016 and 14th November 2016 to progress the appointment of a new Chair of the Trust. These meeting were chaired by Ray Puddifoot, appointed governor for the London Borough of Hillingdon. The Appointment of Baroness (Sally) Morgan was ratified at a meeting of the Council of Governors held on 7th December 2016 and she commenced in post on 1st January 2017.

Other nominations work of the Committee during 2016/17 included:

- 4th May; re appointment of Professor Kim Fox for a second term of three years (ratified by the Council of Governors 11th May 2016)
- 26th September 2016; re appointment of Ms Kate Owen for a period of one year commencing 6th October 2016 (ratified by the Council of Governors 1st November 2016)
- 26th September 2016; re appointment of Mr Neil Lerner for a period of four months commencing 1st February 2017 (ratified by the Council of Governors 1st November 2016)
- 14th November 2016; re appointment of Mr Richard Jones for a second term of three years commencing 24th February 2017 (ratified by the Council of Governors 7th December 2016)

Remuneration of the Non-executive Directors did not change between 2015/16 and 2016/17.

There was a further meeting of the Committee on 12th January 2017 at which the terms of reference of the Committee were reviewed and the work plan for 2017 was considered. This meeting was chaired by Anthony Archer, public governor for Bedfordshire and Hertfordshire.

…… **Date 26th May 2017**

Anthony Archer;
Chair 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 on page 55 of this Annual Report	None disclosed	As set out on page 55 of this Annual Report	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 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 2nd March 2016 and 8th March 2017 with Ms Kate Owen as Chair.

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 2016/17 was based upon comparison with salaries paid to directors of comparable health care organisations. 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 Chief Executive is in turn appraised by the Chair of the Trust

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 and the Chair of the Trust) met on met on 4th, 18th and 31st May 2016, 26th September 2016 and 14th November 2016 with Councillor Raymond Puddifoot as Chair.

There was a further meeting of the Committee on 12th January 2017 with Anthony Archer as Chair, Ray Puddifoot having stood down as appointed Governor for the London Borough of Hillingdon on 31st December 2016.

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

During his period as Acting Chair (1st April 2016 – 31st December 2016), Neil Lerner was remunerated at the rate paid for the Chair position.

Remuneration of the Non-executive Directors, apart from the Deputy Chair, did not change between 2015/16 and 2016/17.

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 2017
Baroness (Sally) Morgan	Chair	1 Jan 17	33 months
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 1 Nov16	2 months
Dr Andrew Vallance-Owen	Senior Independent Director	26 Feb 13 Renewed 26 Feb 16	23 months
Mrs Lesley-Anne Alexander	Non-Executive Director	26 Feb 13 Renewed 26 Feb 16	23 months
Prof Kim Fox	Non-Executive Director	1 Jun 13 Renewed 11 May 16	26 months
Mr Richard Jones	Non-Executive Director	25 Feb 14 Renewed 7 Dec 16	35 months
Ms Kate Owen	Non-Executive Director	6 Oct 10 Renewed 1 Nov 16	6 months
Mr Philip Dodd	Non-Executive Director	21 Jul 14	4 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	27 Jul 16	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

Note: renewal of Non-executive appointments is dated from the meeting of the Council of Governors at which the appointment was ratified. The term of the appointment itself is contiguous with the preceding term and this is reflected in the calculation of the unexpired period.

The standard notice period for an executive director is 3 months. No termination payments have been made during the reporting period.

Salary and Pension Entitlements of Directors (Audited Information)

£000 unless otherwise stated	1 April 2016-31 March 2017								1 April 2015-31 March 2016							
	Salary	Other Remuneration	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
Baroness S Morgan Chairman (from 1/1/17)	15-20						15-20									
Sir Robert Finch Chairman (until 31/3/16)									60 - 65						60 - 65	2,100
Robert J. Bell Chief Executive	280-285					nil	280-285	1,000	260 - 265					nil	260 - 265	4,000
Prof. T Evans Medical Director (until 14/12/15)									45-50	100-105					145-150	
Dr R Grocott-Mason Medical Director (from 14/12/15)	65-70	120-125		45-50*		nil	235-240		15 - 20	35-40		10 - 15		nil	65 - 70	
Robert Craig Chief Operating Officer	160-165					nil	160-165		155 - 160					nil	155 - 160	
Joy Godden Director of Nursing (from 29/7/15)	120-125					nil	120-125		75 - 80					nil	75 - 80	
Richard Paterson Associate Chief Executive - Finance	195-200						195-200	100	195 - 200						195 - 200	100
Nick Hunt Director of Service Development	120-125					nil	120-125		125 -130					nil	125 - 130	

*Clinical Excellence Award

£000 unless otherwise stated	1 April 2016-31 March 2017								1 April 2015-31 March 2016							
	Salary	Other Remuneration	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
Kate Owen Non-Executive Director	15-20						15-20		15 - 20						15 - 20	
Neil Lerner Non-Executive Director (interim Chairman 01/04/16-31/12/16)	50-55						50-55	300	25 - 30						25 - 30	800
Dr Andrew Vallance-Owen Non-Executive Director	20-25						20-25	100	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	1,600	15 - 20						15 - 20	1,000
Philip Dodd Non-Executive Director	15-20						15-20		15 - 20						15 - 20	
Luc Bardin Non-Executive Director	15-20						15-20		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 tables on pages 54 and 55 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)

Median salary for Trust employee	2016/17	2015/16
	36,362	36,002

The highest paid officer of the Trust (total remuneration £280k-£285k, 2015/16 £260k-£265k) represented a multiple of 7.7 times that of the median employee (2015/16: 7.3).

Pension Entitlements of Directors
(Audited Information)

Name and title	Real increase/ (decrease) in pension at retirement age at 31 March 2017 (bands of £2,500) £000	Real increase/ (decrease) in lump sum at retirement age at 31 March 2017 (bands of £2,500) £000	Total accrued pension at retirement age at 31 March 2017 (bands of £5,000) £000	Lump sum at retirement age to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000
Robert J. Bell Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Richard Grocott-Mason Medical Director	0.0 – 2.5	2.5 – 5.0	50.0 - 55.0	155.0 – 160.0	1,045	48	971
Robert Craig Chief Operating Officer	0.0 – 2.5	0.0 – 2.5	60.0 - 65.0	160.0 - 165.0	1,033	66	942
Joy Godden Director of Nursing	2.5 – 5.0	12.5 – 15.0	45.0 - 50.0	145.0 - 150.0	990	124	843
Nick Hunt Director of Service Development	0.0 – 2.5	0.0 – 2.5	55.0 - 60.0	170.0 - 175.0	n/a	n/a	n/a

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

Nick Hunt retired from the existing scheme on 31st December 2016

Robert Bell retired from the existing scheme on 14th March 2016, therefore no figures are provided

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.

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 2017.

For all off-payroll engagements as of 31 March 2017, 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 2017	25
Of which:	
Number that have existed for less than one year at the time of reporting	8
Number that have existed for between one and two years at the time of reporting	8
Number that have existed for between two and three years at the time of reporting	4
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 2016 and 31 March 2017, 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 2016 and 31 March 2017	16
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	12
Number for whom assurance has been requested	9
Of which:	
Number for whom assurance has been received	8
Number for whom assurance has not been received	1
Number that have been terminated as a result of assurance not being received	0

The Trust employs 17 individuals deemed 'Board members and/ or senior officials with significant financial responsibility'.

All of these were on-payroll between 1st April 2016 and 31st March 2017.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2016 and 31 Mar 2017	**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 2016/17

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		3	**3**
£10,001 - £25,000		6	**6**
£25,001 - 50,000	1		**1**
£50,001 - £100,000		1	**1**
£100,001 - £150,000		1	**1**
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	1	11	**12**
Total resource cost (£000)	49	296	**345**

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**

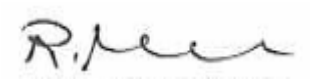
Exit packages: other (non-compulsory) departure payments

	Year ended 31 March 2017		**Year ended 31 March 2016**	
	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	1	26	14	273
Early retirements	1	23	1	2
Contractual payments in lieu of notice	4	35	14	259
Exit payments following employment tribunals or court orders	5	212	2	45
Non-contractual payments requiring HMT approval			1	16
Total	**11**	**296**	**35**	**635**

Average numbers of employees (WTE basis)

	Year Ended 31 March 2017			Year Ended 31 March 2016
	Permanent Number	Other Number	Total Number	Total Number
Medical	479	24	503	494
Administration and estates	773	53	826	800
Healthcare assistants and other support staff	98	38	136	128
Nursing, midwifery and health visiting staff	1,389	163	1,552	1,508
Scientific, therapeutic and technical staff	606	33	639	595
Total average numbers	3,345	311	3,656	3,525

This Remuneration Report has been prepared having regard to the requirements of the NHS Foundation Trust Annual Reporting Manual 2016/17.



..... **Robert J Bell** **26th May 2017**
Chief Executive
On behalf of the Board of Directors

2.3 Staff Report

Introduction

The 2016 Staff Survey was conducted in the months of October and November and the results were published by the Care Quality Commission in March 2017.

