



Whittington Health
NHS Trust

Annual Report & Financial Accounts 2017/8



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OVERVIEW

CHIEF EXECUTIVE AND CHAIRMAN

Welcome to our 2017/18 Annual Report. We are proud of the work our staff and volunteers do to support over 500,000 people living across north central London to live longer, healthier lives.

We want to thank all our colleagues for what we have achieved together in such a tough year. A year that was characterised by many improvements including our CQC result of 'Good' for hospital services, 'Good' overall and 'Outstanding' for caring. We delivered an in year surplus of £0.6m surplus whilst achieving a cost improvement of over £11.7m.

Like most trusts we struggled with increased demand, particularly in urgent and emergency care, both in our emergency department and our community services. We have in place recovery improvement plans that will enable us to meet the NHS constitution standards.

Making sure we deliver the right services, in the right place and at the right time is vital but we cannot do this alone. We want to deliver services that enable better independence and health for our diverse population which is why we are active partners in delivering the North Central London Health and Care Partnership. Together with our CCGs and other stakeholders, we share the same vision of improving our population's health. We are working to reorganise services, improve public health and achieve financial balance in the face of rising demand. Our work with Islington and Haringey Health and Wellbeing Partnership is helping us focus on bringing together health and social care services to support people living with long term conditions whether they are frail and elderly or the young.

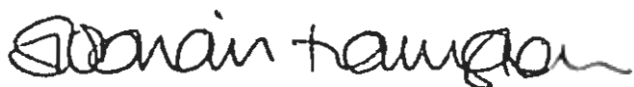
We have further developed our clinical collaboration with University College London Hospitals NHS Foundation Trust. This builds on our work to develop more integrated care to our communities that is closer to their homes. This year we expanded our successful 'Hospital at Home' service, and now run a 'Virtual Ward' that enables the prompt discharge of medically optimised patients with high levels of care support in their own home. We will build more successful partnerships with our clinical teams to continuously improve the quality and safety of our services which includes maternity, cancer and surgery.

An important part of our planning is our estate and delivering our estates strategy. Through the year we have been considering how we might undertake the work to transform the way our estate delivers care to our patients, and how we might ensure the development of our estates is guided by estate development experts working with clinicians, residents, staff and patients, so that we can meet the changing needs of our workforce and our population.

Any significant changes we plan to implement to maintain delivering high quality and safe services will continue to be shared with our stakeholders. We are fully committed to open engagement and consultation with our local community.

The world in which we currently work is challenging with increasing numbers of patients needing our services, restricted financial resources and limited recruitment potential. To do as well as we have over the past year is an outstanding achievement and credit to all our staff and our many hundreds of volunteers. We hope that the individual achievements in every sector of our Trust across both community and acute services highlighted throughout this report are acknowledged and celebrated by everyone.

We will continue on this improvement pathway and are proud of our staff and the service that we are delivering to our community.



Siobhan Harrington
Chief Executive



Steve Hitchins
Chairman

STATEMENT OF PURPOSE AND ACTIVITIES

Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

We provide hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. Whittington Health provided 101 different types of health service (41 acute and 60 community services) in 2017/18. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our mission and vision

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best care for our patients.

Our mission

Helping local people live longer, healthier lives.



Our vision

Provide safe, personal, co-ordinated care for the community we serve.

Our clinical strategy

Our five year [Clinical Strategy](#) was launched in 2015, and we continue to implement the service improvements agreed by the Trust Board, engaging with staff and stakeholders to help us collectively meet the challenges our community and local health and social economy face.

Our values

[Our values](#) underpin everything we do. Our staff are committed to upholding our values which we have collectively agreed:



Our services

Our priority is to deliver the right care, at the right time, and at the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across Camden, Islington, Haringey and Enfield.

As an integrated care organisation we bring safe and high-quality services closer to home and speed up communication between community and hospital services, improving our patients' experience. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

Our organisation has a highly-regarded educational role. We teach undergraduate medical students (as part of UCL Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals.

Our strategic goals

Providing the best possible healthcare services to patients will be achieved by delivering our clinical strategy. We have six strategic goals that guide us in delivering safe and high-quality care for all.

- To secure the best possible health and wellbeing for all our community
- To integrate and coordinate care in person-centred teams
- To deliver consistent, high quality, safe services
- To support our patients and users in being active partners in their care
- To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

KEY ISSUES

Increasing demand for our services, coupled with growing financial constraints, means that there are several key challenges and issues we must overcome to enable us to deliver the best possible services to our patients.

Recruitment and retention of staff

Recruiting the best possible staff underpins the successful delivery of our strategic goals. Retaining our staff is as important. Over the past year we have worked hard to introduce a number of improvements to help our staff feel more connected to the organisation these included; increasing our activity and improving how we understand and meet the needs of our staff through our equality, diversity and inclusion work, further addressing bullying and harassment, improving our health and wellbeing offer to our staff with mindfulness training, stress reduction workshops and exercise classes, as well as working to improve visible leadership of senior managers with frontline staff. We are determined that this year staff will feel a difference following the work we undertake to address the concerns they have raised in the staff survey.

Spending on agency and temporary staff

The Trust has successfully delivered on the NHSI target for agency staff reduction. However, we know that maintaining and improving our performance in relation to the use of agency and

temporary staff is key to delivering quality and financial sustainability. Agency and temporary staff are only used to help us maintain safe levels of staffing as a result of sickness or unplanned absences as a last resort. We have introduced more stringent financial controls that are closely monitored to help us to continue our reduced use of agency staff.

Emergency department performance

We saw a record number of visitors come to our emergency department – over 100,000 – against a very busy winter period. This was replicated in emergency departments across the whole of London. Patient safety remains our top priority and our teams have worked hard to ensure that despite these increasing pressures our performance remains in the top quartile of performance across London.

To help us meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure:

- Further capacity is available in primary care systems to offer an alternative to patients other than attending the Emergency Department
- Improving the redirection rate from NHS 111, whereby extended access hub capacity is better utilised
- Increasing the number of patients who are discharged to assess, following national best practice
- Reducing the numbers of Delayed Transfers of Care (DTOCs)
- Improving the re-ablement capacity, to enable medically fit patients to be discharged to receive on-going re-ablement at home

Financial position

The Trust agreed a control total target of a £0.6m surplus in year with the Department of Health. We bettered the target, ending the year with a £0.8m surplus. This financial performance made the Trust eligible for £4.7m in additional incentive and bonus STP (Sustainability and Transformation Plan) funding from the Department of Health (DH). The result of this was a £5.4m surplus against control total. While we have been able to meet our financial targets for this year, the Trust still has a historic deficit to clear; and plans to do this further in 2018-19, with a forecast for a £4.7m surplus.

Going concern and value for money

As with previous years, we have prepared our annual accounts for 2017-18 on the going concern basis. This is in line with DH accounting guidance, which states that the Trust is a going concern if continuation of services exists. As the Trust's financial performance and circumstances have improved in 2017-18 our external auditors have not included an emphasis of matter paragraph in their opinion on the financial statements, which is an improvement on previous years.

However, because of historical losses, the Trust is unable to breakeven across a three-year period. As a result our external auditors are obliged to give a qualified opinion on the Trust's arrangements to provide value for money in its use of resources for 2017-18.

PERFORMANCE AND ACHIEVEMENTS SUMMARY

Overall demand for our services in 2017/18

- We had **101,814** visits to our emergency department
- There were **2,269** elective admissions
- Our maternity staff delivered **3,761** babies
- We had **797,634** contacts with patients in the community
- We had an annual turnover of **£323** million
- We employed over **4,200** staff
- We worked with over **150** volunteers who support us

We are proud of our staff and their commitment to delivering safe and high-quality care – over the past year our community and hospital teams have helped to pioneer new projects, secure numerous national professional awards and accolades that include leadership and education, diabetes, cancer and maternity services. The details of some of our staff achievements are set out within this report and below provides highlights of others:

- CQC ranked the Hospital 'Good', the Trust 'Good' overall and 'outstanding' for caring
- Placed 35 overall in the UK and **2nd in London** – behind the Royal Marsden from the **National Cancer Patient Experience Survey**
- Simmons House rated as **"excellent"** by the **Quality Network for Inpatient CAMHS**.

- June 2017 CHKS Top Hospital Award for the best performing Trust for ‘**quality of care**’ across the UK
- Recognition from the national Medical Director for Clinical Effectiveness at NHS England for the **greatest improvements in timely identification and timely treatment of sepsis**
- **Highest quartile for reporting** incidents on the National Reporting Learning Services which demonstrates a strong culture of openness and reporting to **continuously improve patient safety**
- One of four teams across the country to **pilot a new model of supervision** for midwives
- Footprints social media project ‘**hearing women's voices on patient experience**’ to improve care based on human rights principles; shortlisted for the Patient Experience National Network Awards
- **Shortlisted for the 2018 HSJ Value awards for Clinical support services**, for **improving the pharmacy outpatient service through design**
- **Shortlisted for the 2018 HSJ Value awards for Community health service redesign**, for **the implementation of the eCommunity** paperless system
- The Trust had the **second highest uptake of flu vaccine by our staff across London**
- The proportion of staff taking part in the annual staff survey rose to 42%
- **Patient self-management** partnership with Tottenham Hotspur
- Staff and supporters **raised over £21,000** in the London Marathon for our **charity**

PERFORMANCE

HOW WE MEASURE PERFORMANCE

To make sure we provide the best possible services to our patients, we are set a range of national targets. For a number of these we often apply a set of stretch targets, aiming higher than the minimum requirement of nationally set targets.

In 2017/18 we tracked and measured our progress against 21 targets, known as key performance indicators (KPIs), which are derived from our goals and national standards of care. Of these targets 12 were fully met and eight were missed.

Every month we review our progress against these targets to help understand and improve our performance. Our performance is published monthly in our board papers.

PERFORMANCE ANALYSIS

We believe it is important to set targets that fully reflect the service and care we want to provide to our patients, so whilst it is disappointing to see that we have missed some of our targets, we are working to understand the reasons why, making sure that progress is being made to meet all targets in the future.

Emergency department performance

We saw a record number of visitors come to our emergency department – over 100,000 – and a very busy winter period. This was replicated in emergency departments across the whole of London. Patient safety remains our top priority and our teams have worked hard to ensure that despite these increasing pressures our performance remains in the top quartile of performance across London.

To help us meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure we make the necessary service and system changes to improve our performance against the constitution 4-hour standard. Our ED performance improved in 2017/18

with an outturn performance of 89.4% against 87.4% in 2016/17, against the significant increase in activity highlighted above.

Our performance improvement plan is detailed in our annual governance statement.

The following tables provide an overview of our performance against key performance indicators in 2017/18.

Table one: Performance against national targets 2017/18, at a glance

Goal	Standard/benchmark	Our performance
Emergency Department		
4 hour wait in emergency department	95% of patients to be seen within four hours of arriving at the emergency department to admission, transfer or discharge	89.4%
Average waiting time for treatment	No longer than 60 minutes	74 minutes
Admissions		
Non-elective readmissions within 30 days	Less than 5.5%	6.4%
Delayed transfers of care	Less than 4.5%	6.2%
Access to treatment		
18 weeks wait for patients waiting to be seen	92% of patients to be waiting within 18 weeks	92.2%
Urgent operations cancelled	0 cancellations	86
Waiting times for diagnostic tests	99% of patients waiting less than six weeks	99.1%
Hospital stays		
Zero mixed sex accommodation breaches	0 breaches	0 breaches
Cancer waiting times		
2 weeks wait from urgent referral to date first seen: all cancers	93% patients seen by a specialist within 2 weeks of referral for suspected cancer	94.7%
Diagnosis to first treatment	96% of patients treated began first treatment within 31 days of receiving their diagnosis	100%

Two month (62 day) wait from urgent GP referral to first definitive treatment	85% of patients treated began first definitive treatment within 62 days of being urgently referred for suspected cancer by their GP	88.1%
Maternity		
Smoking in pregnancy at delivery	Less than 6%	5.4%
Rate of breast feeding at birth	More than 90%	92.4%
New birth visits (Islington)	95% seen within 14 days	94.4%
New birth visits (Haringey)	95% seen within 14 days	90.0%
Friends and Family Test		
Outpatients recommending Whittington Health as a place to receive treatment to family and friends	90%	92.4%
Community patients recommending Whittington Health as a place to receive treatment to family and friends	90%	95.5%
Staff recommending Whittington Health as a place to receive treatment to family and friends	70%	71.0%
Complaints		
Complaints responded to within 25 working days	80%	82.7%
Complaints to Parliamentary Health Service Ombudsman	No benchmark	1 complaint (Still under investigation).
Workforce		
Staff sickness absence	Less than 3.5%	3.54% (Data up to February 2018)

OUR ACTIVITY

We are proud to serve our local community and over the forthcoming year we will continue to integrate and strengthen our hospital and community services to help local people live longer, healthier lives.

Table two: Our 2017/18 acute activity

Activity	2017/18	2016/17
Emergency department visits	101,814	97,136
Emergency inpatient admissions	17,449	16,593
First outpatient attendances	165,457	99,505
Follow-up outpatient attendances	214,520	218,028
Elective inpatient admissions	2,269	2,361
Day case admissions	19,674	20,090
Maternity deliveries	3,761	3,690

Table three: Our 2017/18 community activity

Activity	2017/18	2016/17
Community contacts (all face to face)	759,490	797,634
Community nursing	302,000	295,620
Health visiting and school nursing	84,001	74,703
Physiotherapy (adults)	79,532	82,213
Sexual health	4,980	28,113
Dental	39,899	28,630

STATEMENT OF FINANCIAL POSITION

Like many NHS Trusts, we continue to face a challenging financial future. However, the Trust achieved an in-year surplus for the first time since 2013-14. Due to historic deficits, the Trust failed to achieve its obligation to break even across a three-year period. However, in year we agreed and met a surplus target of £0.6m, finishing the year with a £0.8m surplus before incentive and bonus STF funding was allocated. As part of this process, we received an additional £4.7m, meaning that the Trust's reported surplus for 2017-18 is £5.4m against control total.

Our cumulative deficit at the end of the financial year was lower than planned at £9.8m against an expected figure of £14.6m – this is as a result of achieving the control total and the Trust's entitlement to the additional STF listed above. The Trust plans to report a surplus of £4.7m in 2018/19, and as a result, further reduce the cumulative deficit. Achievement of this target depends significantly on the success of the Trust's Cost Improvement Plan, which for 2018-19 is £16.5m. As such, it remains essential that we continue to reduce our overall expenditure and running costs so that our financial recovery plan remains on track.

Over the year we generated £323.4m in income, which was £10.9m above plan. This was the result of the following factors:

- STF awarded, described above;
- The Trust's financial plan included a high level of CCG QIPP delivery in the final quarter and this has not been achieved. This created an over-performance of approximately £1.5m;
- Recovery actions implemented with clinical ICSUs drove a positive trend in activity in the last three months of the year and created a recurrent benefit of approximately £1.0m;
- Receipt of £1.8m of additional education funding;
- Receipt of additional £1.2m of A&E tranche 1 and 2 funding; and
- Full recognition of £1.1m of income that had previously not been recognised due to a dispute with the counterparty. Having revisited contractual guidance, the Trust is confident that the outstanding balances will be paid. Therefore, the income has been recognised.

Our expenditure on pay costs exceeded our budgeted level by £2.2m, largely driven by the costs associated with the Trust's commitment to move from using temporary staff to substantive staff. The Trust spent £19.4m on bank staff and £9.3m on agency staff in 2017-18; these figures are both significantly lower than the comparative year 2016-17 and meant that the Trust remained within its agency ceiling for 2017-18. We continue to apply strict control on requests for temporary staffing.

Property, plant and equipment

£9.9m of capital expenditure has been incurred for the year against total capital allocations of £11.3m (excluding commitments on PFI and finance lease arrangements). The Trust was awarded £2.3m of additional funding from DH during the year for Fast Follower (£1.3m) and A&E Primary Care Streaming (£1.0m) projects. As such, we underspent our capital target by £0.5m while meeting our financial obligations and minimising our need for cash support borrowing.

Trade receivables

Our trade receivables are £2.4m higher than planned. This is the result of the £6.3m that the Trust is now owed in STF. Besides this, levels of debt collection during the year have been good; and management of relationships with key NHS and non-NHS partners has been improved.

Cash

We ended the year with £4.1m in cash, which was in line with our financial plans. Liquidity has been strong throughout 2017-18 - during the year, the Trust did not receive any additional cash support from Department of Health, and has continued to pay down historic cash support loans. We are conscious, however, that the Trust may face cash challenges in 2018-19 as it is operating in a financially challenged environment across the STP area. Our cash management plan is focused on collecting outstanding debt and managing our financial obligations over the year. We have agreed a minimum cash balance with NHS Improvement and the Department of Health, and are managing our cash flow in line with this position.

Payables

Payables balances as at the end of 2017-18 are £1.0m below plan. We are managing our creditor payments to ensure we meet our supplier obligations whilst maintaining an appropriate level of working capital. During the year, we have averaged 86.2% payment of creditors within 30 days, which is a significant improvement on 2016-17 (67.8%). We also expected to require cash support from DH, but due to the strong cash position throughout the year, this was not required during 2017-18.