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 four 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.

The Trust has continued with 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.

An initiative entitled 'Working Together Better for Patients' continues, to drive bullying and harrassment figures down. Listening groups have also taken place in departments where these figures are higher, and will continue across the Trust where necessary.

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, which have increased significantly in the past year.

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.

Workshops and forums will be held with staff to report results from the survey and take any questions and feedback.

Summary of performance - NHS staff survey

The Trust participates in the annual NHS Staff Survey and the results from the 2016 survey are summarised below.

Response Rate:

At the time of sampling, 3504 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.

1380 staff at the Trust took part in this survey. This is a response rate of 39.4% which has risen by over 7% from the 2015 survey.

Response Rate			
Trust 2015	**Trust 2016**	**Benchmarking Group Average 2016**	**Trust Improvement/ Deterioration**
32%	39%	48%	+7%

Areas of improvement and deterioration from the prior year:

The Trust has shown significant improvement in 5 Key Findings since the 2015 survey, and impressively has not shown a significant decrease in any Key Finding.

Improvements

Key Finding	**Trust 2015**	**Trust 2016**	**Benchmarking Group Average 2016**
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	37%	28%	28%
KF11. Percentage of staff appraised in last 12 months	74%	80%	87%
KF32. Effective use of patient/service user feedback	3.83	3.94	3.81
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.89	3.96	3.79
KF31. Staff confidence and security in reporting unsafe clinical practice	3.77	3.84	3.73

Top 5 Ranking Scores:
**where NA is noted due to updated questions the data from 2015 is not directly comparable to 2016, or was not included in the 2015 survey at all.*

Top 5 Ranking Scores	Trust 2015	Trust 2016	Benchmarking Group Average 2016	Trust Improvement/ Deterioration
KF14. Staff satisfaction with resourcing and support	3.54	3.59	3.43	+ 0.05
KF4. Staff motivation at work	4.01	4.02	3.98	+ 0.01
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	50%	48%	57%	- 2%
KF12. Quality of appraisals	3.35	3.36	3.21	+ 0.01
KF13. Quality of non-mandatory training, learning or development	4.07	4.11	4.07	+ 0.04

Bottom 5 Ranking Scores:

Bottom 5 Ranking Scores	Trust 2015	Trust 2016	Benchmarking Group Average 2016	Trust Improvement/ Deterioration
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	28%	30%	25%	+ 2%
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	42%	36%	47%	- 6%
KF11. Percentage of staff appraised in last 12 months	74%	80%	87%	+ 6%
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	84%	84%	86%	0%
KF16. Percentage of staff working extra hours	77%	76%	74%	- 1%

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.

Departments/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, and appears regularly on the Trust Board agenda and will be one of the Quality Priorities for 2017/18. 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.

HR leads have also run a number of 'listening groups' in areas where there have been higher reports of bullying or harassment, and more of these will continue to be rolled out across the Trust as necessary.

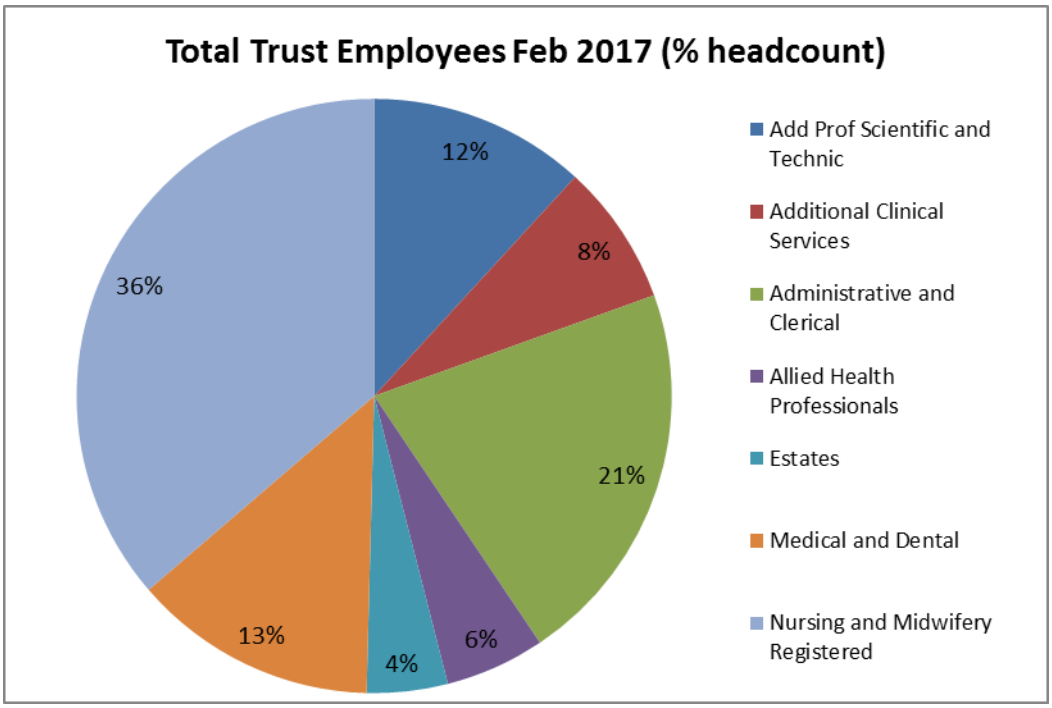
The overall response rate remains an area for improvement. Further publications of results and staff forums and feedback groups will be held, to give staff detailed results and the opportunity to raise any queries or put forward any suggestions.

The Trust's Employees

As at 28th Feb 2017, the Electronic Staff Record showed that the Trust employed 3,575 people (expressed as head count).

Of these 1,298 were registered as nurses and a further 475 were doctors. There were 194 allied health professionals and 275 people employed to provide additional clinical services (mostly health care assistants). Scientific and professional staff numbered 422. There were 157 estates and ancillary staff. The administrative and clerical staff numbered 754; 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:



Within the nursing workforce, the main countries of origin of the nurses were:

- British (55.1%)
- Portuguese (7.6%)
- Spanish (6.1%)
- Irish (5.0%)
- Filipino (4.3%)
- Indian (3.7%)
- Italian (1.9%)
- Polish (1.3%)
- Zimbabwean (1.3%)
- Other countries – less than 1% each

In total, 26.8% of the nursing workforce is from the European Union, excluding the UK. The Trust is concerned about the impact that Brexit may have with regards to staff from the rest of the European Union who are living and working in the UK.

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)	4	11
Senior Managers (grade 8c or above)	67	43
All employees	2565	1010

Occupational Health Service

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. Additionally, an employee assistance programme has recently been commissioned to provide additional support to staff.

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.

Health and Wellbeing

A health and wellbeing event was held at Harefield Hospital in October 2016. The event, which was attended by 171 staff members, was organised in collaboration with the dieticians, diabetic nurse specialists, cardiac nurse specialists, cardiac and respiratory highly specialist physiotherapists and FHL nurse specialists.

The event gave staff members an opportunity to access health and lifestyle advice covering a number of topics from professionals within the organisation, these included:

- Weight loss and healthy eating advice
- Cholesterol screening
- Blood pressure screening
- Smoking cessation advice
- Diabetes screening
- The importance of flu vaccinations
- Health and wellbeing initiatives

Staff were provided with guidance to help them manage their results.

The Seasonal flu campaign for 2016/17

We were able to commence the seasonal flu vaccination campaign for staff members on the 25th September 2016 which was two weeks earlier than previous campaigns. Due to negative press regarding the efficacy of the seasonal flu vaccination during 2014/2015 and staff reluctance to have the flu vaccination in preceding years we were concerned regarding the uptake of the flu vaccination this season. In an attempt to increase awareness and publicise the flu vaccination the communication department provided additional support in publicising the campaign and screen savers were used early on and throughout the campaign.

The uptake for the flu vaccination amongst front line health care workers this season was reported nationally as 61.3% across both sites. This compares favourably to an uptake of 45.9% the previous year but remains below our target uptake of 75%. The majority of flu vaccinations are generally administered towards the beginning of the campaign and gradually reduces. Due to incidences of flu amongst patients during January and February 2017 staff who had previously declined vaccination took the opportunity to have the flu vaccination.

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 September 2016 to December 2016. If staff could not attend the walk in clinics or clinics off site, individual appointments were offered.

In an attempt to increase uptake of flu vaccination next season we are planning to record additional data so we are able to breakdown the flu vaccination uptake figures into department and staff group so managers can identify the uptake in their areas more readily. This will hopefully enable us, with the support of line managers, to specifically targeted areas with low uptake of vaccination to increase vaccination uptake.

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 FTE	Total Days Lost	Average Sick Days per FTE
3,383	33,367	9.86

The most recent information published by NHS Digital (as at 24th May 2017) is for the month of December 2016 and shows a national average figure for sickness absence in the NHS of 4.55%. During that month the Trust rate for sickness absence was less than the national average at 2.84 %.