OUR SUCCESSES

Helping local people live longer and healthier lives by providing safe, personal, co-ordinated care for the community we serve will be achieved by implementing our clinical strategy and delivering our six strategic goals. This report highlights examples of our achievements in delivering our goals throughout 2017/18

Strategic Goal One – Secure the best possible health and wellbeing for our community

To support the health and wellbeing of the communities we serve, it is important that we understand and evolve to meet their changing needs. Here are just some of the things we have achieved:

A Good Trust with Outstanding for Care

- CQC ranked the Hospital 'Good', the Trust 'Good' overall and 'outstanding' for caring

A 'top hospital'

- June 2017 CHKS Top Hospital Award for the best performing Trust for 'quality of care' across the UK

Strategic Goal Two – Integrate care in patient centred teams

As a leading integrated care organisation, we provide care to our patients in hospital and closer to home. The services we provide should support patients along every step of their healthcare journey and we work closely with GPs and other primary care teams to help make that happen. Here are some of the steps we have taken in the last year to deliver on this goal.

Integrated Community Ageing Team

The ICAT is a consultant-led multidisciplinary team (MDT) specialising in Comprehensive Geriatric Assessments (CGA) for patients who are registered with an Islington GP. This is usually carried out in the patient's own home, or special short notice clinic bookings are offered at Whittington Hospital and at University College Hospital which may be more appropriate where further investigations such as x-rays are required. The ICAT geriatricians and specialist pharmacists also provide visits and support to patients in Care Homes in Islington.

The ICAT (Care Homes) consists of a Consultant Geriatrician and Specialist Pharmacist who work with GPs and other community services to provide care for patients residing in care homes according to their wishes and needs.

Their objectives are as follows:

- Improve communication between secondary care and primary care for patients in care homes
- Maximise the number of days spent at home by reducing unnecessary hospital admissions and length of inpatient hospital stay
- Work closely with care home staff and support their education and development
- Work closely with allied GP practices to support ongoing professional development in complex geriatric case management

Respiratory Ward Board Rounds

Our respiratory team delivers an integrated service for people with long term conditions. They have taken a cultural approach to integration and include every member of the team in a weekly integrated Board Round. By reviewing the treatment and status of every patient under their care, be they at home or in the hospital, they ensure a truly holistic approach to helping people to manage their health. As well as the medical, they also take account of the wider physical, mental and emotional aspects of care as well as putting thought into how to patients and their carers are able to cope at home.

Extending our Hospital at Home

We have further developed our clinical collaboration with University College London Hospitals NHS Foundation Trust. This year we expanded our successful 'Hospital at Home' service, and now run a 'Virtual Ward' that enables the prompt discharge of medically optimised patients with high levels of care support in their own home. We will build more successful partnerships with our clinical teams to continuously improve the quality and safety of our services which includes maternity, cancer and surgery.

Strategic Goal Three – Deliver consistent, high quality, safe services

One of our biggest roles is to ensure that we are delivering the best possible services to our patients. We are committed to taking on this role and helping local people live longer, healthier lives.

The Trust is ranked in the highest quartile for reporting incidents on the National Reporting Learning Services which demonstrates a strong culture of openness and reporting to continuously improve patient safety. The latest data (October 2016-September 2017) shows that we have the lowest Standardised Hospital Mortality Index (SHMI) in the country.

Stopping sepsis in its tracks

Being able to spot the signs of sepsis early is key in stopping this potentially fatal condition in its tracks. We have made significant progress in tackling the number of people with sepsis we are able to treat successfully by monitoring and screening admissions to our emergency department so that we can spot the disease quickly. The Trust was recognised by the national Medical

Director for Clinical Effectiveness at NHS England for the greatest improvements in timely identification and timely treatment of sepsis

The sepsis CQUIN was launched in 2015 to improve the management of sepsis. Since then we have seen an increase in Emergency Department assessment for sepsis from 52% to 89%, and timely treatment increased from 49% to 76%. In-patient assessment for sepsis increased from 62% to 70%, and timely treatment has increased from 58% to 80% for these patients. Ms Ingham Clark Medical Director for Clinical Effectiveness, NHS England said “I would like to congratulate you and your colleagues for all the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place. Please pass my thanks on to the staff concerned for their achievements in improving the care for patients with sepsis. “

Top London Flu Fighters

During the winter months the flu virus can be particularly dangerous – especially for our older and more vulnerable patients. To make sure we are doing everything we can to keep the virus at bay and protect our patients, we encourage our staff to have their flu jab. In 2017/18 we were pleased to be the second highest Trust in London for our uptake of the flu vaccine. In total, 80.2% of our staff received a flu jab, compared with 79% in 2015. This is an excellent result and we are pleased to see so many colleagues taking this important step to protect themselves, their families and their patients from this potentially fatal virus.

Strategic Goal Four – Support our patients in being active partners in their care

Our commitment to listening to the needs of our patients and partners has driven many new projects throughout the year.

- Placed 35 overall in the UK and **2nd in London** – behind the Royal Marsden from the **National Cancer Patient Experience Survey**
- Simmons House rated as “**excellent**” by the **Quality Network for Inpatient CAMHS**.
- Footprints social media project ‘**hearing women's voices on patient experience**’ to improve care based on human rights principles; shortlisted for the Patient Experience National Network Awards

Strategic Goal Five – To be recognised as a leader in the fields of medical and multi-professional education and population based research

Investing in education can make a clear difference to the lives of the patients we support. To ensure the best possible experience for all our patients, it is vital that we embrace education and research.

Commitment to multi-professional education and training

It is now a requirement for all students to have a learning portfolio to keep a log of education and training activities and reflective practice throughout their undergraduate training. As part of this process, all students need to have access to a mentor or supervisor.

Throughout the year, there are about 800 medical students, 550 nursing students and 190 midwifery students completing their clinical placements at the Whittington. All of them have access to 'NHS ePortfolio' or a 'Practice Assessment Document' and have an allocated mentor or educational/clinical supervisor.

We ran seven half day 'Learning together' inter-professional workshops in 2017/18 based on real patient stories from serious incidents that have happened at Whittington Health. Each workshop discussed a number of key themes and focused on shared learning and quality improvement. Themes such as adult safeguarding, cross-organisational working, discharge planning, end of life care, handover, information sharing, learning disability, mental and physical health, pressure ulcers, sepsis and team working were all explored in a positive and engaging learning environment. All workshops were facilitated by Whittington Health staff (from various professional backgrounds) and opened up to colleagues working in health, social care and the charity sector in Camden, Haringey and Islington. In total, the workshops were attended by 290 professionals from various backgrounds, with an average attendance of 40 people per workshop. Learning materials from all sessions have been made available on Whittington Moodle to share learning within Whittington Health and other local health and social care colleagues such as district nurses, GPs or social workers.

Excellence in medical education

As well as delivering first class care to our patients, we are committed to delivering the very best education and training to support our clinical student colleagues take the next steps in their careers. In recognition of this commitment, we were pleased to see the work of two of our

consultants celebrated with a Top Teacher Award from UCL Medical School; Dr Bernard Davis, Consultant Haematologist, and Dr Chee Yee Loong, Consultant Cardiologist, were presented with the awards in 2017.

Supporting our doctors in training

We had some outstanding feedback in the GMC survey of doctors in training, with some specialties receiving the highest rating in the country. This is a national survey, sent to all doctors in training, and it asks them about the hospital where they are working and the support and education that they receive there.

The trust continues to be recognised for its reporting culture – trainees feel able to report issues without repercussions, that there are systems in place to deal with issues or concerns, and that concerns will be acted upon.

The trust is committed to moving forward with the Faculty of Medical Leadership/ NHS Providers/ NHS Improvement 'Eight high impact actions to improve the working environment for junior doctors' and the Board will be exploring ways to implement these in 2018.

Research

Research at Whittington Health has had a successful year. The target set by North Thames Local Clinical Research Network (LCRN) was for 474 patients to be recruited in to National Institute of Health Research (NIHR) portfolio studies. This was met within the first six months of the year and overall we recruited 742 patients into these trials (56% over target). We continue to deliver a cost-effective service, with a low cost per patient recruited compared with other trusts in the North Thames CLRN. In addition we recruited the first patient in the UK into 'Asteroid 5', a commercial study of the treatment of fibroids.

In this study we have recruited over the originally agreed target, and we have had similar success with other commercial studies, such as the ECZTRA2 trial, looking at severe eczema in adults in which we recruited the required number of patients within 6 months and the BC Study which investigates prosthetic hip cups, in which we recruited the highest number of patients in the UK.

We have also increased the size of the research delivery team, allowing more capacity for recruiting and also more capacity for raising the profile of research within the trust. Securing CRN funding for additional posts has enabled significant growth and the introduction of a Trainee Research Practitioner role has been well received. Osinachi Egole (Research Midwife) and Sheik

Pahary (formerly Research Nurse) were both nominated for Trust excellence awards and Kayleigh Gilbert (Research Team Lead) was accepted onto the NIHR Advanced Leadership Programme. The increased size of our team has enabled us to expand the number of clinical specialities participating in research, and to raise the profile and the level of interest in research within the trust. As part of this, we have introduced face to face research training courses on site at Whittington Health, which we plan to continue in the future.

Strategic Goal Six – To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

Innovation is key to transforming the services we deliver to our patients. We are focussed not only on how we treat illness, but also prevention and awareness that will empower our staff to deliver the best possible care.

Ambulatory Care

Our Ambulatory Care Centre is one of the largest and most innovative in the country. It sits between the Emergency Department, inpatient wards, community teams and local GPs to provide urgent care in a dedicated calm environment. They see patients referred by A&E, sent in by GPs or a community team and provide planned follow-up care for patients who have been discharged from hospital. Consultants in the Ambulatory Care Centre also provide senior, experienced advice and support to local GPs that can help to avoid patients needing to be referred to hospital. 75% of the patients sent to hospital by their GP can be seen straight by the Ambulatory Care Team and do not need to go to A&E and 95% of the 70 patients seen in the Ambulatory Care Centre every day are able to avoid being admitted to hospital altogether. Whittington Health is now sharing the success of its Ambulatory Care Centre and advises other trusts on establishing a similar model.

E-community district nursing

To improve the quality and capacity of our busy district nursing service we introduced an electronic system, e-community. This system has helped to not only increase the number of patient visits our nurses are able to make, but also helps to ensure that we are sending the right care team, with the right skills, to the right patients. By reducing the amount of time our nurses need to spend on administration, we now have the equivalent of around six extra nurses available to devote more time to delivering care to our patients in the community. The Trust has been Shortlisted for the

2018 HSJ Value awards for Community health service redesign, for the implementation of the eCommunity system.

Additionally, the Trust is shortlisted for the 2018 HSJ Value awards for Clinical support services, for improving the pharmacy outpatient service.

OUR WORKFORCE

At the heart of delivering high quality and safe care is our staff, both those who work directly with patients and those who provide the support they need to keep our services running.

Our workforce strategy, which was developed with our staff, outlines our ambition to nurture a dynamic and flexible workforce with the skills, expertise and equipment.

A great place to work

We want to make sure that we thank our staff for the work they do by providing a supportive and positive working environment.

Staff survey results

This is the seventh year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey. This year the Trust opted to invite all eligible staff to complete the staff survey.

Of Whittington Health's (WH) 4102 eligible staff, 1704 staff took part in this survey. This is a response rate of **42%** which is **average** for combined acute and community trusts in England (43%) and compares with a response rate of 36% (441 eligible staff) out of a randomised sample of 1250 in the 2016 survey.

Like many parts of the NHS there has been an increase in the demand for our services and as we rise to meet this growing challenge, our teams are committed to providing the best care possible. Our latest staff survey demonstrates the commitment of our staff despite these increasing pressures:

- 77% of staff think that care of patients is the organisation's top priority

- 71% of staff would recommend the Trust to friends and family if they needed treatment
- 59% of staff would recommend the Trust to friends and family as a good place to work

Our top scoring areas are:

KF	Key Findings	Score Type	Trust	National
12	Quality of appraisals	1-5 scale summary – the higher score the better	3.27	3.11
22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	% score – the lower score the better	11%	14%
28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	% score – the lower score the better	27%	29%
4	Staff motivation at work	1-5 scale summary – the higher score the better	3.94	3.91
27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	% score – the higher score the better	49%	47%

It is encouraging to note improvements in areas such as the quality of appraisals, as these were targeted improvement actions from last year's survey. There has been a focus on incident reporting and feedback and this appears to have been reflected in the results. It is particularly encouraging to see 'staff motivation at work' appearing in the top five. Of note is the positive decrease of staff suffering physical violence from patients, relatives or the public which scored as one of the bottom ranking findings last year with a Whittington score of 31%.

Whilst our staff survey highlights many areas we can be proud of, there are some areas we must improve outlined in the table below:

KF	Key Findings	Score Type	Trust	National
17	Percentage of staff feeling unwell due to work related stress in the last 12 months	% score – the lower score the better	45%	38%
26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	% score – the lower score the better	31%	24%
21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	% score – the higher score the better	73%	85%
29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	% score – the higher score the better	87%	91%
20	Percentage of staff experiencing discrimination at work in the last 12 months	% score – the lower score the better	19%	10%

Disappointingly and for the second year running the percentage of staff experiencing discrimination or harassment, bullying or abuse from other staff are highlighted as concerns as is work related stress. Equally dissappointingly is the low percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion.

Over the next year we will in particular, take active steps to address issues around bullying, harassment and discrimination, and introduce new measures to help colleagues manage workplace stress.

Health and wellbeing

Making sure we have a healthy and happy workforce is vitally important. Over the past year we have worked to improve the health and wellbeing of our staff. Our Health and Wellbeing Committee have supported several initiatives to improve working life, including mindfulness training, stress management workshops and encouraging staff getting moving through walking and fitness activities.

Supporting colleagues with disabilities

Whittington Health is committed to ensuring all existing staff, including newly appointed staff have equal access to opportunities relating to personal, educational and professional development opportunities.

Our overall approach continues to be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment.

Our recruitment processes are robust, and we adhere with National NHS Employment standards ensuring that all development opportunities are promoted in an open and transparent manner to reinforce an inclusive working environment. Our commitment has been underlined by signing the NHS Learning Disability Employment Pledge.

Equality and Diversity training is a mandatory training module that must be completed by all our new employees, and is accessible via the e-learning. Further Equality, Diversity and Inclusion

training such as Unconscious Bias and Customer Care for a Diverse Client Group is also available.

We have an occupational health department who provide support to staff and managers in recommending reasonable adjustments to staff duties and their environment when they become disabled in employment. The Trust also has an employee assistance programme to support staff both practically and emotionally.

Modern Slavery Act

Whittington Health NHS Trust has a clear commitment to respect fundamental human rights and fully supports all initiatives to eradicate modern slavery and human trafficking. We are dedicated to ensuring that there is no modern slavery or human trafficking in any part of our business activity and in so far as is possible to holding our suppliers to account to do likewise. We will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation. Our overall approach will be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment.

Our recruitment processes are robust, and we adhere with National NHS Employment checks. This includes strict requirements in respect of identity checks, references, work permits and criminal records. Our pay structure is derived from national collective agreements and is based on equal pay principles with rates of pay that are nationally determined.

We are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in our supply chain.

Our response to human trafficking and modern slavery is coordinated by Safeguarding Team. The subject is included in all safeguarding training and will form a key work stream of our safeguarding strategy and associated work plan. Any identified concerns would be escalated as part of the organisational safeguarding process; and in conjunction with partner agencies such as the local authorities and police.

PROVIDING HIGH QUALITY AND SAFE CARE

We are committed to providing safe, effective and high-quality care to all our patients. Our patients and their experiences of our care drive everything we do, and we are working hard to make sure we deliver the best possible healthcare to all.

Our work to deliver excellent care to patients is underpinned by our key quality principles:

- Providing safe services
- Providing clinically effective services
- Providing the best experience of our services.

MRSA

We have a zero-tolerance approach towards MRSA and have an active infection control campaign across our hospital and community to help stop the spread of this potentially deadly infection. In 2017/18 we had three reported cases of MRSA, and in 2018/19 we hope to reduce the number of reported cases to zero.

Clostridium Difficile (C. difficile)

The number of reported cases of c. difficile remained consistent with last year, with a total of 11 cases against a target of no more than 17.

Mixed sex accommodation

We had zero mixed sex accommodation breaches in 2017/18.

For more a more in-depth review of how our services are working to improve safety and quality, refer to our Quality Account which is available at www.whittington.nhs.uk or communications.whitthealth@nhs.net.

SUSTAINABILITY REPORT

We are committed to delivering a clear programme of sustainable development across our services. Our plan aligns to the national strategy 'Sustainable, Resilient, Healthy People and Places'.

Our plan

Our Sustainable Development Management Plan (SDMP) outlines the steps we are taking to reduce our emissions. Key points include:

- Helping staff and patients reduce carbon emissions by publishing green travel plans, and providing information on how to reduce carbon emissions in their personal lives
- Ensuring that our plans for the future include an assessment of their environmental impact
- Actively encourage and reward recycling as well as reducing the volume of waste through procurement and purchasing plans.

Reducing carbon emissions

The Trust has continued to invest in projects to reduce carbon emissions, including: investing in heating and ventilation controls and more efficient boiler plant in our community properties, and continuing to roll-out a programme of LED lighting installation in outpatients and staff residences. The Trust is also embarking on a project to implement automatic meter reading to improve the monitoring and targeting of further energy reductions.

Estates Strategy

An important part of our planning is our estate and delivering our estates strategy. Through the year we have been considering how we might undertake the work to transform the way our estate delivers care to our patients, and how we might ensure the development of our estates is guided by estate development experts working with clinicians, residents, staff and patients, so that we can meet the changing needs of our workforce and our population. In 2018/19 we will undertake a master planning exercise to enable the Board to take a holistic view of the estate across both Islington and Haringey, and to determine how we might maximise its full potential to benefit the people living in both Boroughs.

Affordability of estates development is key to our success and has been the limitation of progress with major developments over the past 17 years. Our work to date has demonstrated that if we develop the estate in a joined-up way over the next 10 years, the developments can be self-funding. A development plan that encompasses our whole estate will provide us with an overall view of the condition and future potential of the estate that is needed to finance the necessary work.

Waste disposal

In 2017/18 the Trust integrated the recycling centre onto the Hospital site and it is now directly managed by the Facilities Directorate. This has allowed for greater control in how our waste is processed and segregated.

A new initiative in 2017/18 is a food waste recycling scheme. The hospital now recycles all food waste through a dedicated food waste collection stream. Early indications are suggesting the Trust will recycle 1 tonne of food waste each week.

Alongside this we are recycling 6 tonnes of cardboard and approx. 5 tonnes of dry mixed recyclables materials per month.

Procurement

We continue our commitment to reduce the wider environmental and social impact associated with the procurement of goods and services, in addition to our focus on carbon.

Travel and transport

We have a plan in place that sets out our commitment to provide sustainable transport for our staff teams while providing front line services within our community. As part of this plan we operated a total of twenty one electric cars in 2017/18, issued approximately 350 Oyster cards to community staff to encourage the use of public transport while undertaking Trust business. Staff can take part in the Cycle2Work salary sacrifice scheme, and we have engaged with the London Borough of Islington's Zero Emission Network. Our transport staff have undertaken training that ensures they meet the requirements of Islington's anti-idling campaign.

In line with our clinical strategy, the Estates Strategy will reduce the number of locations we deliver clinical services from, ensuring they are demographically positioned to serve our community more efficiently. This will reduce the travel times of our patients and staff, therefore reducing the carbon impact of all associated journeys made.

EMERGENCY PREPAREDNESS

We have a dedicated team that brings our colleagues together to help us plan and prepare for a wide range of incidents and emergencies. This could be anything from extreme weather events,

infectious disease outbreaks, terrorist attacks or major transport accidents. We work closely with our partners in other hospitals and emergency services to ensure we have effective plans in place.

Over the past year we have:

- Updated our Business Continuity Plans
- Conducted a business continuity table top exercise
- Implemented new emergency response training programme for staff belonging to our on-call team.
- Implemented updated heatwave and cold weather plans in line with national guidance .
- Reviewed and updated our incident response and recovery plan

Over the next year we will continue to

- Work closely with our partners to ensure we have clear plans in place to respond to potential emergency situations
- Introduce a new hospital and full site evacuation plan
- Provide business continuity training and coaching for staff
- Staff to participate in major incidents exercises across London

Set in the context of increasing activity, restricted financial resources and a challenging recruitment potential, the Trust has performed well in 2017/18. This gives us a firm footing to look ahead to 2018/19 , as we continue to deliver our Clinical Strategy and transform the services we are delivering to our community.



Siobhan Harrington, Chief Executive

25 May 2018

ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT AND ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's mission, vision, goals, objectives and policies, whilst safeguarding standards and the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am responsible for ensuring that the Trust is administered prudently and economically, and the responsibilities set out in the NHS Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level, and as such can only provide reasonable level not absolute assurance of effectiveness.

The system of control is based on an on-going process designed to identify and prioritise the risks to achievement of Whittington Health NHS Trust's mission, vision, goals, objectives and policies, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. This system has been in place at the Trust for the year ended 31 March 2018, and up to the date of approval of the Annual Report and Accounts.

The system of internal control is underpinned by the existence of several individual controls that are in place, executive and senior manager review, policies, procedures and clinical guidelines.

To align with the regulatory accountability framework the governance statement is structured against the domains of the well-led framework; strategy and planning; capability and culture; process and structures; and measurement. Well led is also one of the Care Quality Commission's domains (CQC) and the Trust uses these domains as a reporting structure.

In listing 'significant issues' a number of factors have been considered, including whether:

- it may prejudice the achievement of priorities;
- the significant issue outlined could undermine integrity or reputation;

- the issue may divert resources from another significant aspect of business; and
- the issue could have a material impact on the accounts.

Strategy and planning - how the Board sets the direction for the organisation

Our mission as a Trust is to help local people live longer, healthier lives and our vision is to provide safe, personal, co-ordinated care for the community we serve. To deliver the mission and vision, we need to achieve and sustain the following strategic goals:

- to secure the best possible health and wellbeing for all our community;
- to integrate and coordinate care in person centred teams;
- to deliver consistent, high quality, safe services;
- to support our patients and users in being active partners in their care;
- to be recognised as a leader in the fields of medical and multi professional education and population based clinical research; and
- to innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

The goals reflect our long-term commitment to continuously improve safety and quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce. They are supported by our values and behaviours and will be delivered by our core strategies - clinical, estates, workforce, health and wellbeing, communication and engagement and finance.

The Trust health and wellbeing strategy sets out our commitment to staff and patients that their health and wellbeing matters. The strategy has three main priorities: improving healthy life expectancy, improving mental health and wellbeing and improving psychosocial working conditions. This is supported by a range of annual training and development courses available to staff which are promoted internally to encourage wide participation and engagement. Our values underpin everything we do, and these are; ICARE - innovation, compassionate, accountable, respectful and excellent. These have been embedded into our appraisal and planning processes and form part of our staff excellence awards.

The Trust Board has agreed an operational plan which describes how the Trust will look in the future and how it will operate. The Trust is in North Central London with a portfolio of services covering the populations of Haringey and Islington, with some community services in Camden,

Enfield, Barnet and Hackney. The Trust is an Integrated Care Organisation and delivers some of the most innovative models of ambulatory and integrated care in the region such as our Integrated Respiratory Services, Integrated Care of the Ageing, Integrated Care Hubs and TB centre. We have taken this further by signing a Memorandum of Understanding with University College London Hospitals NHS Foundation Trust which forms part of a clinical collaboration that will enable our collective services to meet the health care needs of our changing demographic.

We work closely with Haringey and Islington Clinical Commissioning Groups, Local Health Authorities, and other providers such as Mental Health trusts, in developing the Haringey & Islington Health and Wellbeing Partnership. The objective of this partnership is to work in an integrated and collaborative way to provide high quality health and social care for our local population. This work has been recognised, supported and integrated into the North Central London Sustainability and Transformation Plan (STP). As an Integrated Care Organisation with community and hospital services we are in a unique and important position to deliver the strategic objectives of the STP.

Aligned with this are other Trust top priorities which are to deliver financial sustainability, and to continue to increase the quality, safety, responsiveness and productivity of the care we provide to patients. Implementation of our clinical and estates strategies, developed through an engagement process with staff and stakeholders, will enable the Trust to improve services and deliver them in the most clinically and cost-effective setting to address the challenges and opportunities set out in our two-year Operational Plan.

Capacity to handle risk

The Trust Board has overall accountability for the Trust's risk management approach through the executive and associate directors. The framework and policy, approved at the Quality and Audit & Risk Committees and Trust Board, supports the development of an organisational style whereby effective risk management is an integral part of providing healthcare and day to day decision making.

Whilst executive and associate directors are full time employees who manage the daily running of the Trust, the entire Trust Board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The Trust Board is

accountable for upholding high standards of governance and probity. The Chairman and non-executives provide strategic guidance and support.

The Board Assurance Framework provides a high-level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities, determine its target risk score and risk appetite, and highlights the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.

The Assurance Framework has been reviewed and updated during the year and continues to be developed to ensure it aligns with best practice and meets the evolving needs of the Trust. Accountability and responsibility for maintaining the Framework has rested with the Acting Director of Strategy and from May 2018 with the newly appointed Director of Strategy, Development and Corporate Affairs. The Framework is described further in the capability and culture section.

Annual Quality Account

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Quality Account 2018/19 sets out our future goals for quality, under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction of travel ensuring quality is our number one priority. The Quality Account supports our work to ensure we are providing safe, high quality care. It aligns to our Sign up to Safety Plan and will help us build on our overall good rating from the CQC to achieve our aspiration to become outstanding in future years.

The Quality Account was developed following a consultation period with internal and external stakeholders to ensure it meets national, local and Trust priorities. The data included within the Quality Account is subject to audit by the external auditors KPMG.

The external auditor performs limited scope procedures on two of the indicators shown in the quality accounts. The indicators for the year ended 31 March 2018 subject to limited assurance consist of the percentage of patients risk-assessed for VTE and the rate of clostridium difficile infections. The external auditor performs a review of the consistency of the quality accounts in

relation to the Trust's performance and communication with regulators in the year. This is supplemented by regular clinical audits of data within specialities and national audits.

Significant issue: The Trust's financial position

For the financial year 2017-18, the Trust posted a surplus of £5.4m, by which we significantly outperformed our control total target of a £0.6m surplus. Within this position the Trust received core sustainability and transformation funding of £6.0m and an additional £4.6m in incentive and bonus funding. As in 2016-17, while this is an excellent result, several non-recurrent benefits needed to be used to achieve the target.

The Trust continues to face the challenge of reducing its underlying deficit. It aims to do this in 2018-19, with an agreed control total of a £4.7m surplus inclusive of £9.4m sustainability and transformation funding and a cost improvement target of £16.5m.

The Trust Board exercises much of its financial governance via the Finance and Business Development Committee and Audit and Risk Committee.

The Finance and Business Development Committee reviews financial performance, business development and investment decisions of the Trust. The Committee focuses on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee seeks assurances, mitigations and recovery action plans where appropriate.

The Audit Committee reviews the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accounting Officer's requirements. To support this, the Audit Committee oversees the work of Internal and External Audit and with financial reporting issues.

Significant issue: condition of the estate

As in previous years, this remains a significant issue for the Trust, and will not be fully resolved until the Trust is able to implement its estate strategy by rationalising its 49 sites and commence redevelopment and modernisation. The backlog maintenance needed to bring our existing buildings up to standard would cost c£23m. Most costs relate to the hospital site, The Northern, Hornsey Rise Health Centre, Highbury Grange Health Centre, Crouch End and Lansdowne Road.

The risk mitigation strategy includes continued investment in the high-risk items, pro-active risk surveys and targeted remedial works.

Significant issue: improving the flow of the emergency care patient pathway and achieving the emergency department target

We saw a record number of attendances to our Emergency Department – over 100,000 – in 2017/18. These extreme pressures within the emergency and urgent care pathway continued to be a challenge throughout 2017/18 however the Trust reported 89.4%% performance for the year against the target of 95% for 4hr waits.

A significant and increasing pressure for our emergency department is our changing population healthcare needs, such as acuity, complexity, age (elderly/frail) and high dependency of some patients. To respond to these changing population healthcare needs, we continue to work together in North Central London (NCL) Strategic Transformation Plan (STP) in a strong partnership of 21 health and social care organisations, to develop a whole emergency and urgent care system. This approach aligns with our focus on population health and delivering integrated care to provide more services closer to peoples' homes, as set out in our Clinical Strategy.

The ongoing challenge to delivering the 4-Hour Emergency care standard includes an overall increase in attendances with unpredictable spikes of emergency department attendances over short periods, and the usual winter pressures. This is reflective of national pressures on the entire emergency service system, with acute trusts, ambulance services, mental health and social services. We are also experiencing an impact from increased ambulance conveyances. There was an increase in ambulance conveyances of 8.8% in Q4, coupled with a rise in acuity with activity through our Majors area increasing by 12.3% in Q4 on previous years. Our A&E Delivery Board recovery plan includes the following priorities:

- Increasing flow through Ambulatory Emergency Care
- Greater emphasis on Fit 2 Sit quality improvement programme
- Criteria led nurse discharge
- Increased Social Services presence on the hospital site to improve rapid discharge decision making
- Weekly Multi-Agency Discharge Events (MADE) with partners

To further help to meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure:

- Further capacity is available in primary care systems to offer an alternative to patients other than attending the Emergency Department
- Improving the redirection rate from NHS 111, whereby extended access hub capacity is better utilised
- Increasing the number of patients who are discharged to assess, following national best practice
- Reducing the numbers of Delayed Transfers of Care (DTOCs)
- Improving the re-ablement capacity, to enable medically fit patients to be discharged to receive on-going re-ablement at home

A recruitment initiative for additional consultant cover in the emergency department launched in the year has resulted in more consultants being appointed – although we continue to cover vacancies with locum staff.

Capability and culture: how the Board ensures it has the appropriate experience and ability and positively shapes culture

Trust Board

As outlined in the Directors' Report, the Trust Board is accountable through the Chairman to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The Trust Board Committees undertake a self-assessment of performance and effectiveness each year and report the findings to members for discussion to agree revisions to their terms of reference or administrative functions to improve effectiveness. The Trust Board receives the committees' terms of reference each year to ratify alongside the annual review of the standing orders, standing financial instructions and scheme of delegation.

Risk assessment

The risk management strategy sets out how the Trust manages the process of identification, assessment, analysis and management of risks and incidents. The risk management strategy was

refreshed this year. Board members receive annual training in risk management and an overview of the risk systems. In year, the Trust Board held a workshop seminar to review the board's risks and risk appetite and the process for updating the Board Assurance Framework and Corporate Risk Register.

The appetite of the Board for risk is that all significant red risks are recorded on the Board committees' risk registers scored >15. This approach enables the Board to scrutinise in-depth risks being escalated from the Corporate risk register.

The Corporate Risk Register brings together all significant risks which are derived from a bottom up and top down process which escalates from a number of sources to ensure totality of risk management across the Trust. These include the Trust Board, Committees, Executive, Trust management group, ICSUs, corporate project management office, and working groups such as Capital, Investment. The Chief Nurse is the responsible lead for the corporate risk register.

The Board Assurance Framework ensures that there is clarity over the risks that may impact the Trust's ability to deliver its goals and objectives together with any gaps in the robustness of internal controls or assurance to reduce or manage the risks to an acceptable level. This year the deputy chief executive/director of strategy was the responsible lead for the board assurance framework, this will move in 2018/19 to the newly appointed Director for Strategy, Development and Corporate Affairs.

Strategic risks

The Trust Board discussed and agreed the strategic risks that are recorded on the board assurance framework 2017/18. The mitigating action plans for each risk are considered at the Trust Board, Committees, executive and Trust management group meetings, as well as the working groups who lead on the subject expert areas for each topic. As part of our ongoing risk management the risks will be further reviewed and refined over 2017/18 as mitigations are implemented and progressed.

The BAF risks at 31 March 2018 were as follows:

- Failure to meet performance targets in ED
- Failure to deliver safe and high quality urgent and emergency pathway

- Inability to increase substantive workforce capacity
- Failure to deliver CIPs and transformation savings for 2017/18 and failure to plan for 2018/19
- Failure to modernise the Trust's estate
- Failure to establish cyber security across the Trust
- Failure to deliver compliant junior doctor rotas across the Trust
- Failure to provide an ongoing service to LUTS patients
- Failure to sustain the breast service due to workforce changes
- Failure to align Whittington Health's population health model to the final NCL STP

The Trust management group comprises of the executive, associate and clinical directors and was established in late 2015. The executive and associate directors lead the corporate functions and the clinical directors lead the ICSUs. This group have significantly strengthened risk management and brings together a holistic overview of the strategic, corporate, governance, financial, operational, I&MT, estates and facilities, workforce and organisational development, medical, clinical, quality, safety, patient experience, educational and research risks.

The ICSUs have monthly boards which review their risks and mitigating action plans to report to the quarterly performance and review meetings led by the chief executive. The ICSUs ensure risks are operationally managed and each has their own local risk manager who works with the corporate head of integrated risk management who leads the overall Trust corporate risk management analysis, quality assurance and reporting.

Staff job descriptions set out their responsibilities for effective and efficient risk management. New staff receive risk training at corporate Induction, face to face workshops and online training. The head of integrated risk provides one to one and group training on a continual rolling programme throughout the year. Guidance for risk management is available on the Trust intranet and good practice is shared through multiple channels including a learning zone on the intranet, a patient safety newsletter, the Chief Executive monthly Staff Briefing and the weekly electronic staff Noticeboard.