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.

Analysis of Staff Costs
This table provides an analysis of staff costs which follows the format in the FTC template. It is the format specified within the Staff report section of the NHS FT Annual Reporting Manual 2016/17.

	Year Ended 31 March 2017				Year Ended 31 March 2016
	Permanent	**Other**	**Total**		**Total**
	£000	**£000**	**£000**		**£000**
Salaries and wages	156,301	2,999	**159,300**		150,378
Social security costs	18,275	-	**18,275**		14,645
Employer's contributions to NHS pensions	18,036	-	**18,036**		17,611
Termination benefits	345	-	**345**		1,282
Temporary staff (including agency)	-	22,955	**22,955**		23,624
Total staff costs	**192,957**	**25,954**	**218,911**		**207,540**

Note: Social security costs are for employer's national insurance. Employer's national insurance contributions increased in 2016/17 due to removal of the 3.4% rebate with regard to employees in contracted-out pension schemes

Temporary staff costs, of which the main element is agency nursing, were £669k lower for 2016/17 compared to 2015/16. This reflects reductions in both the number of shifts covered by agency staff and reductions in the hourly rates paid to agency nurses.

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 2016.

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.5.6 Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS FTs forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied[1]

During 2015/16 an article in patient Focus provided members with information about the Trust's strategy and views of members were sought and communicated to Governors. This exercise is to be repeated during 2017/18, but has not been undertaken during the period covered by this Annual Report.

B.2.4 The Chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the Chair.

At a meeting of the Nominations and Remuneration Committee of the Council of Governors, held on 12th January 2017, Governors were of the firm view that this committee must be chaired by a Governor and terms of reference to this effect were ratified by the Council of Governors when it met on 23rd February 2017.

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

[1] The NHS Foundation Trust Code of Governance, Monitor, July 2014 (p50)

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 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 seventh Annual Members' Meeting on 20th July 2016 and approximately 70 members attended. The next Annual Members Meeting is scheduled for 19th July 2017 and once again all members will be invited. The Trust has engaged its members in a number of ways during 2016-2017. A series of member's events were held, these included talks entitled 'Lung transplantation at Harefield Hospital. Tour of the primary ciliary dyskinesia service at Royal Brompton Hospital and a tour of the Hybrid Theatre at 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 2017. 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.

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

Public			2015-2016	2016-2017
	At year start (April 1)	+ve	2,838	2,850
	New members	+ve	51	39
	Members leaving	+ve	(39)	(61)
	At year end (31 March)		**2,850**	**2,828**
Staff	At year start (April 1)	+ve	3,464	3,499
	New members	+ve	516	500
	Members leaving	+ve	(481)	(504)
	At year end (31 March)		**3,499**	**3,495**
Patient	At year start (April 1)	+ve	4,599	4,680
	New members	+ve	241	292
	Members leaving	+ve	(160)	(232)
	At year end (31 March)		**4,680**	**4,740**
	TOTAL		**11,038**	**11,063**

In Year Movements

	Members Leaving	Members Joining	Net
Public	61	39	-22
Patient	232	292	60
Staff	504	500	-4
Total	**797**	**831**	**34**

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
- Members of the Royal Brompton and Harefield Alumni are invited to join the membership
- publication of articles setting out the advantages of Foundation Trust membership in local newspapers, charity newsletters and hospital newsletters.

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.

The Trust intends to canvass the opinion of the trust's members and the public by publishing its forward plan, including its objectives, priorities and strategy via the members newsletter.

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 NHS Improvement's Single Oversight Framework

Single Oversight Framework
NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation
The Trust is currently placed in Segment 2.

This segmentation information is the Trust's position as at 7th March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	1
	Liquidity	1	1
Financial efficiency	I&E margin	4	1
Financial controls	Distance from financial plan	2	1
	Agency spend	2	3
Overall scoring		**3**	**1**

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Royal Brompton & Harefield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 *Department of Health Group Accounting Manual* and in particular to:

• Observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual)* 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 the *NHS Foundation Trust Accounting Officer Memorandum*.

..... **Robert J Bell**
Chief Executive and Accounting Officer **26th May 2017**

2.7 Annual Governance Statement 2016-17

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 policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS 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 2017 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 at 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 a Health and Safety Lead. The Health and Safety Lead is assisted in their work by an external specialist contractor who assists with the monitoring of compliance with 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 2016/17 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, 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

Organisational Excellence: Estates – out of date areas, lack of modern facilities 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. • Buildings have been risk assessed and deemed acceptable for occupancy • 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. • NHS Improvement are aware of 2 Single Oversight Framework Targets at risk during 2017/18; 62 day cancer target / incomplete RTT . • 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 • Regular oversight of key performance indicators by commissioners through the Clinical Quality Review Group.
Financial Risk: Failure to maintain adequate liquidity, ensuring availability of cash	• Trust has initiated a 'transformation' programme to review all areas of operational performance with the aim of significant improvements to the cost base; • Trust is undertaking a review of all clinical recording and coding practice to ensure appropriate classification and reimbursement under HRG4+ with effect from 1 April 2017; • Trust has processes in place to monitor and forecast liquidity levels;

	• 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; • We have RCF in place to meet short term cash requirements that occur; and • 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. • The PAS Implementation Group has been established to provide oversight for the implementation of the new PAS system.
Failure to execute property re-development effectively and within budget	• Existence of the Property Committee 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 NHSI's requirements for major capital projects; • Establishment and maintenance of a detailed project model which includes milestones, cash flows and sensitivities; • Production of forward plan for capital programme facilitates integration and funding requirements; and • 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 on-going 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:

- NHS Improvement, 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.
- 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
- The Trust's membership of the Institute of Cardiovascular Medicine & Science, 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 last 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 in the Directors' Report contained within this Annual Report.

Care Quality Commission (CQC)
The Trust is fully compliant with the registration requirements of the CQC. The Trust was inspected by the CQC in June 2016 and the inspection report was published on 10th January 2017. Overall, the Trust was rated by the CQC as 'Requires Improvement'. Within this rating Harefield Hospital was rated as 'Good' and the Royal Brompton Hospital as 'Requires Improvement'. An action plan has been developed and is currently being implemented prior to re-inspection by the CQC.

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 2016/17. These include:

- Governance framework, to include the Board's committee structure, attendance records and the coverage of its work,
- Board Committee reports,
- An account of corporate governance,

All of these required disclosures are made in section 2, the Accountability Report, which is contained within the main body of the Annual Report 2016/17.

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 2016/17. 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 a minimum of level 2, with an increase in the number assessed at level 3 resulting in an improved overall score of 78% compared to the 2015/16 submission of 69%.

Two incidents were classified as 'Level 2' and reported to the Information Commissioner's Office in 2016/17. The first incident related to a submission of information to NHS England, where redaction of patient data had been attempted but was inadequate. Patients received an explanation and apology from the Trust, the NHS England submission was repeated with correctly-redacted information, and an all-staff message was distributed by the Communications team to raise awareness. The second incident related to a technical configuration on a Trust clinical system which potentially allowed access to Trust patient data from two other NHS hospitals. The system supplier was promptly engaged to correct its configuration in order to contain the risk. No action has been taken by the Information Commissioner's Office.

During 2016/17, 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. NHS Improvement (in exercise of the powers conferred by 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.

An external audit review of referral to treatment time data and the data used to report the 62 day cancer target, led to a modified opinion with regards to the Quality Report 2016/17. The external auditors also made recommendations regarding the management of data quality with respect to these indicators. Further details of these recommendations; and the action to be taken by management, are given in the Quality Report 2016/17.

The Trust's Quality Indicator Assurance Framework (QIAF) has continued to be used to track risks relating to data quality. Use of this framework was assessed by PricewaterhouseCoopers (PwC) as part of their 'Well Led Review'. PwC recommended that the frequency of review of the QIAF by the Risk and Safety Committee (RSC) be increased to twice per year. The QIAF was reviewed by the RSC in February 2017 and is scheduled for further review at the RSC in October 2017.

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 24th May 2017, the Board concluded that an effective system of internal control had been in place during 2016/17.

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 2016/17. There were no never events during 2016/17.

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 2016/17.

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 2016/17.

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

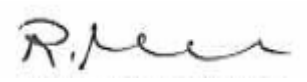
KPMG's conclusion as set out in its formal Head of Internal Audit Opinion is that 'significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control'.

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

5. 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 2016/17 during which time no significant control issues have been identified.

Signed: **Date: 26th May 2017**



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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 2017 (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 2017, 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 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement ("NHSI"):

- 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'. As discussed on page 39 of the Quality Report, the Trust has agreed with NHSI to early adopt the revised National Cancer Breach Allocation Guidance, dated April 2016.

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' and supporting guidance issued by NHSI.

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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; 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 supporting guidance 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 supporting guidance, 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 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to Mach 2017;
- feedback from commissioners, dated 17 May 2017 and 25 May 2017;
- feedback from governors, dated 16 May 2017;
- feedback from local Healthwatch organisations, dated 22 May 2017 and 25 May 2017;
- feedback from Overview and Scrutiny Committee dated 17 May 2017 and 28 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2016;
- the latest national inpatient survey 7 March 2017;
- the latest national staff survey 8 June 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2017; and
- the CQC inspection report dated 10 January 2017

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' and supporting guidance 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' and supporting guidance.

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 20 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 20% of our sample of patients' records tested, non-RTT pathways had been incorrectly created as RTT pathways at the time of migration into the new Patient Administration System (installed July 2016), affecting the calculation of the published indicator;
- For 15% of our sample of patients' records tested, the pathway was incorrectly recorded (including end of treatment not correctly recorded, and duplication of a pathway), affecting the calculation of the published indicator; and
- For 25% 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.

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 2017. We are unable to quantify the effect of these errors on the reported indicator.

The maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers is calculated as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. As a tertiary provider, the Trust receives referrals from other hospitals. In 2016/17 the Trust has agreed with NHS Improvement early adoption of the draft National Cancer Breach Allocation Guidance produced by NHS England and NHS Improvement as published in April 2016. Consequently, this is the first time this new process has been assessed and changes how responsibility for cases is shared between NHS providers, placing greater onus on referring trusts to do so at an early stage in the pathway.

We have tested a sample of 27 patients on the 62 day cancer pathway during the year. Our testing included testing of a mixture of cases in breach and not in breach of the target. While the Trust uploads every referral form to the patients' electronic record (EPR) with a date-stamp, our testing identified that the Trust does not currently have in place a system to ensure retention of an audit trail for the date of receipt of referral, which is a key element of how the pathway is treated in the final metric calculation. We also noted differences in recorded referral dates on 4 cases and stop dates in 3 cases.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting 62 day cancer wait for the year ended 31 March 2017.

The “Performance against key healthcare targets 2016-17” section on page 39 of the Trust’s Quality Report details the actions that the Trust is taking to resolve the issues identified in its processes.

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 2017:

- 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’ and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for quality reports for Foundation Trusts 2016/17; 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’ and supporting guidance.

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom
26 May 2017

Annex 2

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2016 TO 31st MARCH 2017

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2016 TO 31st MARCH 2017

Accounts for the year 1st April 2016 to 31st March 2017

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INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL BROPTON & 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 2017 and of the Trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – 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 that we have audited comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Equity;
- the Statement of Cash Flow; and
- the related notes 1 to 27.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – 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 the Code of Audit Practice.

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: • NHS revenue recognition and provisions • Property valuation • Going concern • Management override of controls Last year our report included capital expenditure as a risk which is not included in our report this year, due to the reduction in size of the capital programme this year.
Materiality	The materiality that we used in the current year was £3.65m which was determined on the basis of approximately 1% of the Trust's total revenue recognised in the year to 2016/17 (excluding Sustainability and Transformation Fund incentive and bonus income, which is one-off in nature).
Scoping	Audit work was performed at the Trust's offices (both Harefield and Brompton) directly by the audit engagement team, led by the senior statutory auditor.
Significant changes in our approach	Other than the changes to key risks as described above, there have been no significant changes in our approach to the audit in 2016/17 compared to 2015/16.

Going concern

We have reviewed the Accounting Officer's statement contained within the Statement of the Accounting Officer's responsibilities as the accounting officer of Royal Brompton & Harefield NHS Foundation Trust on page 77, the going concern disclosure within the Performance Report at page 13 and the going concern disclosure in note 1 of the financial statements on page 5 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 Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards.

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.

NHS revenue recognition and provisions

Risk description

We assessed the risk as relating primarily to the recognition of whether NHS revenue that is unsettled at the year-end (either as a receivable or with potential repayment due), is valid, accurate and valued appropriately. In 2016/17, this revenue includes new funding from the Trust referred to as Sustainability and Transformation Funding (STF).

As described in note 1, Accounting Policies and other information, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime, in particular in determining the level of overperformance and CQUIN (Commissioning for Quality and Innovation) revenue to recognise;

	• the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4; and • the Sustainability and Transformation Funding (STF) which is dependent on the Trust meeting certain financial performance targets and therefore recognition of this funding is affected by other accounting estimates. Details of the Trust's income, including £280m from NHS England and Clinical Commissioning Groups are shown in note 3.2, and £15.5m of Sustainability and Transformation Funding (STF) shown in note 4.1 to the financial statements. NHS debtors of £6.6m and total provision for impaired receivables of £7.9m are shown in note 18 to the financial statements. The majority of the Trust's income is commissioned by NHS England.
How the scope of our audit responded to the risk	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.
Key observations	We did not identify any material misstatements through our procedures in respect of this risk, and we consider the estimates made by the Trust to be within an acceptable range.
Property valuation	
Risk description 	The Trust holds property assets within Property, Plant and Equipment at a valuation of £150m and Investment Properties of £37.3m. 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, the useful hypothetical alternative site and the remaining life of the assets, and for investment properties assumptions about planning permission, associated conditions or other factors impacting potential proceeds) and which can be subject to material changes in value. As detailed in note 1.22, 14 and 15, the Trust has reassessed a number of valuation assumptions in the current year, including: • reducing the assumed land area for the Harefield site by infilling void areas; • changing the assumed yields used to calculate the value of office spaces; and • assumptions over prices a developer would pay for investment

	properties in light of the current status of the planning process The net valuation movement on the Trust's estate shown in note 14 is an impairment of £19m and revaluation gains of £27.2m on Investment Properties in note 15 (which includes gains realised on disposal of an asset in year).
How the scope of our audit responded to the risk	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. We assessed the appropriateness of the further reduction in the Harefield land area the Trust has used in calculating a Modern Equivalent Asset valuation by cross checking the site density based on gross internal floor area and considering the reasonableness of this given the nature of the Trusts activities. We have reviewed the disclosures in notes 1.22, 14 and 15 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.
Key observations	The assessment made in respect of the market value of investment properties reflects current planning permission status and circumstances. Changes in the planning status would significantly affect the valuation of these assets. The assumptions supporting a reduction in the land area required for a Modern Equivalent Asset at the Harefield site, significantly reduce the valuation of land assets. We did not identify any material misstatements through our procedures in respect of this risk and is within an acceptable range.
Going Concern	
Risk description 	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 most significant being the proceeds from the planned sale of an investment property within the going concern assessment period. 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.
How the scope of our audit responded to the risk	We evaluated management's going concern assessment by challenging the key judgements within the Trust's forecasts and annual plan including assumptions over property disposals, financing availability, 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.
Key observations	We concur with the Trust's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.
Management override of controls	
Risk description 	We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The Trust has been allocated £4.8m of the Sustainability and Transformation Fund, contingent on achieving financial and operational targets each year, equivalent to a "control total" for the year of a deficit of £7.5m. NHS Improvement has allocated funding for a "bonus" to organisations that exceed their control total, including offering trusts £1 of additional funding for each £1 above the control total. This creates an incentive for reporting financial results that exceed the control total. The Trust's results show a surplus on a "control total" basis of £12.6m, equivalent to £9.4m above the control total. All NHS Trusts and Foundation Trusts were requested by NHS Improvement in 2016 to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.22.
How the scope of our audit responded to the risk	**Manipulation of accounting estimates** Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third

	party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration, and reviewed the agreements associated with the property disposal in year and evaluated whether they had been appropriately accounted for.
Key observations	We have not identified any material misstatements or findings with respect to management override of controls and the reasonableness of accounting estimates, journal entries, and unusual/significant transactions.

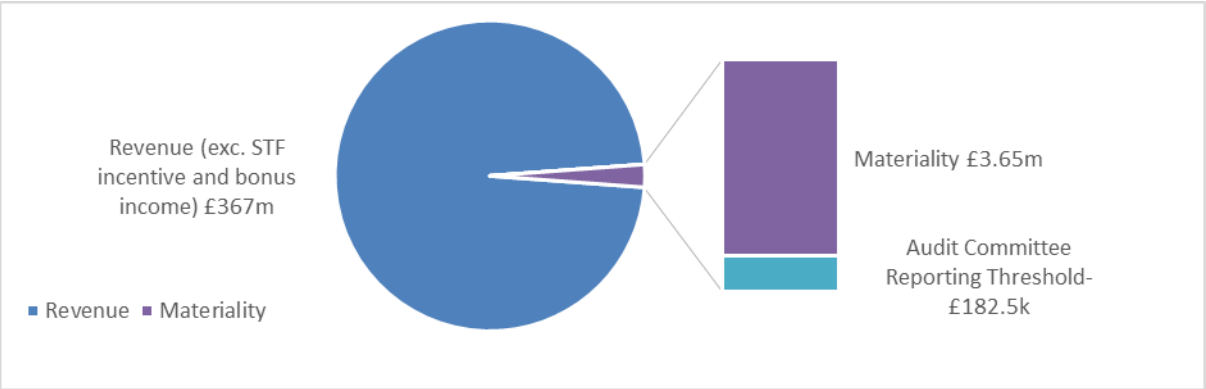
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

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.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£3.65m (2015/16: £3.35m)
Basis for determining materiality	1% of revenue less Sustainability and Transformation Fund incentive and bonus income, which is one-off in nature (2015/16: 1% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £182.5k (2015/16: £167.5k), 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, its environment and service organisations, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's sites in Brompton and Harefield directly by the audit engagement team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have 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:

We have nothing to report in respect of these matters.