The Trust is committed to a learning environment for all levels of staff, to ensure that good practice is developed and disseminated across the organisation and that there is effective and robust learning from incidents and near misses. This is achieved by:

- a commitment to individual appraisal and personal development planning for all staff;
- policies to encourage the open reporting and investigation of adverse incidents including near misses;
- a commitment to root cause analysis of problems and incidents and the avoidance of blame;
- learning from experience and good practice is disseminated across the organisation as set out above;
- annual patient safety masterclasses for staff and key stakeholders focused on listening, learning and sharing from the Trust feedback channels of complaints, concerns and serious incidents;
- a range of problem resolution policies and procedures, including capability, raising concerns or 'whistle-blowing', workplace stress, harassment and discipline which are designed to identify and remedy problems at an early stage;
- supporting operations teams with corporate expertise in developing their risk registers as an effective management tool;
- executive and associate directors detailed scrutiny of ICSU top risks in quarterly performance reviews;
- medical and nursing director and patient experience led quality and risk impact assessments for cost improvement schemes;
- direct recording of risks onto the Datix risk system to improve review and management; and
- a range of clinical and non-clinical audit, reviews and recommendations.

All staff are trained in these policies as part of the corporate induction and local induction policies and updated via regular staff briefings and the Trust intranet.

The Trust recognises that it is important to be outward looking and to learn and improve from the experience of other organisations and experts and where possible to benchmark the quality and performance of the services we provide to our patients. We do this through a variety of ways as follows.

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) with no conditions. The CQC has not taken enforcement action against Whittington Health during 2017/18.

Between 31st October and 2nd November 2017, the CQC inspected four core services rated as requiring improvement in the last inspection in 2015; Outpatients, Critical Care, Community Children's and Young people's services and Simmons House (Children and Adolescent Mental Health Service). The findings identified that the trust's senior management team had the right skills and abilities to run a service providing high-quality sustainable care and therefore rated the trust Good for being Well-Led.

The inspection highlighted numerous areas of good and outstanding practice and found clear evidence of improvements since 2015. In particular, the outpatient department improved in three of the five domains and achieved an overall rating of good. It was clear that significant improvements had been made in relation to information governance, team working and leadership. The inspectors commended the outpatient department for the outstanding practice seen in the hospital one-stop breast and skin cancer clinics. The critical care unit also was deemed to have improved and achieved a rating of good in the domain of safety. Other highlighted areas of good practice include:

- Leaders and staff shared a common vision on supporting their local community
- Patient outcomes in critical care were in-line with or better than national averages
- Improvements in how the critical care team manage and learn from incidents
- Multidisciplinary and joint working for children, young people and their families
- Medicines management systems with medicines appropriately prescribed, administered, recorded and stored

The outcome of the improvements made by the trust and seen by the CQC is that the rating for the Hospital has increased from 'Requires Improvement' to 'Good' following the last inspection. The Whittington Health Trust, encompassing our community services and their individual ratings, maintains a rating of 'good' from the 2015 inspection.

The trust was issued with four regulatory actions that it must address and improve with priority. These are listed below alongside the actions that the trust has taken to reduce these risks.

“Must do” actions from the CQC:	Trust response
Critical Care – reduce length of time patients are delayed waiting for discharge from CCU	The trust has made this one of its Quality Account priorities for 2018/19 and we are aiming to meet the national target of 95% of ward-able patients being stepped down from CC within 4 hours. The focus is on embedding the FLOW improvement process throughout the hospital to improve capacity so that patients are not delayed in critical care. Our acute assessment units, care of elderly wards, general surgery and general medicine wards have been assigned dedicated FLOW co-ordinators to support with patient discharging by unblocking /escalating delays.
Critical Care – ensure equipment is safely maintained and ensure local oversight of risk is appropriate	Critical care have introduced a local servicing log of equipment on the unit in addition to the log kept by medical physics. CC staff now monitor the equipment service dates monthly and any delays are escalated to Medical Physics. Introducing this additional local oversight measure has created a more robust equipment maintenance and safety checking system and expedites early escalation to medical physics in the event of delays.
Critical care – ensure patients receive safe care and treatment in line with the faculty of intensive care medicine (FICM) core standards	The parenteral nutrition (PN) policy has been reviewed and updated to provide clearer guidance for CC staff on the expectations regarding the use of PN both in and out of hours to ensure the trust complies with FICM standards.
Simmons House – ensure ligature risk assessments are up to date and accurately identify all ligature anchor points on the unit. This must be supported by information in patient risk assessments	The Ligature risk assessment has been reviewed and updated to ensure that all ward areas are included. A targeted assessment has been completed of Simmons House to ensure all ligature anchor points have been included in the ligature risk assessment register. A revised process has been designed to ensure that all patient ligature risks are assessed and documented, and nursing care plans have been introduced for all patients who have been risk assessed as at risk of harm from ligature anchor points at Simmons house.

Looking ahead, the Trust’s CQC compliance and quality improvement framework for 2018/19 will take account of:

- lessons learned from implementation of improvement plan actions in 2017/18
- learning from other trusts that have improved and achieved improved ratings following subsequent CQC inspections
- the outcomes and recommendations of internal and external audits
- the CQC new strategy for regulating trusts for 2016/21

- NHS Resolution claims scorecard and benchmarking for trust

Raising concerns and whistleblowing

The Trust policy encourages everyone to raise concerns openly as part of normal day to day practice so that action can be taken to ensure high quality and compassionate care based on individual human rights. The policy outlines the different steps to take for making a qualifying disclosure, as defined by the Public Interest Disclosure Act:

- step 1: raise concern with immediate management team
- step 2: contact the employee relations advisory service
- step 3: raise concern with executive and associate directors

The Trust continues to work to help staff make 'raising concerns' a normal part of day to day practice so that action is always taken to ensure high quality and compassionate care.

The Trust continues to employ a Freedom to Speak Up Guardian and ensuring this postholder is in place is now part of the national NHSE contract. The Trust Freedom To Speak Up Guardian reports to the Executive Lead for Speaking Up, the Chief Nurse, and has strong links with the Trust's NED for Speaking Up.

The Trust is part of the London Region Speaking Up Network and is actively engaged with the work and activity of the National Freedom to Speak Up Guardian Office.

Over the 2017-18 financial year, there have been 108 issues raised with the Trust's Speak Up Guardian. Of these 15% were raised anonymously, and 25% required further action. Of those issues requiring action, 2 have involved escalation outside of the organisation, with the 23 cases being resolved using internal Trust processes.

The themes of the 108 cases raised are: 19% were to do with attitude and bullying; 1% equipment; 28% staffing; 16% quality; 15% patient experience and 3% focused on stress.

The Trust has been further developing its resources to help staff raise concerns, and in May 2018 are launching the Speak Up Inclusion Champion network – a group of nine staff working across the Trust who will work with the Freedom To Speak Up Champion to establish new and wider

ways for staff to raise concerns without fear of reprisal. This network will also focus on making it easier for our BME and minority staff to raise concerns whilst at work.

Leadership development

The Trust has offered a series of leadership programmes in year for clinical leaders and managers across the Trust. During the year we rolled out a comprehensive learning and development programme of events and workshops to bring staff together for training, development and networking. We continue to offer training in appraisal, performance development review skills and coaching and mentoring.

Informal meetings of Board members took place each month during 2017/18. Where appropriate these took a developmental approach, either in learning or in enabling broader debate on key areas of interest. During 2017/18 these included the themes of:

- risk management and board assurance;
- equality and diversity – making equality work
- digital and IT strategy, innovations and resilience systems;
- Patient-Centred Care in managing Long-Term Conditions
- The Untreated Long-Term Condition: Tobacco Dependency
- Unions Q&A session
- strategic choices within the external policy context (five year forward view, sustainability and transformation plan, health and wellbeing partnership, community healthcare networks, NHSI and NHSE reporting requirements);
- strategic estates development;
- finance and cost improvements;
- Quality account;
- Health and Well Being
- Kaiser Permanente: Integration and Innovation in Health Care
- planning, contracting and commissioning;
- operational and capital plans; and
- mandatory training such as fire, H&S.

Emergency preparedness

Each year Whittington Health NHS Trust participates in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process by NHS England. The Core standards for EPRR are set out for NHS organisations to meet and the Trust's annual assessment was completed on the 9th of October 2017 by the North Central NHS England Assurance Team. The following results were achieved:

- 52 EPRR standards evidential measures. 52= Green (Fully Compliant), 0=Amber (Evidence of Progress), 0= (No evidence of progress)
- Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) standards evidential measures 13=Green (Fully Compliant) 1= Amber (Evidence of Progress)
- Governance- Deep Dive Questions 6 = Green (Fully Compliant)

The trust has made progress on last year increasing the level of resilience throughout the Trust. The EPRR action plan for 2018 addresses the one Amber score for CBRNE. The actions are reported through Executive Committee and in six-monthly reports to Trust Board.

In the 2017 assurance process Whittington Health Strategic Business Continuity Plan achieved good practice in relation to:

- Staff support and wellbeing following the event
- Information required to support making a mutual aid request.

Clinical audit and quality improvement

The Trust is committed to delivering effective clinical audit in all the services it provides. The organisation sees clinical audit as an integral part of its arrangements for developing and maintaining high quality patient centred services. When carried out in accordance with best practice, clinical audit improves quality of care and patient outcomes, provides assurance of compliance with clinical standards and identifies and minimises risk, waste and inefficiencies

The medical director has delegated responsibility from the Chief Executive for implementing effective governance arrangements for clinical audit activity and this work is delegated to the head of clinical governance. The medical director is responsible for high quality audit and ensuring that audit informs quality improvements in patient experience and effective care and treatment. The Trust's approach for national audits is to treat all projects sponsored by the National Clinical Audit and Patient Outcomes Programme as priority.

In addition to national clinical audits further audits are based on high risk or high profile areas. They may include national initiatives with Trust wide relevance including adherence to selected NICE guidance.

National audit

During 2017/18, 51 national clinical audits including 11 national confidential enquiries covered relevant health services that Whittington Health provides. During that period the Trust participated in 100% national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in. The Trust will continue to improve the processes for monitoring the recommendations of national audits and confidential enquiries in 2018/19 by ensuring:

- national audit and national confidential enquiries will continue as a key component of the ICSUs quality improvement programmes. Priority will be assigned to mandatory projects to maintain 100% participation rate;
- monthly compliance with these programmes will be monitored via reporting to each ICSU;
- performance outcome presentations for national audits will be given at senior ICSU and corporate level meetings, including speciality half day audit and quality improvement meetings; and
- optimal clinical and managerial leadership will remain essential to ensure national project completion and reflection.

Local audit

The reports of **89** local clinical audits were reviewed by the provider in 2017/18 and Whittington Health intends to take numerous actions to improve the quality of healthcare provided.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2018/19 by ensuring:

- Reactive audits, vital to patient safety, will be the local priority on the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes;
- Project proposals will be subject to a weekly quality review, prior to formal registration, to prevent duplication and to ensure alignment to local speciality priorities;
- Re-launch of the Trust Clinical Audit Registration form. A new, succinct version will facilitate the registration of projects;

- Demonstrable improvements to patient care and/or service provision will be identified monthly, to support Trust Learning from Excellence initiatives;
- Multidisciplinary Quality Improvement sessions will continue to include reflective learning on local clinical audit findings;
- Clinical speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

Serious incidents

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate Medical Directors, Chief Nurse, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to ascertain whether these meet the reporting threshold of a serious incident as described within the NHSE Serious Incident Framework (March 2015).

All serious incidents are reported to North East London Commissioning Support Unit via StEIS and a lead investigator is assigned to each by the clinical director of the relevant ICSU. All serious incidents are uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC statutory notification requirements.

For 2017/18 the Trust reported 38 serious incidents, and these included the themes of

- safeguarding;
- attempted self-harm;
- confidential information leak, loss, information governance breach;
- diagnostic incident including delay;
- failure to source a tier four bed for a child;
- failure to meet expected 12hr trolley breach target;
- maternity obstetric incident mother only;
- medical disposables incident meeting serious incident criteria;
- nasogastric tube;
- slip, trips and falls;
- sub optimal care;
- treatment delay;

- unexpected death; and
- retained foreign object.

Final investigation reports are reviewed at weekly SIEAG meetings and ICSU operational directors or their deputies are required to attend each meeting when an investigation from their service is being presented. The remit of SIEAG meetings is to scrutinise the investigation and findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and appropriate action, both immediate if applicable, and planned, to prevent future harm occurrences.

On completion of the report the patient and/or relevant family member receives an outcome letter highlighting the key findings of the investigation, actions taken to improve services, what has been learnt and what steps are being put in place. A 'being open' meeting is offered in line with duty of candour recommendations.

Lessons learned following the investigation are shared with all staff and ICSUs involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in maternity, obstetrics and other departments. Learning from identified incidents is shared through corporate multi channels including a learning zone on the Trust intranet, a regular patient safety newsletter, the chief executive monthly team briefing and the weekly electronic all staff Noticeboard.

Never events

A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The Trust reported one never event in 2017/18 and this related to:

- a retained foreign object

The never event occurred in Maternity Services and related to a retained foreign object (tampon) post birth. Specific changes in practice to ensure there is no re-occurrence of this type of Never Event included revising the swab count guidance within maternity, updating the maternity swab

needle and instrument checklists and performing live drills in maternity theatres & refresher training on swab counting.

Learning from deaths

During the period 1 April 2017 to 31 March 2018, 421 Whittington Health patients died whilst in hospital. This includes all deaths in our emergency department but excludes deaths post discharge. The following number of deaths occurred in each quarter of 2017/18:

- 99 in the first quarter (April-June 2017)
- 80 in the second quarter (July-Sept 2017)
- 152 in the third quarter (October-Dec 2017)
- 96 in the fourth quarter incomplete data (Jan – Feb 2018)

By the 31st March 2018 the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 69/99 deaths in the first quarter
- 50/80 deaths in the second quarter

Quarter 3 and 4 death reviews are still in progress, so these figures are not available yet.

Key learning identified from the patient death review includes;

- Ensuring there are more robust mechanisms in place to ensure that when VTE prophylaxis is suspended in patients (for clinical reasons) that it is restarted as soon as possible.
- Ensuring all patient deaths that involve a possible/probable medical treatment omission are discussed with families/carers as part of our Duty of Candour processes and with the Coroner's office.
- Our trust based pulmonary embolism guidelines could be made easier to read for users by adding in an algorithm and highlighting two other sections.

Actions taken in response to the findings include;

- Presentation of the patient case as an educational case to a wide audience
- Re-issued the trust guidelines following a consultation and education period
- Shared the results of the investigation with the family and Coroner
- Enhanced education of issuing medical cause of death certificates

- Enhanced knowledge of the VTE guidelines by clinical teams
- Improved processes of maximising learning from all deaths

There were no case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period.

Information governance

Information governance (IG) is to do with the way organisations process or handle information. The Trust takes its requirements to protect confidential data seriously and in 2016/17 made improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

The IG Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS Digital. It combines the legal rules including the Data Protection Act 1998, the Freedom of Information Act 2000 and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Code of Practice on Records Management. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust implemented an improvement plan to achieve IG Toolkit level two and to improve compliance against other standards to level three. As a result, the Trust met level two and declared 77% compliance for 2017/18. The Trust's IG Toolkit submission can be viewed online at www.igt.hscic.gov.uk.

The Trust has received assurance from internal (BDO LLP) and external auditors (KPMG) that appropriate systems and processes are in place in order to safeguard confidentiality and information security in relation to patient and staff information.

All staff are required to undertake IG training. In 2017/18, the Trust reached an annual peak of 80% of staff being IG training compliant. The compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails, includes news features in the weekly electronic staff Noticeboard and manage classroom-based sessions at induction.

Information governance serious incidents

IG serious incidents are reported to the Department of Health and Information Commissioner's Office (ICO). Serious incidents are investigated and reported to the Trust's SIEAG Panel, relevant executive directorate or ICSU and the Caldicott Guardian and the Senior Information Risk Owner (SIRO).