- 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 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.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

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; or
- 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 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

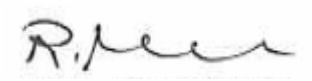
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies 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
26 May 2017

Accounts of Royal Brompton & Harefield NHS Foundation Trust
for the Year ended 31 March 2017

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2017 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** **26th May 2017**
Chief Executive

Accounts of Royal Brompton & Harefield NHS Foundation Trust
for the Year ended 31 March 2017

Statement of Comprehensive Income

	Note	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 (Restated) £000
Operating income from patient care activities	3	329,780	328,957
Other operating income	4	47,550	33,342
Total operating income from continuing operations		**377,330**	**362,299**
Operating expenses	5	(386,151)	(368,279)
Operating deficit from continuing operations		**(8,821)**	**(5,980)**
Finance income	10	42	47
Financial liabilities	11	(1,036)	(564)
Unwinding of discount on provisions	22	(2)	(11)
PDC dividends payable		(6,063)	(6,671)
Net finance costs		**(7,059)**	**(7,199)**
Losses on disposal of non-current assets	12	(59)	(17)
Movement in the fair value of investment property	15	27,206	3,476
Surplus/ (deficit) for the year		**11,267**	**(9,720)**
Other comprehensive income (will not subsequently be reclassified to I&E)			
Revaluations of operational properties & other non-current assets	14	(9,176)	7,148
Other reserve movements		-	(3)
Total comprehensive income/ (expense) for the period		**2,091**	**(2,575)**

The prior year value of other operating income and operating expenses have been decreased by £1,553k to reflect confirmation in the DH GAM that reversals of impairments be recognised in operating expenses rather than in other operating income.

The prior year value of Operating deficit from continuing operations has been decreased by £17k to reflect confirmation in the DH GAM that gains/ (losses) of disposal of non-current assets be recognised as non-operating income/ expenditure rather than other operating income.

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	13	14,983	12,054
Property, plant and equipment	14	186,525	195,510
Investment property	15	37,294	34,088
Total non-current assets		**238,802**	**241,652**
Current assets			
Inventories	17	9,957	9,043
Trade and other receivables	18	45,950	32,512
Cash and cash equivalents	19	32,668	13,777
Total current assets		**88,575**	**55,332**
Current liabilities			
Trade and other payables	20	(49,566)	(49,597)
Borrowings	21	(5,610)	(3,070)
Provisions	22	(2,011)	(1,019)
Total current liabilities		**(57,187)**	**(53,686)**
Total assets less current liabilities		**270,190**	**243,298**
Non-current liabilities			
Borrowings	21	(52,147)	(27,500)
Provisions & liabilities	22	(638)	(690)
Total non-current liabilities		**(52,785)**	**(28,190)**
Total assets employed		**217,404**	**215,108**
Financed by			
Public dividend capital		108,567	108,362
Revaluation reserve		47,894	57,070
Income and expenditure reserve		60,943	49,676
Total taxpayers' equity		**217,404**	**215,108**

The financial statements on pages 1 to 35 were approved by the Trust Board and authorised for issue on, and signed on its behalf by:

Signed 

Name **Robert J Bell**
Position **Chief Executive**
Date **26 May 2017**

Statement of Changes in Equity for the year ended 31 March 2017

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2016		**108,362**	**57,070**	**49,676**	**215,108**
Surplus for the year		-	-	11,267	**11,267**
Revaluations	13, 14	-	(9,176)	-	**(9,176)**
Public dividend capital received		205	-	-	**205**
Taxpayers' equity at 31 March 2017		**108,567**	**47,894**	**60,943**	**217,404**

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

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2015		**108,152**	**49,924**	**59,397**	**217,473**
Deficit for the year		-	-	(9,720)	**(9,720)**
Revaluations	13, 14	-	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**

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 also be issued from time to time to trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital payment.

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 netted off impairment expense. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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

Statement of Cash Flows

	Note	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Cash flows from operating activities			
Operating deficit		(8,821)	(5,980)
Non-cash income and expense:			
Depreciation and amortisation	5	18,399	14,577
Net impairments	6	-	(1,141)
Income recognised in respect of capital donations		(937)	(2,838)
(Increase)/ decrease in receivables and other assets		(12,893)	14,316
(Increase)/ decrease in inventories		(914)	2,143
Increase in payables and other liabilities		902	3,229
Increase/ (decrease) in provisions		938	(1,392)
Other movements in operating cash flows		-	(2)
Net cash (used in)/ generated from operating activities		**(3,326)**	**22,912**
Cash flows from investing activities			
Interest received	10	42	47
Purchase of intangible assets		(5,075)	(4,674)
Purchase of property, plant and equipment		(17,165)	(20,568)
Sales of investment property		24,000	-
Receipt of cash donations to purchase capital assets		937	2,838
Net cash generated from/ (used in) investing activities		**2,739**	**(22,357)**
Cash flows from financing activities			
Public dividend capital received		205	210
Movement on loans from the Department of Health	21	20,000	17,500
Movement on loans from commercial lender	21	7,346	2,275
Other interest paid	11	(1,036)	(564)
PDC dividend paid		(6,878)	(6,431)
Net cash generated from financing activities		**19,637**	**12,990**
Increase in cash and cash equivalents		**19,050**	**13,545**
Cash and cash equivalents at 1 April		**13,021**	**(524)**
Cash and cash equivalents at 31 March	19	**32,071**	**13,021**

Note 19.1 reconciles cash and cash equivalents as presented in the Statement of Cash Flows and the Statement of Financial Position, in the latter case 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

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the accompanying financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual 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, investment properties, 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; and
- 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 commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a 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 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 other goods and services

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

Note 1.4 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 cost at least £5,000; or
- collectively, a number of items have an aggregate cost of at least £5,000 and individually cost more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; 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 substantial asset, for example a building, includes a number of components with significantly different asset lives, eg, 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 in use assets are measured subsequently at current value in existing use. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Note 1.4 cont...

Valuation of Operating Properties
Land and buildings used for the Trust's services or for administration purposes are stated in the balance sheet at their revalued amounts. Under IAS 16 this is the current value in existing use 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.

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, equipment and intangible assets carried at depreciated historic cost, as this is not considered to be materially different from current value in existing use.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits (straight line). 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.

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

Note 1.4 cont...

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
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 de-recognised 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 as a non-operating item. 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 grant 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.

Donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.4 cont...

Useful economic lives of property, plant and equipment

	Min life Years	Max life Years
Buildings, including dwellings	25	60
Plant and machinery	4	10
Transport equipment	2	7
Information technology	2	10
Furniture and fittings	4	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term,

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 and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands 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;
- how the intangible 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 expenses attributable to the asset during development.

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

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

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

Note 1.5 cont...

Useful economic lives of intangible assets

	Min life Years	Max life Years
Development expenditure	2	12
Software	2	10
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 in Note 1.4.

Revenue grants are taken to the Statement of Comprehensive Income to match the related expenditure.

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. 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 instruments and financial liabilities

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

Financial assets and 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 in Note 1.9.

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

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

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

Classification and measurement
Financial assets are categorised between 'fair value through income and expenditure', loans and receivables and 'available-for-sale financial assets'.

Financial liabilities are classified between '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 measured at 'fair value through income and expenditure' are financial assets or financial 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.

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.

Note 1.8 cont...

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

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

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 rate method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest rate method and charged to finance costs. Interest on financial liabilities taken out to finance the acquision of 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, the carrying amounts are determined from quoted market prices where possible and 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 are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset which have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

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 is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance expense in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Note 1.9 cont...

Operating leases
Other leases are regarded as operating leases and the rentals charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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

The implementation of IFRS 16 leases, in 2019, will remove the distinction between finance and operating leases. From then on most leases will be capitalised in the Statement of Financial Position reflecting the right to use the asset and the liability to pay for it. Exceptions are likely to be leases for under 12 months and leases for low value assets.

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

Note 1.10 Provisions

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

Clinical negligence costs
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 22.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays annual contributions to the NHSLA and in return receives assistance with the costs of claims arising. The annual contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.11 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 at the Statement of Financial Position date.

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.

Investment properties are not depreciated.

Note 1.12 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 1.13 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 payment. 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 Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable and (iv) any 'incentive' or 'bonus' Sustainability & Transformation Funding (STF) due at the Statement of Financial Position date. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.14 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 the assets concerned. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Corporation tax

The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this legislation. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988) but this power has not been exercised.

Note 1.16 Foreign exchange

Both 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.

Note 1.16 cont...

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 period 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 functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Gifts

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

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

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial instruments (not yet EU adopted) - applicable to the public sector from 1 January 2018. Impact likely to be minimal as NHS bodies rarely hold complex financial instruments. Not yet adopted by the FreM therefore early adoption is not permitted.
- IFRS 15 Revenue from contracts with customers (not yet EU adopted) - applicable to the public sector from 1 January 2018. This standard may not affect the income recognised by NHS bodies; however applying the standard will require a review of all income streams. Not yet adopted by the FreM therefore early adoption is not permitted.
- IFRS 16 leases - implementation 1 January 2019. This will bring all leases onto the Statement of Financial Position. Not yet adopted by the FreM therefore early adoption is not permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – application required for accounting periods beginning on or after 1 January 2018.

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, with the exception of the Wimpole Street facility which will be impacted by IFRS 16. 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 1.22 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 on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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.

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 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 0.24%.
3) The Trust's Chelsea campus for operational and support purposes (land and buildings) was 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.
4) One of the Trust's investment properties, Chelsea Farmers Market, was revalued upwards to reflect progress with an on-going project to bring this property forward for sale.

Note 1.23 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			
2016/17	**RBH Heart**	**HH Heart**	**Lung**	**Total**
NHS clinical income	111,404	88,274	79,703	279,382
Non NHS income	21,056	5,526	4,838	31,419
Non clinical income	1,635	276	538	2,449
Total income	**134,096**	**94,076**	**85,079**	**313,250**
Pay	(76,064)	(50,127)	(33,830)	(160,022)
Non pay	(43,152)	(30,991)	(26,170)	(100,314)
Total expenditure	**(119,217)**	**(81,119)**	**(60,000)**	**(260,336)**
Contribution	**14,879**	**12,957**	**25,079**	**52,915**
Contribution %	11%	14%	29%	17%
Other income & costs				(44,054)
EBITDA				**8,861**
Capital charges/ other				2,206
Surplus for the year				**11,067**

	£000			
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)**

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Acute services		
Elective income	72,105	69,410
Non elective income	23,664	30,071
Outpatient income	27,010	24,928
Other NHS clinical income	165,512	163,499
Other services		
Private patient income	39,852	39,287
Other clinical income	1,637	1,762
Total	**329,780**	**328,957**

Note 3.2 Income from patient care activities (by source)

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
NHS England and CCGs*	279,813	277,465
Department of Health	-	8
NHS foundation trusts	2,669	2,682
NHS trusts	1,215	1,624
NHS other	4,594	6,129
Non-NHS: private patients	39,852	39,287
Non-NHS: overseas patients (chargeable to patient)	1,007	1,092
NHS injury scheme	225	52
Non NHS: other	405	618
Total	**329,780**	**328,957**

All income relates to continuing operations.

*Income from NHS England & CCGs includes £3,812k at 31 March 2017 (15/16: £5,002k) for partially completed patient episodes.

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

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Income recognised this year	1,007	1,092
Cash payments received in-year	273	440
Amounts added to provision for impairment of receivables	504	546
Amounts written off in-year	123	144

Note 4 Other operating income and income from commissioner related services

Note 4.1 Other operating income

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 (Restated) £000
Research and development	10,895	11,946
Education and training	5,846	6,033
Receipt of capital grants and donations	859	2,926
Charitable and other contributions to expenditure	4,686	2,426
Non-patient care services to other bodies	501	544
Sustainability and Transformation Fund income	15,538	-
Rental income from operating leases (Note 9.1)	1,091	1,198
Income in respect of staff costs where accounted on gross basis	1,619	1,457
Other income:		
Clinical excellence awards	2,529	2,916
Staff accommodation rentals	1,161	1,215
Catering	1,371	1,408
Childcare services	649	673
Car parking	99	194
Other	706	406
Total	**47,550**	**33,342**

All income relates to continuing operations.

The prior year value of other operating income has been decreased by £1,553k to reflect confirmation in the DH GAM that reversals of impairments be recognised in operating expenditure rather than in other operating income.

From 1 April 2016, NHS Improvement (NHSI), an arms length body of DH, has awarded Sustainability and Transformation Fund (STF) income to Trusts which have:
- achieved their assigned financial targets ('control totals') and specified clinical performance trajectories ('core' STF);
- exceeded their assigned 'control totals' through a £ for £ reward scheme ('incentive' STF); and
- to the extent that funds are available to NHSI, additional STF to Trusts meeting and/ or exceeding their assigned 'control totals' ('bonus' STF).

For financial year 2016/17 the Trust received the following STF: £4,800k in 'core', £9,382k in 'incentive' and £1,356k in 'bonus' income.

Note 4.2 Income from commissioner requested and other services

Under the terms of its provider licence, the Trust is required to analyse income between activities representing commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence as services that 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 2017 £000	Year Ended 31 March 2016 £000
Income from services designated (or grandfathered) as commissioner requested services	288,291	287,908
Income from services not designated as commissioner requested services	89,039	74,391
Total	**377,330**	**362,299**

Note 5 Operating expenses

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 (Restated) £000
Employee expenses - executive directors	1,131	1,111
Remuneration of non-executive directors	205	200
Employee expenses - staff	217,780	206,429
Supplies and services - clinical	105,579	106,825
Supplies and services - general	10,697	9,900
Establishment	9,113	8,518
Transport	1,940	1,949
Premises	10,281	8,767
Increase in provision for impairment of receivables	894	2,680
Increase in other provisions	982	126
Depreciation of property, plant and equipment	16,253	14,333
Amortisation of intangible assets	2,146	244
Impairments, net of reversals	-	(1,141)
Audit fees payable to the external auditor		
audit services - statutory audit	103	112
other auditor remuneration (external auditor only)	19	11
Clinical negligence contributions to NHSLA	4,460	3,645
Consultancy costs	2,622	2,310
Internal audit costs	129	95
Training, courses and conferences	760	840
Other	1,057	1,325
Total	**386,151**	**368,279**

All expenses related to continuing operations.

The prior year value of operating expenses has been decreased by £1,553k to reflect confirmation in the DH GAM that reversals of impairments be recognised as reductions to operating expenses rather than as other operating income.

Staff costs include nil (2015/16: £273k) incurred under the Mutually Agreed Resignation Scheme (MARS).

Fees payable to the external auditor include £103k (2015/16: £112k) for statutory audit and other auditor remuneration covers the audit of the Quality Accounts and grant assurance work £19k (2015/16: £11k).

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 Impairments of assets

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Impairments charged to operating expenses: redevelopment fees	-	412
Reversals of impairments credited to operating expenses: redevelopment fees	-	(1,553)
Total	**-**	**(1,141)**

Note 7 Employee benefits

Note 7.1 Employee benefits

	Year Ended 31 March 2017			Year Ended 31 March 2016 (Restated)
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	167,102	2,999	**170,101**	161,606
Social security costs	18,275	-	**18,275**	14,645
Employer's contributions to NHS pensions	18,036	-	**18,036**	17,611
Termination benefits	345	-	**345**	1,282
Agency staff	-	12,154	**12,154**	12,396
Total	**203,758**	**15,153**	**218,911**	**207,540**

Employers National Insurance contributions increased in 2016/17 due to removal of the 3.4% rebate with regard to employees in contracted-out pension schemes.

The prior year value of agency staff has been adjusted to reclassify staff 'bank' costs into salaries and wages to be consistent with the current year costs which only include agency costs.

Note 7.2 Retirements due to ill-health

During 2016/17 there were 4 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £141k (£55k in 2015/16).

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 2017	Year Ended 31 March 2016
	£000	£000
Salary	1,262	1,201
Performance related bonuses	-	12
Employer's pension contributions	74	98
Total	**1,336**	**1,311**

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.

In order that the defined benefit obligations recognised in the Scheme's own 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 liabilities 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 liabilities as at 31 March 2017 is based on valuation data as at 31 March 2016, updated to 31 March 2017 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.

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

Note 9 Operating leases

Note 9.1 The Trust as lessor

The Trust owns five investment properties that are leased out under operating leases. From 1 April 2016, 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 4.1 - Other operating income.

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Rental revenues	1,091	1,198
Total	**1,091**	**1,198**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease receipts due within one year	546	599
Total	**546**	**599**

Note 9.2 The Trust as lessee

The Trust was a party to seven operating leases with a total expenditure of £1,430k during the year to 31 March 2017 (15/16: £52k). One lease is for buildings (Wimpole Street private outpatient and diagnostic facility) and the rest for plant & machinery. The Wimpole Street lease has a term of 15 years from its inception on 3 July 2016.

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.

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 2017 £000	Year Ended 31 March 2016 £000
Operating lease expense		
Minimum lease payments	1,430	52
Total	**1,430**	**52**

Operating leases cont'd

	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	995	27
- later than one year and not later than five years;	3,933	10
- later than five years.	6,714	-
Total	**11,642**	**37**

One condition of the lease for the Wimpole Street private outpatient and diagnostic facility is the Trust's obligation for the removal (and consequent reinstatement works to the property) of all tenant fixtures, fittings, furniture and effects. The current lease expires in 2030, however it is possible that the lease would be extended or renegotiated and there is also uncertainty around the amount and extent of expenditure that would be required, as this is to be agreed with the landlord at the end of the lease.