The IG committee is chaired by the SIRO who maintains a review of all IG serious incidents and pro-actively monitors the action plans. The IG serious incidents declared during 2017/18 were as follows:

Date of incident	Reported date	Nature of Incident	ICO Outcome
08/05/2017	07/06/2017	Lost unencrypted memory stick containing 4 CAMHS clinic letters	No further action
22/06/2017	06/07/2017	Paediatric handover sheet found in Whittington restaurant public toilet	No further action
08/09/2017	25/09/2017	Ward handover sheet on floor near Whittington entrance	No further action
08/03/2018	04/04/2018	Inappropriate access to staff members medical record	TBC
01/02/2018	26/04/2018	Lost patient records after retrieval from external storage	TBC

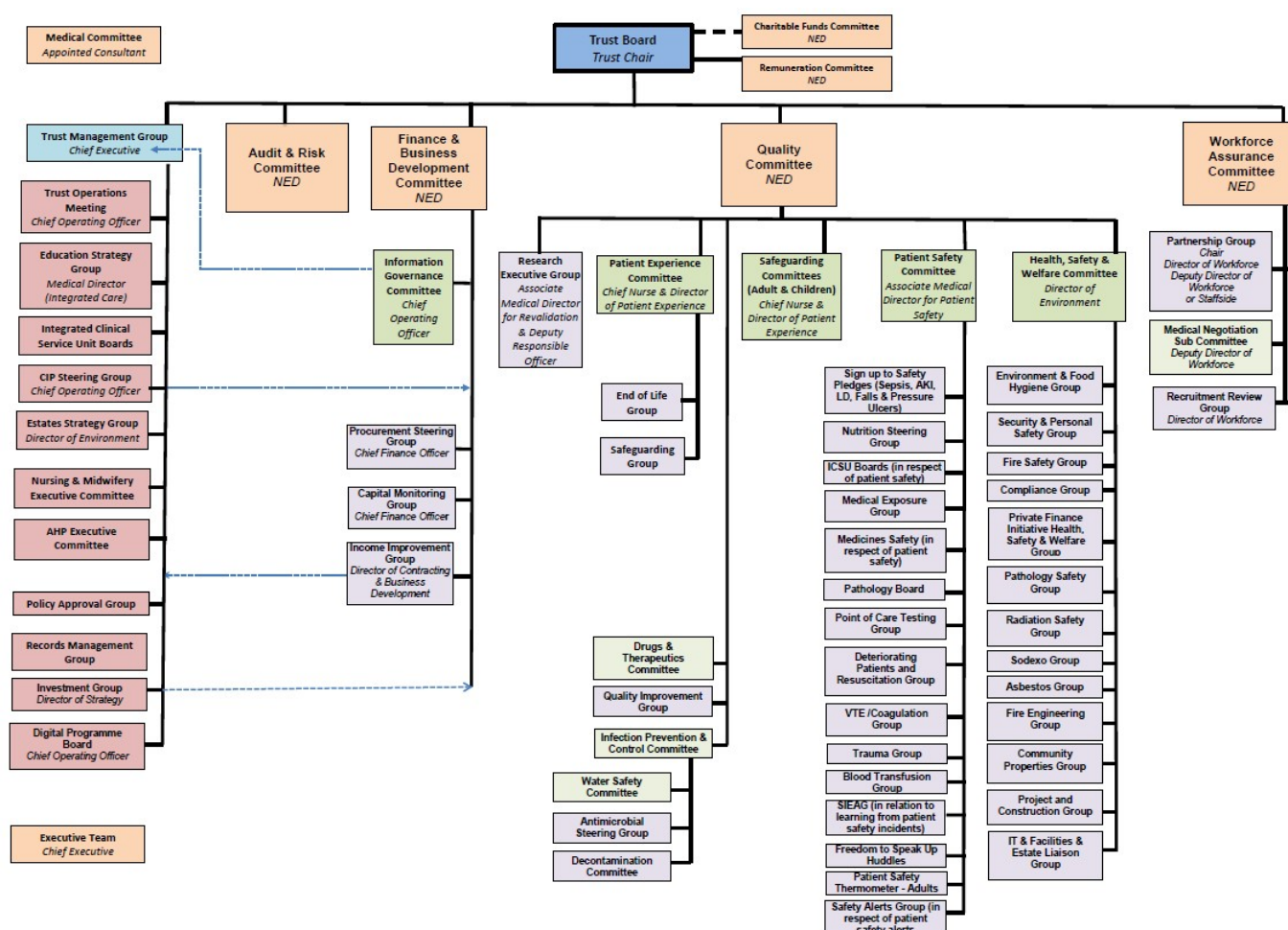
Process and structures: how reporting lines, structures and accountabilities support the effective oversight of the organisation

Trust Board

Details of the Trust Board and its committees are contained within the Directors' Report. As outlined, each of the committees and the Board undertake an annual self-assessment of effectiveness, areas requiring improvement are considered as part of Board development.

Risk and control framework

The Trust has a robust governance framework for ensuring effective reporting mechanisms from the Trust Board and its committees to the ICSU boards and other specialist working groups that report through to the Trust Board committees. The working groups include information governance, infection control, capital working, investment, patient safety and patient experience. The following outlines the Trust Board committee structure and details the underpinning working groups.



The Trust risk management strategy and policy describes the approach the Trust takes to identifying, managing and mitigating risks from across all levels of the organisation. All risks and potential hazards are identified and are recorded at directorate and ICSU level, which identify key controls and mitigating action plans to deal with these. Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be resolved or managed at a local level, they are considered for inclusion in the ICSU and executive directorate risk registers, with risks on these registers reviewed by the head of integrated risk management for inclusion in the corporate risk register.

Trust Board members receive annual training in risk management and an overview of the risk systems. In year, the Trust Board held a workshop seminar led by the internal auditors and this supported a review of the Board's risks and risk appetite and the process for updating the board assurance framework and corporate risk register.

The Trust Board reviews the most significant risks and the associated risk management plans on a regular basis. The head of integrated risk management collates the corporate risk register from the committee risk registers and ICSU boards and corporate project management office to assess the risks and produce reports for the Trust management group and Trust Board.

The Trust Board receives the Trust monthly performance scorecard which consists of a range of key performance indicators that are aligned to the five CQC domains. The report focuses on performance against quality, safety and operational targets.

The medical director's quarterly safety and quality report provides information to the Trust Board on a wider range of quality and safety indicators and this is also reviewed at the trust management group and Quality Committee. Detailed reviews are requested and undertaken for areas where potential issues are identified.

Measurement: how the Board receives appropriate, robust and timely information which supports the leadership of the Trust

The Trust Board ensures that the resources are used economically, efficiently and effectively by means of regular detailed finance and performance reports. These are considered in detail by the Finance and Business Development Committee.

The Audit and Risk Committee receives regular reports from the Trust's internal auditors, BDO LLP and external auditors KPMG. The Head of Internal Audit opinion for the Trust for 2017-18 provides moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. This represents a significant improvement on 2016-17, when limited assurance was awarded.

As part of the Care Act 2014, it has become a criminal offence to provide false or misleading information; this relates to commissioning data and other specified information including information in the quality accounts. The Trust has reviewed the requirements of the Act and has, ensured appropriate managers have been briefed and reviewed and the development of the internal audit plan ensures coverage of these data sets in planned audits.

Quality of Data

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and enable healthcare improvements.

The Trust monitors the quality of data through the use of quarterly benchmark reports and has developed a data quality dashboard for hospital services to monitor their own data quality on a regular basis.

The Trust ICSUs have responsibility for data quality within their ICSU. The Trust has a data quality group which includes representation from both the community and acute services and the ICSUs. This group is chaired by the chief operating officer. This group is responsible for implementing an

annual data improvement and assurance plan and measures the Trust's performance against several internal and external data sources.

The Trust continues to improve data quality, through improving the coding of activity, the systematic use of benchmarking data and other reviews, and developing a programme of audits and action plans to improve data quality. Each ICSU is required to have a data quality improvement plan, which is reported against on a regular basis at the data quality group.

NHS IMPROVEMENT - SINGLE OVERSIGHT FRAMEWORK

The Single Oversight Framework has been designed to help NHS providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The Framework has replaced the former Monitor 'Risk Assessment Framework' and the former NHS Trust Development Authority 'Accountability Framework'. It covers five key themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change; and
- leadership and improvement capability.

NHS Improvement measures NHS trusts in segment ranges from one to four and trusts are segmented according to the level of support required to continuously improve. Our Trust has been segmented as a two which means we have been offered targeted support due to concerns in relation to one or more of the above themes.

ANNUAL GOVERNANCE STATEMENT - CONCLUSION

As Accountable Officer, I have responsibility for reviewing the effectiveness of the systems of internal control. My review of the effectiveness of the system of internal control is informed in several ways that are summarised below.

The annual 2017/18 internal audit programme ensured a range of audits were carried out that provided robust assurance across a wide range of operational areas. The internal audit plan is agreed and monitored at the audit and risk committee and where management control issues have been identified the lead executive presents a comprehensive action plan to provide assurance actions are being implemented in a timely manner.

The Board Assurance Framework provides me with robust evidence that the effectiveness of the controls used to manage the significant risks to the organisation achieving its strategic objectives have been reviewed and agreed by the Board. The corporate risk register provides me with further evidence that the effectiveness of the identification, controls, management and escalation of risks from across the organisation is sound.

The Trust's Committee structures provide effective monitoring and review mechanisms to ensure the systems of internal control are working effectively. Other sources of information including the views and comments of stakeholders, patient and staff surveys, internal and external audit reports, clinical benchmarking and audit reports, mortality monitoring, reports from external assessments, Royal College reviews and recommendations, accreditation of clinical services and the patient environment action team assessments assure me that we are compliant with good governance.

I can confirm, having taken all appropriate steps to be aware of potential breaches or failure to comply, that arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant. I consider that any significant issues are included in the report, namely: the Trust's financial position; condition of the Trust estate; improving the flow of the emergency patient pathway and achieving the emergency department performance target. Action to address each of these areas is detailed in the relevant section of the governance report.



Siobhan Harrington, Chief Executive

25 May 2018

The Trust Board

The Trust Board is accountable, through the Chairman, to NHS Improvement. The Trust Board at 31 March 2018, consisted of the Chairman, six non-executive director posts, the Chief Executive, Medical Director, Chief Nurse, Chief Operating Officer and Chief Financial Officer, as outlined below. They are collectively responsible for the strategic direction and performance of the Trust, and have a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The membership of the Trust Board is balanced and appropriate. Full biographies for each of the Trust's Board executive and non-executive directors are available on the website at www.whittington.nhs.uk.

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

The Trust Board has the capability and experience necessary to deliver the Trust's operational business plan, and the governance structure the Trust has in place (outlined in processes and structures below) is appropriate to assure the board of this delivery. The Board development programme has been largely incorporated into the normal working of the Board via its monthly meeting and development seminars. Its aims are to ensure that the Board is fit to govern the Trust, can set and review performance standards in all areas of responsibility, operates as a unitary function and is aware of, and successfully manages, competing priorities and future challenges against the Trust's strategic goals and corporate objectives and can assure itself on aspects of clinical quality and patient safety.

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust Board directors have been assessed as being a fit and proper person to be directors of the Trust. The performance of directors is reviewed in an annual appraisal which forms the basis

of their individual development; for executive directors, by the Chief Executive, for non-executive directors and the Chief Executive by the Chairman, and for the Chairman, by NHSI. The directors have been responsible for preparing this annual report and the associated accounts, statutory statements and quality account and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, and strategy.

Trust Board Changes

For the reporting year of 2017/18 the Board membership changed with a newly appointed Chief Executive and Chief Nurse.

The voting members of the Board are supported by non-voting director posts who attend Board meetings on a regular basis and these are the Medical Director of Integrated Care (lead for GP liaison), the Director of Workforce and Development and the Director of Communications and Corporate Affairs. A newly appointed Director of Strategy, Development and Corporate Affairs will attend in 2018/19.

A wider senior leadership team, the Trust Management Group, shares in responsibility for the day-to-day activities and delivery of the overall performance of the Trust.

Trust Board members - voting rights

Non-Executive Directors

- Steve Hitchins, Non-Executive Director Chair joined the Trust 1 January 2014
- Anu Singh, Non-Executive Director joined the Trust 14 January 2014, Vice Chair of Trust Board from 1 April 2016 and Chair of Quality Committee from 14 May 2014
- David Holt, Non-Executive Director joined the Trust 13 July 2015 and Chair of Audit and Risk Committee and Senior Independent Director
- Tony Rice, Non-Executive Director joined the Trust from 21 February 2014, Chair of Finance and Business Development and Charitable Funds Committees
- Professor Graham Hart, Non-Executive Director joined the Trust from 1 September 2014 and chair of Workforce Assurance Committee from
- Yua-haw Yoe, Non-Executive Director joined the Trust from 1 April 2016
- Deborah Harris-Ugbomah, Non-Executive Director joined the Trust from 1 May 2016

Executive Directors

- Siobhan Harrington, Chief Executive joined the Trust 1 September 2006, and was appointed CEO on 16 September 2017
- Stephen Bloomer, Chief Finance Officer joined the Trust 3 June 2015
- Dr Richard Jennings, Acting Medical Director from 1 June 2014 to 17 May 2015, substantive 18 May 2015
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Philippa Davies, Interim Director of Nursing and Patient Experience joined the Trust from 1 August 2014, substantive from 1 June 2015 – December 2017
- Michelle Johnson, Chief Nurse joined the Trust on 12 Feb 2018

The accountabilities and responsibilities and roles of the Trust Board and its members are set out below.

Chairman

- Chairing the Board of Executive and Non-Executive Directors
- Ensuring the Board receive accurate, timely and clear information that is appropriate for their respective duties

Non-Executive Directors

- Challenging and supporting the Executive Directors in decision-making and on the Trust's strategy
- Holding collective accountability with the Executive Directors for the exercise of their powers and for the performance of the Trust

Chief Executive

- Leading the Executive and Trust Management Group in the day to day running of the Trust
- As Accountable Officer, working in partnership with the Board to deliver the Trust's strategy
- Ensuring that the Trust meets its statutory obligations and is fully compliant with external regulatory and statutory standards, as the Accountable Officer for the Trust
- Building effective working relationships with the community, Commissioners, Local Authorities, Universities, NHS provider organisations and other key stakeholders

Chief Financial Officer

- Meeting all organisational, statutory and regulatory requirements associated with Trust finances
- Leading the financial strategy and planning including developing the organisation's short, medium and long-term goals
- Ensuring efficiency and effectiveness of the overall finance function and the integrity of processes and systems

Chief Operating Officer

- Ensuring effective and efficient delivery of all operational, clinical and non-clinical support services
- Leading on performance delivery of national and local targets and on delivery of clinical efficiencies and service improvement work programmes
- Effectively engaging across all corporate and service delivery functions to ensure there are robust processes in place to agree and meet financial and activity targets

Medical Director

- Co-leadership with the Director of Nursing and Patient Engagement for clinical quality and patient safety
- Clinical strategy and planning; clinical service developments; contributions to wider Trust strategy and planning
- Medical leadership and clinical governance including management of all medical staff; medical-workforce planning; consultant appraisal; junior-doctor planning; clinical governance; clinical leadership in respect of NHSLA and CQC relationships
- Education and academia including medical education; relationships with Royal Colleges; and research and development

Chief Nurse

- Co-leadership with the Medical Director for clinical quality and patient safety
- Leading the Trust's registration of the Care Quality Commission and action plans
- Corporate Risk Register
- Whistleblowing Guardian
- Trust's risk management strategy and quality improvement work

- Safeguarding lead for adults and children
- Nursing, midwifery and allied health professional leadership for the organisation
- Patient and public engagement
- Complaints and litigation
- Chaplaincy services

Associate Board Attendees - Non-Voting Rights

- Dr Greg Battle, Medical Director of Integrated Care
- Norma French, Director of Workforce and Development
- Lynne Spencer, Director of Communications and Corporate Affairs (until November 2017)

Trust Board Code of Conduct and Code of Accountability

All Board members have signed the NHS Code of Conduct and Code of Accountability and this is presented in a public Board meeting on an annual basis.

Trust Board Registers of Declaration of Conflicts of Interest / Hospitality / Gifts

All Board members declare their interests where applicable and relevant. Registers are held, updated and reported to the Board in line with good governance practice, the NHS Standards of Business Conduct and NHS Improvement and NHS England guidance. During this year the Trust continued to include the interests of clinical and operational directors, including other key senior staff in positions of influence and authority. This has significantly strengthened the Board and public oversight of the Register which is available online at <http://bit.ly/2qnxHQF>.

Trust Board Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

The key financial governance documents were all reviewed during 2017/18 – the outcome of this process and updated documents were presented to the Audit and Risk Committee. During 2018/19 the Trust plans to further promote good financial governance practices across the organisation.

Disclosure to the Auditor

As directors of the Trust, the directors confirm that, as far as they are aware, there is no relevant information of which the auditor is unaware. Each director has taken the steps that they ought to have taken as a director to make himself or herself aware of any relevant information and to establish that the auditor is aware of that information.

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

The Board met a total of eleven times in public in 2017/18, every month except August. Attendance is monitored by the Chairman and all Trust Board meetings were quorate in line with the terms of reference.

The Trust Board met a total of eleven times in private in 2017/18 and the agendas were published on the Trust website to provide transparency of business items being discussed.

Trust Board Member Attendance

Member*	Attendance (actual/possible)
Non-executive directors	
Steve Hitchins, Chairman	11/11
David Holt	10/11
Deborah Harris-Ugbomah	11/11
Tony Rice	11/11
Anu Singh	11/11
Yua-Haw Yoe	11/11
Professor Graham Hart	11/11
Executive directors	
*Simon Pleydell, Chief Executive	5/5
*Siobhan Harrington, Deputy Chief Executive CE from Oct	11/11
Carol Gillen, Chief Operating Officer	10/11
Dr Richard Jennings, Medical Director	11/11
Stephen Bloomer, Chief Finance Officer	11/11
*Philippa Davies, Director of Nursing and Patient Experience	8/8
*Michelle Johnson, Chief Nurse (from February)	2/2

*Membership change in year

Board Committee meetings 1 April 2017 – 31 March 2018

The Board undertakes a proportion of its work through its committees. The structure below was in place throughout the year.