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Interest received on bank accounts	42	47
Total	**42**	**47**

Note 11 Finance expense and late payments

Note 11.1 Finance expense

Finance expense represents interest and other charges incurred in the borrowing of money.

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Interest expense:		
Loans from the Department of Health	903	456
Commercial loans	133	4
Overdrafts - revolving credit facility	-	104
Total	**1,036**	**564**

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 2017 (year to 31 March 2016: nil).

Note 12 Losses on disposal/ derecognition of non-current assets

	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Loss on disposal of non-current assets	(59)	(17)
Total	**(59)**	**(17)**

Note 13 Intangible assets

Note 13.1 Intangible assets - 2016/17

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2016	**2,708**	**8,945**	**4,255**	**15,909**
Additions	-	-	5,075	**5,075**
Reclassifications	2,426	6,778	(9,204)	**(0)**
Disposals/ derecognition	(76)	(11)	-	**(87)**
Cost at 31 March 2017	**5,058**	**15,712**	**127**	**20,897**
Amortisation at 1 April 2016	**1,336**	**2,519**	**-**	**3,855**
Provided during the year	653	1,493	-	**2,146**
Disposals/ derecognition	(76)	(11)	-	**(87)**
Amortisation at 31 March 2017	**1,913**	**4,001**	**-**	**5,914**
Net book value at 31 March 2017	**3,145**	**11,712**	**127**	**14,983**
Financed by:				
Owned	2,974	11,712	127	**14,812**
Donated	171	0	-	**171**
Net book value at 31 March 2017	**3,145**	**11,712**	**127**	**14,983**

Note 13.2 Intangible assets - 2015/16

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2015	-	-	-	-
Additions	-	-	4,674	**4,674**
Reclassifications	2,707	8,944	(419)	**11,232**
Revaluations	2	1	-	**3**
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	1,269	2,341	-	**3,610**
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**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/ cost at 1 April 2016	**31,672**	**120,155**	**6,960**	**12,270**	**56,243**	**13,538**	**240,839**
Additions	-	-	-	16,502	-	-	**16,502**
Reclassifications	-	10,158	253	(18,279)	7,549	318	**-**
Revaluations	(3,265)	(15,869)	90	-	4	-	**(19,040)**
Disposals/ derecognition	-	-	-	-	(924)	(487)	**(1,411)**
Valuation/ cost at 31 March 2017	**28,407**	**114,444**	**7,303**	**10,493**	**62,873**	**13,370**	**236,890**
Accumulated depreciation at 1 April 2016	**-**	**-**	**-**	**-**	**36,604**	**8,724**	**45,328**
Provided during the year	-	9,735	363	-	4,882	1,273	**16,253**
Revaluations	-	(9,501)	(363)	-	-	-	**(9,864)**
Disposals/ derecognition	-	-	-	-	(865)	(487)	**(1,352)**
Accumulated depreciation at 31 March 2017	**-**	**234**	**-**	**-**	**40,621**	**9,510**	**50,365**
Net book value at 31 March 2017	**28,407**	**114,210**	**7,303**	**10,493**	**22,251**	**3,860**	**186,525**
Financed by:							
Owned	28,407	107,809	7,079	10,441	17,750	3,844	**175,331**
Donated	-	6,401	224	52	4,501	16	**11,194**
Net book value at 31 March 2017	**28,407**	**114,210**	**7,303**	**10,493**	**22,251**	**3,860**	**186,525**

Land and buildings were valued by Montagu Evans as at 31 December 2016 in accordance with International Financial Reporting requirements. The assets was valued by reference to the market conditions prevailing at the valuation date. The Trust's Chelsea campus for operational and support purposes (land and buildings) are 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 of land and buildings resulted in a net loss of £9,180k (which is a shown above as the net of the revaluations adjustment to cost/ valuation of £19,044k and to accumulated depreciation of £9,864k). This net loss 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. These fees total £12,125k at 31 March 2017 (31 March 2016: £9,543k) against which the cumulative impairment against the these costs stands at £6,323k as at 31 March 2017.

Note 14.2 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/ 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	-	-	-	(412)	-	-	**(412)**
Reversals of impairments	-	-	-	1,553	-	-	**1,553**
Reclassifications	-	7,379	531	(17,009)	6,116	(8,248)	**(11,232)**
Revaluations	(17,648)	16,643	727	-	17	7	**(254)**
Disposals/ derecognition	-	-	-	-	(16,987)	(9,837)	**(26,824)**
Valuation/ 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	-	-	-	-	-	(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**

Note 15 Investment properties

	31 March 2017 £000	31 March 2016 £000
Carrying value at 1 April	**34,088**	**30,612**
Movement in fair value	27,206	3,476
Disposals	(24,000)	-
Carrying value at 31 March	**37,294**	**34,088**

Investment properties were valued as at 31 December 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.

One investment property was sold to the Royal Brompton & Harefield Hospitals Charity during the year.

Note 16 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 including their original respentice contributons of £50,000.

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 annual 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 its accounts as it deems the impact to be immaterial. The Trust has made £nil contribution to ICMS's operating costs in 2016/17 (2015/16: £nil).

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 annual 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 (2015/16: £nil).

Note 17 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	1,380	1,458
Consumables	8,577	7,585
Total	**9,957**	**9,043**

Inventories recognised in operating expenses for the year were £103,690k (2015/16: £104,040k).

Note 18 Trade and other receivables

Note 18.1 Trade and other receivables*

	31 March 2017 £000	31 March 2016 £000
Receivables from related parties	6,550	6,467
Prepayments	5,598	4,891
Accrued income	20,579	6,714
VAT receivable	536	395
PDC dividend overpaid	545	-
Other receivables, principally private patient debtors	20,031	21,363
Provision for impaired receivables	(7,889)	(7,318)
Total	**45,950**	**32,512**

*Trade and other receivables include £3,812k at 31 March 2017 (15/16: £5,002k) for partially completed patient episodes.

Accrued income contains £11,938k for STF income to reflect the Q4 element of the 'core' fund plus the 'incentive' and 'bonus' fund.

Note 18.2 Provision for impairment of receivables

	31 March 2017 £000	31 March 2016 £000
At 1 April	**7,318**	**5,567**
Increase in provision	1,653	3,232
Amounts utilised	(323)	(929)
Unused amounts reversed	(759)	(552)
At 31 March	**7,889**	**7,318**

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

Note 18.3 Aged analysis of receivables

	31 March 2017 £000	31 March 2016 £000
Ageing of impaired financial assets		
0-30 days	175	117
30-60 Days	240	414
60-90 days	16	60
90-180 days	292	460
Over 180 days	7,166	6,267
Total	**7,889**	**7,318**
Ageing of non-impaired financial assets past their due date		
0-30 days	5,724	5,001
30-60 Days	3,846	3,495
60-90 days	347	3,071
90-180 days	3,743	4,295
Over 180 days	2,823	2,120
Total	**16,483**	**17,982**

Note 19 Cash and cash equivalents

Note 19.1 Cash and cash equivalents movements

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.

	2016/17	2015/16
	£000	£000
At 1 April	**13,777**	**9,476**
Net change in year	18,891	4,301
At 31 March	**32,668**	**13,777**
Analysed as:		
Cash at commercial banks and in hand	69	93
Cash with the Government Banking Service	32,599	13,684
Total cash and cash equivalents as in SoFP	**32,668**	**13,777**
Bank overdraft	(597)	(756)
Net cash and cash equivalents as in SoCF	**32,071**	**13,021**

Note 19.2 Third party assets held by the Trust

Under the Tenancy Deposits Scheme, at 31 March 2017 the Trust held £139k (31 March 2016: £169k) in a deposit account for tenants renting accommodation owned by the Trust. These deposits are not recognised in reported cash and cash equivalents as the Trust has no beneficial interest in them.

The Trust also held a deposit of £58k in respect of a third party commercial tenant at Wimpole Street.

Note 20 Trade and other payables

	31 March 2017	31 March 2016
	£000	£000
Receipts in advance	7,049	6,152
Amounts due to related parties	5,368	3,507
Other trade payables	8,536	10,496
Other payables	1,870	2,533
Social security costs	2,572	2,131
Other taxes payable	2,480	2,313
Accruals	21,691	22,195
PDC dividend payable	-	270
Total	**49,566**	**49,597**

Note 21 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Bank overdraft	597	756
Loans from the Department of Health	3,695	-
Other loans	1,318	2,314
Total current borrowings	**5,610**	**3,070**
Non-current		
Loans from the Department of Health	43,805	27,500
Other loans	8,342	-
Total non-current borrowings	**52,147**	**27,500**
Total	**57,757**	**30,570**

Bank overdraft

Bank overdraft of £597k (31 March 2016: £756k) represented a temporary negative cash balance in the Trust's books of acccount (but not in its bank account) for payments processed on 31 March 2017 that cleared in April 2017.