Each committee has its own terms of reference, formally adopted by the Trust Board that reviews all terms of reference annually. The non-executive Chairman of each committee presents a summary of each meeting or draft minutes to the Trust Board to ensure transparency and openness of Trust business to members of the public.

All committee meetings were quorate in line with their terms of reference.

The committees ensure the Trust Board, Chairman and Chief Executive discharge the Trust's statutory duties, accountabilities and responsibilities. During each year the Trust reviews the work and performance of each committee to ensure they remain fit for purpose as changes occur in line with Trust strategic intent and national policy directives.

The Trust Chairman attends all Trust Board committee meetings on at least an annual basis. The Trust Chief Executive attends at least one Audit and Risk Committee at the end of the year.

The Trust Board Committees' terms of reference enable non-executive directors to substitute for each other.

Audit and Risk Committee

The Audit and Risk Committee assures the Board of Directors that probity and professional judgement are exercised. It advises the Board on the adequacy and effectiveness of the Trust's internal control systems, risk management arrangements, and governance processes, with a primary focus on finance.

The Committee prepares an Annual Report for the Board on these matters and receives and reviews the Annual Governance Statement, which describes and evaluates the Trust's control environment. The Chief Executive is the Trust's designated Accountable Officer who has the duty of preparing the Annual Accounts in accordance with the NHS Act 2006.

The Committee ensures the Trust is compliant with relevant regulatory, legal, and code of conduct requirements in conjunction with the Quality Committee and that the policies and procedures for all work related to fraud and corruption, are as set out in the Secretary of State Directions and NHS Protect.

The Committee is responsible for overseeing management's arrangements for ensuring sound financial systems; and leads on liaison and compliance with Internal Audit, External Audit and Local Counter Fraud Services.

The Committee approved the internal audit programme based on risks identified through the Board Assurance Framework, Corporate Risk Register and results of previous audit activities.

The Committee will receive and agree the report of external audit findings in May 2018.

The Audit and Risk Committee met four times in 2017-18. All meetings were quorate and in accordance with its terms of reference. In line with good governance principles, the Chairman of the Trust Board is not a member of the Audit and Risk Committee.

Membership

- David Holt, Non-Executive Director and Chair from 13 July 2015
- Tony Rice, Non-Executive Director from 1 April 2016
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016

Attendance

Member	Attendance (actual/possible)
Non-executive directors	
David Holt	4/4
Tony Rice	4/4
Deborah Harris-Ugbomah	4/4

The Chairman attended the January 2018 meeting of the Audit and Risk Committee.

Quality Committee

The Quality Committee assures the Trust Board on all issues of quality, patient safety, patient experience and clinical effectiveness. It seeks assurance from across the whole of the

organisation on systems, processes and outcomes relating to these areas including the environment. It and monitors compliance with the Trust statutory duties to comply and register with the Care Quality Commission and its quality and safety standards.

The Quality Committee met six times in 2017/18. All meetings were quorate and in accordance with its terms of reference. The Committee has embedded significant and improved changes to its management, administration and effectiveness in year.

Membership

- Anu Singh, Non-Executive Director Chair from 14 April 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Yua Haw-Yoe, Non-Executive Director from 1 April 2016
- Philippa Davies, Director of Nursing and Patient Experience, from 1 August 2014 to 1st January 2018
- Dr Richard Jennings, Medical Director, from 2 June 2014
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Michelle Johnson, Chief Nurse, from 12th February 2018

Member*	Attendance (actual/possible)
Non-executive directors	
Anu Singh	05/06
Deborah Harris-Ugbomah	04/06
Yua-haw Yoe	05/06
Executive directors	
*Philippa Davies, <i>Executive Director of Nursing and Patient Experience</i>	04/04
*Michelle Johnson, Chief Nurse	01/01
Dr Richard M Jennings, <i>Executive Medical Director</i>	04/06
Carol Gillen, <i>Chief Operating Officer</i>	06/06

***membership change during the year**

The Chairman attended 1 meetings of the Quality Committee in 2017/18

Finance and Business Development

The Finance and Business Development Committee receives reports and verbal updates on issues relating to the delivery of the finance and business plan for the current year and future

periods. The Committee provides assurance to the Trust Board on all aspects of financial performance, including the operational financial performance, capital investment and working capital issues. The Committee also considers updates on the implementation of business development programmes and proposals for new development opportunities. The Committee ensures compliance with statutory and regulatory requirements placed on the Trust by relevant authorities.

The Finance and Business Development Committee met six times during 2017-18 and was quorate in line with its terms of reference. The Chair of the Committee was Tony Rice, non-executive director, who has continued in the role since 2013/14.

The Finance and Business Development Committee is responsible for seeking assurance as to the satisfactory management of the Trust's finances, cost improvement plan, cash management and capital programme. The Committee reviews and recommends to the Board for approval business cases that meet the scheme of delegation threshold for financial sign off and those of high-level strategic significance.

Membership

- Tony Rice, Non-Executive Director Chair from February 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Professor Graham Hart, Non-Executive Director from 1 April 2016
- *Simon Pleydell, Chief Executive from 1 April 2014, substantive from 1 January 2015 – Aug 2017
- *Siobhan Harrington, Chief Executive from 16 September 2017
- *Siobhan Harrington, Deputy Chief Executive and Director of Strategy from 1 September 2006 – September 2017
- *Helen Taylor, Interim Director of Strategy from September 2017 – May 2018
- Stephen Bloomer, Chief Finance Officer from 3 June 2015
- Carol Gillen, Chief Operating Officer from 1 April 2016

Member*	Attendance (actual/possible)
Non-executive directors	
Tony Rice	06/06
Deborah Harris-Ugbomah	06/06

Professor Graham Hart	04/06
Executive directors	
*Simon Pleydell, <i>Chief executive</i>	0/3
*Siobhan Harrington, <i>Deputy Chief Executive</i>	1/3
*Siobhan Harrington, <i>Chief Executive</i>	2/3
Stephen Bloomer, <i>Chief Finance Officer</i>	6/6
Carol Gillen, <i>Chief Operating Officer</i>	4/6
*Helen Taylor, <i>Interim Director of Strategy</i>	3/3

*Membership change in year

The Chairman attended three meetings of the Committee in December 2017 and February 2018.

Charitable Funds Committee

The Charitable Funds Committee manages the receipt and spending of the Trust's charitable donations, ensuring that donated funds are invested and spent in line with Trust policies and legal requirements. The Charitable Funds annual report and account is reported to the Charities Commission each year. The Committee met three times during 2017-18 and was quorate in line with its terms of reference. The Chair of the Committee was Tony Rice, non-executive director, who has continued in the role since 2013-14.

Membership

- Tony Rice, Non-Executive Director Chair from February 2014
- Steve Hitchins, Non-Executive Director from January 2014
- *Simon Pleydell, Chief Executive from 1 April 2014, substantive from 1 January 2015 – August 2017
- *Siobhan Harrington, Chief Executive from 16 September 2017
- Stephen Bloomer, Chief Finance Officer from 3 June 2015

Member*	Attendance (actual/possible)
Non-executive directors	
Tony Rice	4/4
Steve Hitchins, <i>Chairman of Trust</i>	3/4
Executive directors	
*Simon Pleydell, <i>Chief executive</i>	2/4
*Siobhan Harrington, <i>Chief Executive</i>	1/2
Stephen Bloomer, <i>Chief Finance Officer</i>	3/4

*Membership change in year

Remuneration Committee

The Remuneration Committee determines the appointment, remuneration, terms of service and performance of the Executive and Associate Directors. It considers issues relating to employees in line with its terms of reference such as severance and redundancies. The Committee met once in 2017/18 to review the performance of the executive and associate directors and was chaired by Steve Hitchins, non-executive director.

The Remuneration Committee is a statutory Committee comprising of the non-executive directors that oversee the appointment, performance assessment and remuneration of the executive/associate directors and senior staff.

The Director of Workforce and Development attends at the request of the Chair in advisory capacity as relevant and appropriate. External advisors are invited to meetings where required.

Membership

- Steve Hitchins, Non-Executive Director Chair from January 2014
- Tony Rice, Non-Executive Director Chair from February 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Anu Singh, Non-Executive Director from January 2014
- Prof. Graham Hart, Non-Executive Director from September 2015
- Yua Haw-Yoe, Non-Executive Director from 1 April 2016
- David Holt, Non-Executive Director from 13 July 2016

Member*	Attendance (actual/possible)
Non-executive directors	
Steve Hitchins, <i>Chairman</i>	1/1/
Tony Rice	1/1
Deborah Harris-Ugbomah	1/1
Anu Singh	1/1/
Yua-haw Yoe	1/1/
Professor Graham Hart	0/1/
David Holt	1/1/

There were a further two virtual remuneration committees, one following the appointment of a new CEO in July 2017; and a second to agree a redundancy package in November 2017.

The Chief Executive attended part of the meeting to report on the executive team's objectives, appraisals and performance.

Workforce Assurance Committee

The Committee ensures an effective structure, process and system of control for workforce governance and risk management; that human resources services are provided in line with national and local standards and policy, in line with the Trust's corporate objectives; development and delivery of the Trust's workforce strategy and compliance with relevant equality, diversity and human rights legislation.

The Workforce Assurance Committee met four times during 2017/18 and was at all times quorate in accordance with its terms of reference. The Chair of the Committee was Professor Graham Hart. Attendance at meetings is shown below.

Membership

- Steve Hitchins, Non-Executive Director Chair from 1 April 2016 to 31 December 2016
- Prof. Graham Hart, Non-Executive Director from 1 April 2016 and Chair from January 2017
- Norma French, Director of Workforce from 1 April 2016
- *Philippa Davies, Director of Nursing and Patient Experience, from 1 August 2014 to 1st January 2018
- *Michelle Johnson, Chief Nurse, from 12th February 2018
- Philippa Davies, Director of Nursing and Patient Experience
- Steve Bloomer, Chief Finance Officer
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Helen Gordon, Deputy Director of Workforce from 1 April 2016

Member	Attendance (actual/possible)
Non-executive directors	
Professor Graham Hart (Committee Chair)	4/4
Steve Hitchins, <i>Chairman of Trust</i>	4/4
Executive / Associate directors	
Norma French, <i>Director of Workforce</i>	4/4
Steve Bloomer, Chief Finance Officer	3 /4
*Philippa Davies, <i>Executive Director of Nursing and Patient Experience</i>	3 /4

*Michelle Johnson, Chief Nurse	0/0
Carol Gillen, <i>Chief Operating Officer from 1 April 2016</i>	3 /4
Helen Gordon, <i>Deputy Associate Director of Workforce</i>	3 /4
Helen Kent, HR	3/3
Jana Kristienova, <i>Education</i>	1/4

*change in membership through year

Other Disclosures

Interests

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties. The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust Board directors which may conflict with their management responsibilities. This register is updated at each Board meeting as a standing item for declaration invites members to update the Board so that the main register is continually updated with any changes in year; the register as at 31 March 2018 is available to the public on the website at <http://www.whittington.nhs.uk/document.ashx?id=6207>.

The Trust Board considers that all its non-executive directors are independent in character and judgement.

Pensions and remuneration

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Details of directors' remuneration are set out in the remuneration report. The Trust's external audit and details of their remuneration and fees are set out in the summary accounts, as are exit packages and severance payments, and the Trust off-payroll engagement disclosures in accordance with HMRC requirements.

Cost allocation and charges for information

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

Equality disclosures

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

Better payment for suppliers

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

Emergency preparedness

The Trust is required, and has put in place, arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005. Details are included in the annual governance statement.

Principles for Remedy

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



Siobhan Harrington, Chief Executive

25 May 2018

REMUNERATION AND STAFF REPORT

The salaries and allowances of senior managers who held office during the year ended 31 March 2018 are shown in Table 1 below.

The definition of 'Senior Managers' given in paragraph 3.35 of the Department of Health Group Accounting Manual (GAM) 2017-18 is: "...those persons in senior positions having authority or responsibility for directing or controlling the major activities within the group body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments". For the purposes of this report, senior managers are defined as the chief executive, non-executive directors and executive directors, all Board members with voting rights.

Table four: Salaries and allowances 2017-18

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension- related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice (Note 2)	5-10	0	0	0	0	5-10
Anu Singh	5-10	0	0	0	0	5-10
Professor Graham Hart	5-10	0	0	0	0	5-10
Yua Haw Yoe	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah	5-10	0	0	0	0	5-10
Executive						
Simon Pleydell Chief executive to 15/9/2017	100-105	0	0	0	0	100-105
Siobhan Harrington, Director of Strategy / Deputy CEO to 15/9/2017 Chief Executive from 15/9/2017	140-145	0	0	0	127.5-130	270-275

Carol Gillen, Chief Operating Officer	120-125	0	0	0	0	120-125
Dr Richard Jennings, Medical Director	160-165	0	0	0	5-7.5	165-170
Dr Greg Battle, Executive medical director integrated care	35-40	0	0	0	2.5-5	40-45
Stephen Bloomer, Chief Finance Officer	145-150	0	0	0	10-12.5	155-160
Norma French, Director of Workforce	115-120	0	0	0	12.5-15	130-135
Philippa Davies, Director of Nursing / Patient Experience	90-95	0	0	0	0	90-95
Sarah Hayes, Acting Chief Nurse (15/12/2017 to 12/2/2018)	10-15	0	0	0	35-37.5	45-50
Michelle Johnson, Chief Nurse and Director of Patient Experience (from 12/2/2018)	10-15	0	0	0	180-182.5	195-200

(not all executives are members of the pension scheme)

Notes

1. The salary figures above represent the 2017-18 financial year and, therefore, reflect that some Directors were only in post for part of the year.
2. Tony Rice donated his salary to Whittington Hospital NHS Trust Charitable Funds.
3. Simon Pleydell was not a member of the NHS Pension Scheme.

Table five: Salaries and allowances 2016/17

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension- related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice	5-10	0	0	0	0	5-10

Anu Singh	5-10	0	0	0	0	5-10
Professor Graham Hart	5-10	0	0	0	0	5-10
Yua Haw Yoe from 1 April 2016	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah from 1 May 2016	5-10	0	0	0	0	5-10
Executive						
Simon Pleydell, Chief executive	190-195	0	0	0	0	190-195
Siobhan Harrington, Director strategy/Deputy CEO	110-115	0	0	0	40-42.5	150-155
Carol Gillen, Chief operating officer	120-125	0	0	0	197.5-200	320-325
Dr Richard Jennings, Medical director	155-160	0	0	0	22.5-25	180-185
Stephen Bloomer, Chief finance officer	140-145	0	0	0	97.5-100	240-245
Philippa Davies, Director of nursing/patient experience	120-125	0	0	0	0	120-125

(not all executives are members of the pension scheme)

Statement of the policy on senior managers' remuneration

The remuneration committee follows national guidance on the salary of senior managers.

All elements of remuneration, including 'annual cost of living increases' (when applicable) continue to be subject to performance conditions. Executive directors were awarded a 1% cost of living increase by the remuneration committee in July 2017. This is subject to the achievement of goals being objectively assessed. The governance arrangements for the committee form part of the Whittington Health's standing orders, reservations and delegation of powers and standing financial instructions last updated in April 2017.

In line with the requirements of the NHS Codes of Conduct and Accountability, the purpose of the committee is to advise the Trust Board about appropriate remuneration and terms of service for the chief executive and other executive directors including

- all aspects of salary (including any performance-related elements/bonuses)
- provisions for other benefits, including pensions and cars

- arrangements for termination of employment and other contractual terms

Policy on duration of contracts, notice periods, termination payments

The contracts of employment for all senior managers are substantive (permanent), subject to market conditions when it may be imperative to consider other recruitment options. Senior managers are subject to regular and rigorous review of performance. All such contracts contain notice periods of either three months or six months. There is no provision for compensation for early termination in the contract of employment, but provision is made in the standard contract as follows

Clause 11: 'The Trust may at its discretion terminate a senior manager's contract with less or no notice by paying a sum equal to but no more than basic salary in lieu of notice less any appropriate tax and statutory deductions.'

Clause 12: 'Senior manager contracts may be terminated with immediate effect and without compensation for gross misconduct.'