Revolving credit facility

The Trust has a £10m Revolving Credit Facility, from Barclays Bank PLC which has a £nil balance drawn down at 31 March 2017 (31 March 2016: £nil). The current agreement runs until 28 November 2018.

Loans from the Department of Health

A £30m loan facility from the Independent Trust Financing Facility, a Department of Health funding entity, to support the Trust's 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 £30m at 31 March 2017 (2015/16: £20m). Repayments on the loan commence in April 2017 (with final repayment in April 2029) and the amount due within 12 months is included within the current balance in the table above.

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 £17.5m at 31 March 2017 (2015/16: £7.5m). Repayments on the loan commence in June 2017 (with final repayment in June 2030) and the amount due within 12 months is included within the current balance in the table above.

Other loans

A £10m loan facility has been granted by Barclays Bank PLC to fund the costs associated with the fitting out and equipping of the leased suite of private patient outpatient and diagnostic facilties at Wimpole Street. During the period of the Progress Payment (PP) agreement interest only was payable, at 1.95%pa above base rate. The PP period concluded in January 2017 and the £10m capital balance then rolled into a 5 year amortising 'mortgage-style' loan facility, at an interest rate of 2.76%. Repayments commenced in January 2017 and at 31 March 2017 the balance is £9.6m (31 March 2016: £2.3m). The amount due within 12 months is included within the current balance in the table above. Equipment assets are pledged as full security against the loan.

Note 22 Provisions and other liabilities

Note 22.1 Provisions

	Pensions - early departure costs	Other legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2016	**769**	**57**	**883**	**1,709**
Arising during the year	19	71	1,593	**1,683**
Utilised during the year	(76)	-	-	**(76)**
Reversed unused	-	(57)	(612)	**(669)**
Unwinding of discount	2	-	-	**2**
At 31 March 2017	**714**	**71**	**1,864**	**2,649**
Expected timing of cash flows:				
- not later than one year;	76	71	1,864	**2,011**
- later than one year and not later than five years;	304	-	-	**304**
- later than five years.	334	-	-	**334**
Total	**714**	**71**	**1,864**	**2,649**

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

Note 22.2 Clinical negligence liabilities

At 31 March 2017, £79,848k was included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust (31 March 2016: £66,325k).

Note 23 Contractual capital commitments

	31 March 2017	31 March 2016
	£000	£000
Property, plant and equipment	15,912	5,263
Intangible assets	251	2,436
Total	**16,163**	**7,699**

Note 24 Financial instruments

Note 24.1 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 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 significant 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 21. Interest rates on all three loans are fixed. The Trust therefore has minimal exposure to interest rate fluctuations.

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 2017 is in receivables from other customers, as disclosed in Note 18 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 24.2 Financial assets

	31 March 2017 £000	31 March 2016 £000
Assets		
Trade and other receivables (excluding prepayments)	40,352	27,621
Cash and cash equivalents at bank and in hand	32,668	13,777
Total	**73,020**	**41,398**

Note 24.3 Financial liabilities

	31 March 2017 £000	31 March 2016 £000
Liabilities		
Borrowings	57,757	30,570
Trade and other payables (excluding accruals)	27,875	27,402
Total	**85,632**	**57,972**

Note 24.4 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 £000
In one year or less	33,485	30,472
In more than one year but not more than two years	5,211	2,155
In more than two years but not more than five years	17,918	6,467
In more than five years	29,018	18,878
Total	**85,632**	**57,972**

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

Note 25 Losses and special payments

The table below outlines 129 cases of losses and special payments totalling £486k during the year to 31 March 2017 (year to 31 March 2016: 75 cases, £284k). These amounts are reported on an accruals basis when identified but exclude provisions for future losses.

	Year Ended 31 March 2017		Year Ended 31 March 2016	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	8	-	9	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	96	168	44	212
Stores losses and damage to property	14	311	12	53
Total losses	**118**	**479**	**65**	**265**
Special payments				
Extra-contractual to contractors	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation under legal obligation	-	-	-	-
Special severence payments	-	-	1	16
Ex-gratia payments	11	7	9	3
Total special payments	**11**	**7**	**10**	**19**
Total	**129**	**486**	**75**	**284**

Note 26 Events after the reporting date

There were no disclosable events after the reporting date.

Note 27 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 with the Trust other than receipt of remuneration.

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

Note 27.1 Related party balances

	Receivable		Payable	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Department of Health Group				
Department of Health	578	54	-	270
NHS England and CCGs	20,888	6,962	3,139	904
of which >£250k:				
NHS England	*11,950*	*497*	*2,338*	-
NHS Slough CCG	*915*	-	-	-
NHS Hillingdon CCG	*883*	*700*	-	-
NHS West London CCG	*646*	*502*	-	-
NHS South Devon & Torbay CCG	*487*	-	-	-
NHS Harrow CCG	*349*	-	-	-
NHS Herefordshire CCG	*317*	-	-	-
Sub-total	*15,547*	*1,699*	*2,338*	-
%	*74%*	*24%*	*74%*	*0%*
Foundation Trusts	1,354	1,636	1,159	1,549
NHS Trusts	848	1,130	398	417
Other DH Bodies	80	78	8	8
Total DH Group	**23,748**	**9,860**	**4,704**	**3,148**
Other Whole of Government (WGA)				
Central Government Departments	897	725	8,112	7,026
of which:				
HMRC	*536*	*395*	*5,052*	*4,444*
NHS Pension Scheme	-	-	*2,624*	*2,540*
Sub-total	*536*	*395*	*7,676*	*6,984*
%	*60%*	*54%*	*95%*	*99%*
Local Government	-	-	-	-
TOTAL Other WGA	**897**	**725**	**8,112**	**7,026**
Other (non-WGA) related parties				
Royal Brompton & Harefield Hospitals Charity	30	377	-	-
Total Non-WGA	**30**	**377**	**-**	**-**
Total related parties receivable and payable balances	**24,675**	**10,962**	**12,816**	**10,174**
Total non-related party receivable and payable balances	*21,275*	*21,550*	*36,750*	*39,423*
Total receivable and payable balance	**45,950**	**32,512**	**49,566**	**49,597**

Note 27.2 Related party transactions

	Income		Expenditure	
	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000	Year Ended 31 March 2017 £000	Year Ended 31 March 2016 £000
Department of Health Group				
Department of Health	6,686	7,643	3	4
NHS England and CCGs	297,981	280,159	27	-
of which >£2,000k:				
NHS England	*240,081*	*227,636*	*4*	-
NHS Hillingdon CCG	*8,216*	*6,626*	-	-
NHS Herts Valleys CCG	*4,303*	*4,050*	-	-
NHS Ealing CCG	*2,446*	*2,137*	-	-
NHS Harrow CCG	*2,611*	*2,062*	-	-
NHS West London CCG	*2,290*	*2,013*	-	-
Sub-total	*259,947*	*244,524*	*4*	-
%	*87%*	*87%*	*15%*	*0%*
Foundation Trusts	3,603	3,436	3,744	4,327
NHS Trusts	2,755	2,965	1,910	2,167
Other DH Bodies	6,167	5,864	4,729	3,809
Total NHS	**317,192**	**300,067**	**10,413**	**10,307**
Other Whole of Government (WGA)				
Central Government Departments	4,638	6,204	38,928	35,206
of which:				
Welsh Assembly Government	*2,990*	*3,865*	-	
NHS Blood & Transplant	*1,208*	*1,927*	*2,565*	*2,905*
HMRC	-	-	*18,275*	*14,645*
NHS Pension Scheme	-	-	*18,036*	*17,611*
Sub-total	*4,198*	*5,792*	*38,876*	*35,161*
%	*91%*	*93%*	*100%*	*100%*
Local Government	-	-	1,244	1,070
TOTAL Other WGA	**4,638**	**6,204**	**40,172**	**36,276**
Other (non-WGA) related parties				
Royal Brompton & Harefield Hospitals Charity	29,545	5,352	-	-
Total Non-WGA	**29,545**	**5,352**	-	-
Total related parties income and expenditure	**351,375**	**311,623**	**50,585**	**46,583**
Total non-related party income and expenditure	*49,955*	*50,676*	*335,566*	*321,696*
Total income and expenditure*	**401,330**	**362,299**	**386,151**	**368,279**

*The total income value for 2016/17 includes £24m received from Royal Brompton & Harefield Hospitals Charity as per note 15.

Note 27.3 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 related balances and transactions are as follows:

	Receivable 31 March 2017 £000	Payable 31 March 2017 £000	Income Year Ended 31 March 2017 £000	Expenditure Year Ended 31 March 2017 £000
British Telecom	-	-	-	347
Cumberland Lodge	-	-	-	-
London School of Economics	-	-	-	6
Medical Research Council	-	-	-	111
Medicines and Healthcare Products Regulatory Agency	-	2	-	5
Total	**-**	**2**	**-**	***470***