Table six: Board members' pension entitlements for those in the pension scheme 2017-18

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Siobhan Harrington	5-7.5	17.5-20	35-40	115-120	609	169	795	21
Stephen Bloomer	0-2.5	0	45-50	115-120	687	58	765	21
Greg Battle	0-2.5	0-2.5	10-15	35-40	231	13	250	5
Carol Gillen	0-2.5	0-2.5	40-45	125-130	916	56	999	18
Richard Jennings	0-2.5	2.5-5	40-45	125-130	784	72	878	23
Philippa Davies	0	0	30-35	90-95	764	0	638	13
Norma French	0-2.5	0	20-25	55-60	448	29	489	17
Sarah Hayes	0-2.5	0-2.5	25-30	60-65	307	25	342	2
Michelle Johnson	7.5-10	22.5-25	25-30	85-90	376	159	547	2

Notes

The Trust's accounting policy in respect of pensions is described in Note 8.3 of the complete annual accounts document that will be uploaded to www.whittington.nhs.uk in September 2018. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a 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 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 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 of additional years of service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in the 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.

The membership of the remuneration committee comprises the chairman and all the non-executive directors of Whittington Health NHS Trust. The committee has agreed several key principles to guide the remuneration of directors of the Trust.

Simon Pleydell, Chief Executive was not enrolled in the pension scheme.

Pay multiples

Non-Executive Directors

The Trust follows NHS Improvement guidance for appointing non-executive directors.

The terms of the contract apply equally to all non-executive directors with the exception of the Chairman, who has additional responsibilities and accountabilities. The remuneration of a non-executive director is £6,157. The Chairman receives £21,105.

Salary range

The Trust is required to disclose the ratio between the remuneration of the highest-paid director in their organisation and the median remuneration of the workforce.

The mid-point remuneration of the highest paid director at Whittington Health in 2017-18 was £162,500 (2016-17 £191,900). This was 4.71 times the median remuneration of the workforce, which was £34,495 (2016-17 £34,154). The multiple has reduced from 2016-17 due to a change of the most highly paid individual.

In 2017-18, we had no employees (unchanged from 2016-17) who received remuneration in excess of the highest-paid director. Remuneration ranged from £6,157 to £159,950 (2016-17 £6,157 - £191,900).

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

Staff numbers and composition

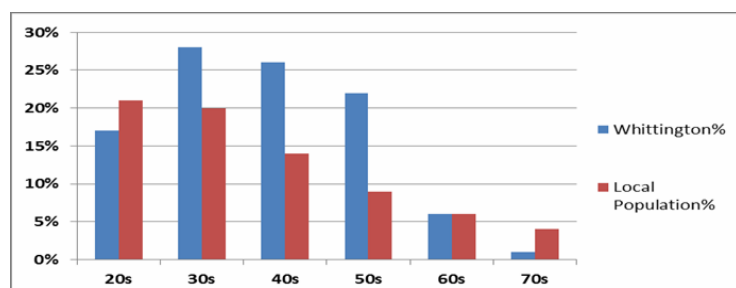
Equality, diversity and inclusion

We believe that employing a workforce that reflects the diverse nature of the communities we serve will make us better at meeting the needs of our patients.

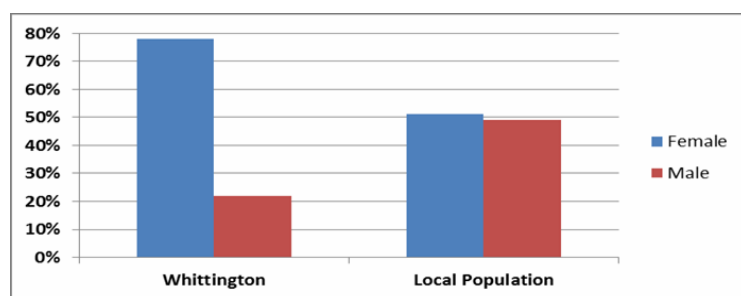
At 31st March 2018 the Trust had 4,219 staff in post.

The graphs below indicate our staff profile by gender and age.

Graph one: Staff profile by age



Graph two: Staff profile by gender



The table below provides a breakdown of ethnicity across the Trust, the local population served by Whittington Health staff and a comparison of the NHS workforce.

Table seven: Breakdown of all ethnic groups

Breakdown of Ethnic group	Whittington Health %	Local Population %	NHS Workforce % *
White	48	64	78
Black or Black British	23	16	5
Asian or Asian British	13	9	9
Mixed	3	7	1
Any other ethnic group	6	4	2
Not stated/Unknown	7	-	4

* Source: NHS Digital – December 2017 Data

Empowering staff from black and minority ethnic (BME) backgrounds to take the next steps in their career with us remains key. To help us achieve this, a comprehensive equality, diversity and inclusion improvement plan, including Trust Board development, was implemented during the year.

The inaugural Staff Equalities Engagement Event held in September 2017 identified priority initiatives for addressing inequalities impacting the workforce. They are:

- Setting up the Trust's Staff Equality & Inclusion Network which has been meeting monthly since it was launched in January 2018.
- Nine Speak Up Inclusion Champions (SUICs) have been trained and actively working across the Trust.
- A campaign to recruit additional SUICs will take place over the summer period.

- During the month of May two master classes launched the work for newly set up Task & Finish Groups on issues relating to Recruitment, Selection and Appointment (RSA); and Disciplinary and Grievance (D&G). This will include investigating and seeking ways to address over-representation of BME staff facing disciplinary action compared to non-BME staff.
- A workshop for demystifying and enhancing your understanding of LGBT+ issues will be delivered in conjunction with colleagues from the Trust participating in this year's Pride in London Parade event on the 7th July.
- Created a working group to investigate, review, improve and promote effective use of the Trust's equalities monitoring data. This will include becoming part of a Pan-London initiative to explore models of better practices for addressing the WRES indicator 3 issues.
- Actively seeking to address and increase the low number of staff with disability status recorded on the Trust's Electronic Staff Record (ESR) and explore how individuals with disabilities workplace experiences can be improved through better understanding the results of the recent staff survey results and the Staff Equality & Inclusion Network.
- Refresh the equalities objectives under the Well-Led domain of the EDS2 in line with the six strategic goals articulated in the Workforce Strategy and the Trust's Corporate objectives.
- Ensure improved access and patient experience for all, regardless of their protected characteristic group identity, using equalities monitoring data and our organisational values, ICARE.

Table eight: Sickness absence data

Staff Sickness Absence	2017/18	2016/17
Total days lost (Calendar Days Lost)	49,323	30,098
Average working days lost	8	8
Number of persons retired early on ill health grounds	0	6

Table nine: Breakdown of band 8A – Very Senior Managers

Band/Grade	Headcount	% of total B8A-VSM	% of Total substantive headcount (4,219)
JQ00 Personal Salary	3	3	0.07
WCEX Chief Executive	1	1	0.02
WDIR Director	5	5	0.12

Band 8A	47	44	1.11
Band 8B	18	17	0.43
Band 8C	21	19	0.50
Band 8D	9	8	0.21
Band 9	4	4	0.09
Total	108	101	

Table ten: Breakdown of temporary and permanent staff members

	Average WTE	
	2016/17	2017/18
Permanent staff		
Administration and Estates	1017	993
Medical and Dental	441	458
Nurses & Midwives	1114	1069
Scientific, Therapeutic & Technical	675	680
Healthcare Assistants	508	516
Permanent staff total	3754	3717
Temporary staff		
Administration and Estates	229	201
Medical and Dental	49	47
Nurses & Midwives	263	222
Scientific, Therapeutic & Technical	44	48
Healthcare Assistants	87	113
Temporary staff total	671	631
All staff total	4425	4348

Table eleven: Breakdown of temporary and permanent staff members

	Costs (£k)
	2017/18
Permanent staff	
Administration and Estates	39,853
Medical and Dental	42,208
Nurses & Midwives	55,484
Scientific, Therapeutic & Technical	36,538
Healthcare Assistants	16,248
Permanent staff total	190,331
Temporary staff	
Administration and Estates	6,024

Medical and Dental	6,001
Nurses & Midwives	10,829
Scientific, Therapeutic & Technical	2,119
Healthcare Assistants	3,766
Temporary staff total	28,739
All staff total	219,070

Consultancy Spend

The Trust spent £1.2m on consultancy in 2017-18 (£0.9m in 2016-17). The majority of this expenditure was incurred with a partner organisation to help the Trust develop savings scheme ideas.

Off-payroll engagements

The Trust is required to disclose all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months. The Trust does not have any of these engagements.

Table eleven: Exit packages for 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000	2	15,510	0	0	0	15,510	0	0
£10,000 -£25,000	1	21,455	0	0	0	21,455	0	0
£25,001 -£50,000	2	99,244	0	0	0	99,244	0	0
£50,001 - £100,000	2	159,117	0	0	0	159,117	0	0
£100,001 - £150,000	1	120,790	0	0	0	120,790	0	0
£150,001 - £200,000	1	170,560	0	0	0	170,560	0	0

>£200,000	0	0	0	0	0	0	0	0
Total	9	586,677	0	0	9	586,677	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where Whittington Health has agreed early retirements, the additional costs are met by the Trust.



Siobhan Harrington, Chief Executive

25 May 2018

FINANCIAL SUMMARY STATEMENTS

Statutory financial duties

The Trust did not meet all its statutory financial duties in 2017/18. These are described below:

Breakeven duty

(Not achieved) – the Trust is required to break-even on its income and expenditure account over a rolling three-year period. This year, the Trust ended with a surplus of £5.4m against a control total of £0.6m surplus. However, due to losses reported in 2015-16 and 2016-17, the Trust still has a cumulative historic deficit of £9.1m. While financial performance has significantly improved, there is still work to be done to address the historic deficit. The Trust aims to continue its financial recovery and plans to make a £4.7m surplus in 2018-19.

External financing limit (EFL)

(Achieved) — this determines how much more (or less) cash can be spent by the Trust compared to that which is generated from its operations. The Trust is required by the Department of Health to maintain net external financing within its approved EFL. The Trust had an EFL of -£0.7million and undershot this limit by £32k.

Capital resource limit (CRL)

(Achieved) – this determines the amount that can be spent by the Trust each year on new capital purchases. The Trust had a revised CRL of £11.3m and used £9.9m of this.

Capital cost absorption duty

(Achieved) – The Trust is required to absorb a cost of capital at a rate of 3.5 per cent. This means the total dividends paid on the Public Dividend Capital (PDC) must be 3.5 per cent of average net relevant assets.

Principles for Remedy

The Trust has a policy for dealing with complaints and is supported by complaints procedures. The Trust Board receives regular reports concerning our compliance to the complaints policy. All

compensation and ex-gratia payments made are reported through to the Audit Committee. These payments are governed by the Trust's Standing Financial Instructions (SFI).

Going Concern

As with previous years, we have prepared our annual accounts for 2017-18 on the going concern basis. This is in line with DH accounting guidance, which states that the Trust is a going concern if continuation of services exists. However, because the Trust is unable to breakeven across a three-year period, our external auditors are obliged to give a qualified opinion on the Trust's arrangements to provide value for money in its use of resources for 2017-18.

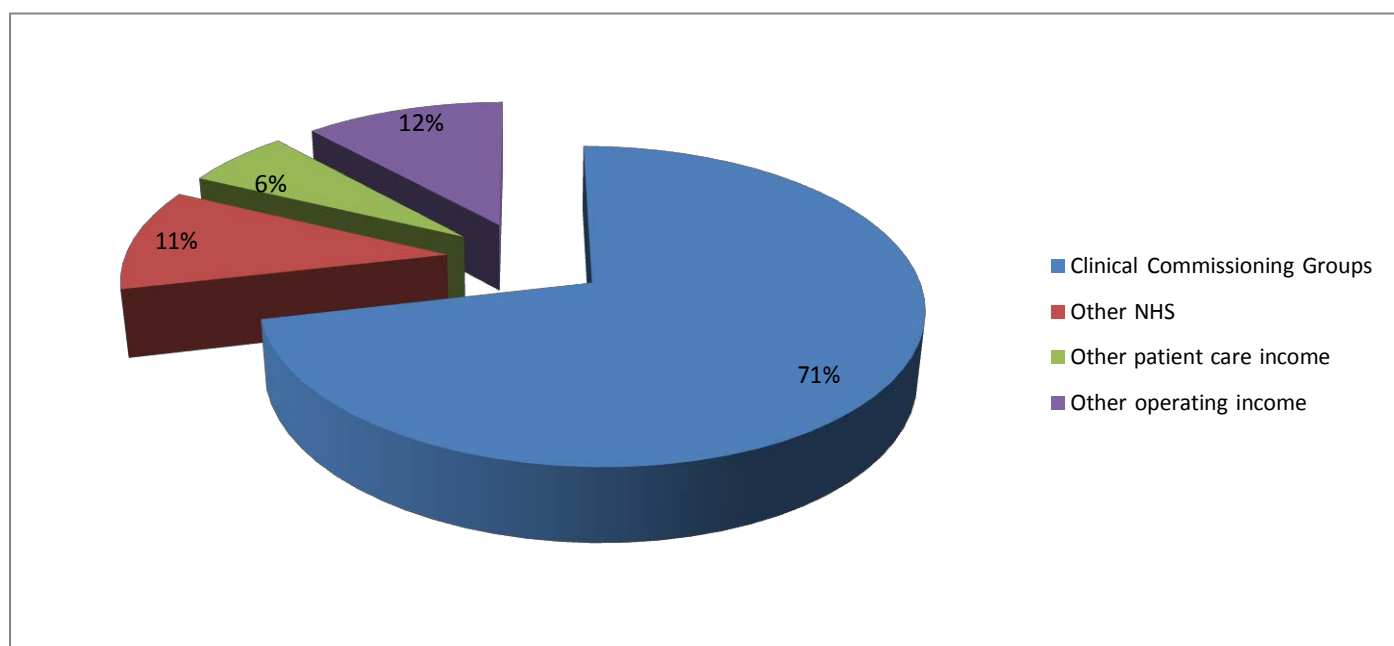
Financial Outlook

The Trust's financial performance in 2017-18 is significantly better than in 2016-17, making the first surplus at the Trust since 2013-14. The Trust has submitted an operating plan to NHS Improvement that shows achievement of a £4.7m surplus in 2018-19. To support delivery of this surplus, the Trust has a challenging but robust cost improvement programme to achieve in year.

FINANCIAL OVERVIEW

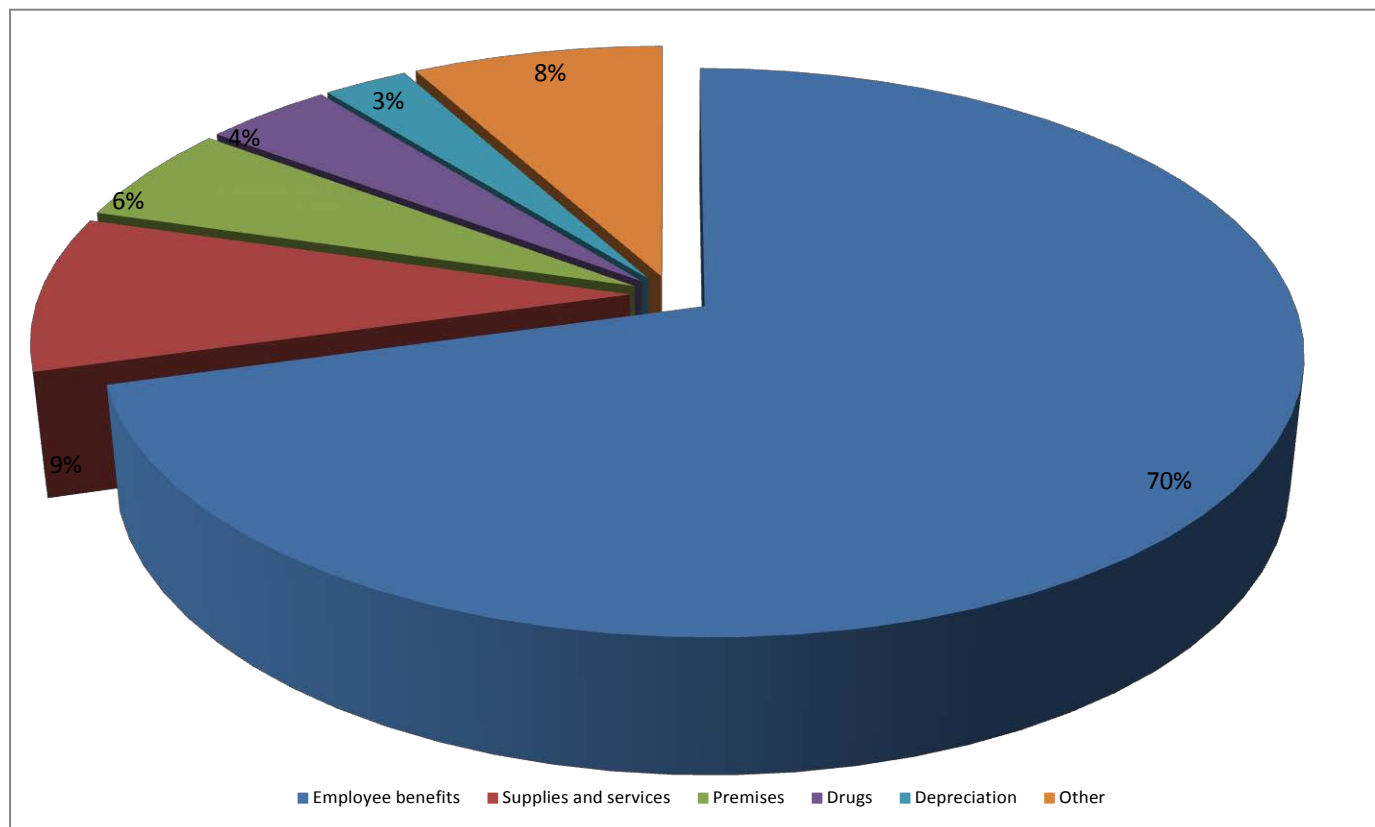
Like many NHS Trusts, we are facing a challenging financial future and have challenging financial plans to achieve for 2018-19. We finished 2017-18 with a £5.4m surplus against control total, which was £4.8m better than our planned position.

Fig 1: Our Income



In 2017-18, we received income of £323.4m, a 4.6% increase on the 2016-17 total of £309.3m. This increase was the result of improved contracts with CCG commissioners, expanded activity with NHS England, and Sustainability and Transformation Plan funding from NHS England. Around 71% of our income came from clinical commissioning groups (CCGs), much from the two main boroughs we work in. We also received significant income from NHS England, local authorities and from some other partner NHS Trusts.

Fig 2: where we spend our money



Our expenditure in 2017-18 was £310m, a 1.6% increase on our previous year's spending of £305m. Our spending on staffing has decreased slightly as a proportion of our total spend, decreasing from 73% to 70%. Non-pay expenditure has increased year on year.

Table twelve: Our break-even performance

	2017-18	2016-17	2015-16	2014-15	2013-14
	£'000	£'000	£'000	£'000	£'000
Revenue	323,394	309,255	294,211	295,007	297,397
Operating expenses (including depreciation)	(310,067)	(305,157)	(301,033)	(297,694)	(294,953)
Surplus before interest and dividends	13,327	4,098	(6,822)	(2,687)	2,444
Other losses				0	0
Net interest payable	(3,119)	(3,160)	(3,138)	(2,864)	(2,748)
Other gains and (losses)	(28)	(7)	(25)		
Dividends payable	(4,667)	(4,550)	(4,503)	(3,828)	(2,817)
Retained surplus / (deficit)	5,514	(3,619)	(14,488)	(9,379)	(3,121)
Adjustment for non-PFI impairments included in retained deficit	0	0	(248)	1,950	3,136
Adjustments in respect of donated gov't grant asset reserve elimination	(81)	(51)	(52)	87	
Adjustment for impact of IFRS accounting on PFI included in retained deficit	0	0	0	0	1,062
Position against statutory break-even duty	5,433	(3,670)	(14,788)	(7,342)	1,077

Payment of invoices

The Department of Health requires that invoices be paid in accordance with the Better Payments Practice Code. The target is to pay within 30 days of receipt of goods or a valid invoice, whichever is later, unless other terms have been agreed.

Our performance for the last two years, which is measured both in terms of volume and value of invoices, is shown below:

Table thirteen: Performance on payment of creditors

	2017-18	2017-18	2016-17	2016-17
	Number	£000s	Number	£000s
NHS Payables				
Total NHS Trade Invoices Paid in the Year	7,019	19,622	5,974	19,145
Total NHS Trade Invoices Paid Within Target	2,541	5,660	4,231	6,021
Percentage of NHS Trade Invoices Paid Within Target	36%	29%	71%	31%
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	88,858	130,706	85,572	137,226
Total Non-NHS Trade Invoices Paid Within Target	80,109	119,686	57,864	113,373
Percentage of NHS Trade Invoices Paid Within Target	90%	92%	68%	83%

Prompt payment code

We subscribe to the Prompt Payment Code.

Independent auditors report

KPMG signed off Whittington Health NHS Trust Accounts on 25 May 2018. The full accounts are available on request by emailing communications.whitthealth@nhs.net.

Whittington Health NHS Trust
The Whittington Hospital
Magdala Avenue
London
N19 5NF
020 7272 3070
[Communications.whitthealth@nhs.net](mailto:communications.whitthealth@nhs.net)

Appendix A

The Whittington Health NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of the chief executive's responsibilities as the accountable officer of the trust

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

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

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



Siobhan Harrington
Chief Executive Officer

25 May 2018

Statement of directors' responsibilities in respect of the accounts

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

In preparing those accounts, the directors are required to:

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

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

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

By order of the Board



Siobhan Harrington
Chief Executive Officer



Stephen Bloomer
Chief Finance Officer

25 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE WHITTINGTON HEALTH NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Whittington Health NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 3, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 2 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Except for the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience and its arrangements for challenging how it secures economy, efficiency and effectiveness we identified that the Trust achieved a surplus of £5.513 million in 2017/18 but has a cumulative deficit of £5.095 million as at 31 March 2018.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 2 the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 3 May 2018 a referral was made to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break even duty.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of the Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

25 May 2018

Statement of Comprehensive Income

		2017/18	2016/17
	Note	£000	£000
Revenue from patient care activities (NHS providers)	3	285,506	270,966
Other operating revenue	4	37,889	38,289
Operating expenses	5, 7	(310,068)	(305,157)
Net operating surplus		13,327	4,098
Finance income	10	44	20
Finance costs	11	(3,163)	(3,180)
PDC dividends payable		(4,667)	(4,550)
Net finance costs		(7,786)	(7,710)
Other gains / (losses)	12	(28)	(7)
Surplus / (deficit) for the year from continuing operations		5,513	(3,619)
Surplus / (deficit) for the year		5,513	(3,619)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(119)	-
Gain on revaluations	16	4,981	15,979
Other reserve movements		470	38
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		10,845	12,398

Statement of Financial Position

		31 March 2018 £000	31 March 2017 £000
Note			
Non-current assets			
	Intangible assets	13 4 144	985
	Property, plant and equipment	14 215,731	209 356
	Trade and other receivables	18 656	626
	Total non-current assets	220,531	213,967
Current assets			
	Inventories	17 1,354	1 70
	Trade and other receivable	18 30,363	25 490
	Cash and cash equivalents	19 4,051	3,161
	Total current assets	35,768	30,353
Current liabilities			
	Trade and other payables	20 (36,977)	(35,117)
	Borrowings	22 (20,195)	(1,845)
	Provisions	24 (1,343)	(691)
	Other liabilities	21 320	-
	Total current liabilities	(58,835)	(37,653)
	Total assets less current liabilities	197,464	206,667
Non-current liabilities			
	Borrowings	22 (38,448)	(60,112)
	Provisions	24 (890)	(1,549)
	Total non-current liabilities	(39,338)	(61,661)
	Total assets employed	158,126	145,006
Financed by			
	Public dividend capital	64,679	62,404
	Revaluation reserve	98,542	94,093
	Income and expenditure reserve	5,095	(11,491)
	Total taxpayers' equity	158,126	145,006

The notes on pages 14 to 57 form part of these accounts

Siobhan Harrington

Siobhan Harrington
Chief Executive Officer
25 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	62,404	94,093	-	-	-	(11,491)	145,006
Surplus/(deficit) for the year	-	-	-	-	-	5,513	5,513
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(413)	-	-	-	413	-
Other transfers between reserves	-	-	-	-	-	470	470
Impairments	-	(119)	-	-	-	-	(119)
Revaluations	-	4,981	-	-	-	-	4,981
Public dividend capital received	2,275	-	-	-	-	-	2,275
Transfer to FT upon authorisation	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2018	64,679	98,542	-	-	-	(5,095)	158,126

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

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	62,404	78,076	-	-	-	(7,872)	132,608
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	62,404	78,076	-	-	-	(7,872)	132,608
Surplus/(deficit) for the year	-	-	-	-	-	(3,619)	(3,619)
Revaluations	-	15,979	-	-	-	-	15,979
Other reserve movements	-	38	-	-	-	-	38
Taxpayers' equity at 31 March 2017	62,404	94,093	-	-	-	(11,491)	145,006

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

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

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,327	4,098
Non-cash income and expense:			
Depreciation and amortisation	5	8,375	7,991
Net impairments	6	25	-
Income recognised in respect of capital donations	4	(187)	(138)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(4,696)	(1,888)
(Increase) / decrease in inventories		347	(298)
Increase / (decrease) in payables and other liabilities		(2,515)	(3,725)
Increase / (decrease) in provisions		(7)	(345)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		14,669	5,695
Cash flows from investing activities			
Interest received		28	20
Purchase and sale of financial assets / investments		-	(47)
Purchase of intangible assets		(1,107)	(1,046)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(4,924)	(4,637)
Sales of property, plant, equipment and investment property		-	-
Receipt of cash donations to purchase capital assets		-	138
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		(6,003)	(5,572)
Cash flows from financing activities			
Public dividend capital received		2,275	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(164)	8,736
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		(848)	-
Capital element of PFI, LIFT and other service concession payments		(1,121)	(1,084)
Interest paid on finance lease liabilities		(197)	-
Interest paid on PFI, LIFT and other service concession obligations		(2,437)	-
Other interest paid		(405)	(3,180)
PDC dividend (paid) / refunded		(4,879)	(4,031)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		(7,776)	441
Increase / (decrease) in cash and cash equivalents		890	564
Cash and cash equivalents at 1 April - brought forward		3,161	2,597
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		3,161	2,597
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	19.1	4,051	3,161

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

This year the Trust has continued to meet its financial targets, against a backdrop of increased financial pressure across the NHS. In achieving these, the Trust exceeded its agreed control total by £4.8m in delivering a surplus of £5.4m. By bettering the control total, the Trust became eligible for incentive and bonus Sustainability and Transformation Funding (STF) of £4.7m, which is included in our reported position. The reported surplus represents the Trust's first surplus since 2013-14. No cash support was required from DH to achieve this.

The Trust has agreed its control total for 2018-19, for an in-year surplus of £4.7m. The Trust's financial priority for the year is to further reduce its underlying deficit and generate a surplus, whilst further embedding processes for Quality and Cost Improvement, as part of its longer term financial strategy. At the time of writing, 2018-19 contracts with principal Clinical Commissioning Groups (CCGs) in North Central London have not yet been signed. The outstanding points to be resolved are ones of detail and the majority of the contract schedules are agreed therefore we do not believe there to be a risk to liquidity. In support of this point CCGs are continuing to pay the Trust based on 2017-18 contract values.

The Trust has a £18.3m loan with the Department of Health that expires in February 2019 and we expect to be extended. The Trust submitted its annual plan to NHSI having agreed that outstanding loans would be extended at the point they crystallise. The Trust has set a challenging £16.5m CIP target for 2018-19 (representing 5.2% of expenditure) of which there are plans in place for £14.5m (88%) which will improve the underlying deficit and underpin the achievement of the control total which will unlock the payment of STF funding.

In the event of a slowdown in liquidity, the Trust can take the following actions to ensure that cash continues to flow:

- Controls are in place to enable us to manage working capital through the capital programme and the speed of payment of creditors; and
- Access to an emergency working capital facility managed by the Department of Health.

Taking these factors into account the following factors, and the intention that the healthcare and other services will continue to be provided by the public sector for the foreseeable future, the Directors consider the Trust will continue to operate as a going concern.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, plant and equipment

The Trust's land and building assets are valued on the basis explained in note 16 to the accounts. Cushman & Wakefield (C&W), our independent valuer, provided the Trust with a valuation of land and building assets (estimated fair value and remaining useful life). The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to revaluation adjustments. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

Provisions

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the accounts are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made. The carrying amounts and basis of the Trust's provisions are detailed in note 24 to the accounts.

Impairment of receivables

The Trust impairs different categories of receivables at rates determined by the age of the debt. Additionally, specific receivables are impaired where the Trust deems it will not be able to collect the amounts due. Amounts impaired are disclosed in note 18.2 to the accounts.

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. 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. We also refer to the following financial statement disclosure notes where further detail is provided on individual balances containing areas of judgement:

Notes 3 and 4: revenue - work in progress and credit note provisions;
Note 14.3: property, plant and equipment;
Note 18.2: provisions for credit notes and impairment of receivables.

Note 1.3 Income

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

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

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

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

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

The Trust has a local capitalisation threshold of £5,000, which applies unless a group of similar assets is purchased together with a combined value exceeding this threshold.

Where a large 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.

Note 1.6.2 Measurement

Valuation

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

All assets are measured subsequently at valuation:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings (hospital and community buildings with no open market) – depreciated replacement cost.

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

Subsequent expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Note 1.6.3 Derecognition

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

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

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

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.

Note 1.6.4 Donated and 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.

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

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income. Lifecycle costs are capitalised in the same way as other capital expenditure.

Note 1.6.6 Useful economic lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	85
Dwellings	66	66
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	5

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

Note 1.7 Intangible assets**Note 1.7.1 Recognition**

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, 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, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

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

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

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

Amortisation

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

Note 1.7.3 Useful economic lives of intangible assets

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

	Min life Years	Max life Years
Software licences	5	5
Licences & trademarks	5	5
Patents	5	5
Other (purchased)	5	5

Note 1.8 Inventories

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

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of [the entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.11 Financial instruments and financial liabilities***Recognition***

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

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

Regular purchases or sales are recognised and de-recognised, as applicable, using the trade date. All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as loans and receivables. The Trust does not hold any "available-for-sale financial assets" or assets held for trading.

Financial liabilities are classified as "other financial liabilities".

Loans and receivables

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

The trust's loans and receivables comprise cash and cash equivalents, NHS receivables, accrued income and "other receivables".

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

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

Financial liabilities

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

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

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

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

Where a bad debt provision is used, the accounting policies should include the criteria for determining when an asset's carrying value is written down directly and when the allowance account is used, and the criteria for writing off amounts charged to the allowance account against the carrying amount of the financial asset.

Note 1.12 Leases

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

Note 1.12.1 The trust as lessee

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

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

Operating leases

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

Note 1.12.2 The trust as lessor

Finance leases

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

Operating leases

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

Note 1.13 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 24.2 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 an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; 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 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax

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

Note 1.17 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 the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

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

As required by IAS 8, trusts should disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

IFRS 9

The Trust is reviewing the possible impact of IFRS 9 (Financial Instruments). As stated above, the majority of the Trust's financial instruments are simple in nature and will not be significantly impacted by the standard.

IFRS 15

The Trust is reviewing the possible impact of IFRS 15 (Revenue from Contracts with Customers). Our expectation is that the implementation of IFRS 15 may potentially have some impact on partially completed spells and maternity pathways, but these are not material in quantum, so the change in the timing of income recognition is also not likely to be material.

Note 2 Operating Segments

As in the previous financial year, the Trust's operational management structure is undertaken through seven clinical divisions covering both acute and community services, and the divisional structure is reflected in the Trust Board report. These divisions comprise Integrated Medicine; Children's Services; Surgery and Cancer; Emergency and Urgent Care; Patient Access, Prevention and Planned Care; Women's Health Services and Clinical Support Services.

The Trust has aggregated its operating segments in line with IFRS 8 on the basis that the nature of the services continue to be the same - the provision of healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18	2016/17
	£000	£000
Acute services		
Elective income	21,831	20,218
Non elective income	50,077	56,575
First outpatient income	10,604	10,012
Follow up outpatient income	9,909	11,470
A & E income	10,953	9,512
High cost drugs income from commissioners (excluding pass-through costs)	7,883	6,842
Other NHS clinical income	69,416	69,897
Community services		
Income from other sources (e.g. local authorities)	68,952	69,491
All services		
Patient care income from private patients	195	205
Other clinical income	35,685	16,745
Total income from activities	285,505	270,966

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	30,953	23,279
Clinical commissioning groups	230,841	221,173
Other NHS providers	3,833	2,312
Local authorities	18,210	22,408
Non-NHS: private patients	62	22
Patient care income from overseas patients	120	84
Injury costs recovery	319	343
Other non-NHS patient care income	1,167	1,345
Total income from activities	285,505	270,966
Of which:		
Related to continuing operations	285,505	270,966
Related to discontinued operations	-	-

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

	2017/18	2016/17
	£000	£000
Income recognised this year	120	84
Cash payments received in-year	98	155
Amounts added to provision for impairment of receivables	169	159
Amounts written off in-year	105	40

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research	186	-
Education and training	17,943	18,859
Receipt of capital grants and donations for capital expenditure	187	138
Non-patient care services to other bodies	6,048	6,587
Sustainability and transformation fund income (NHS providers)	10,640	8,833
Rental revenue from operating leases	875	904
Income in respect of staff costs (where treated gross)	253	332
Other income	1,757	2,636
Total other operating income	37,889	38,289
Of which:		
Related to continuing operations	37,889	38,289
Related to discontinued operations	-	-

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS bodies	626	541
Staff and executive directors costs	219,002	221,333
Remuneration of non-executive directors	60	60
Supplies and services - clinical	23,390	21,922
Supplies and services - general	4,159	3,495
Drug costs (NHS providers only)	12,601	12,709
Consultancy services	1,229	860
Establishment	2,084	2,756
Premises	12,425	12,013
Transport	378	361
Depreciation on property, plant and equipment	6,188	6,138
Amortisation on intangible assets	2,187	1,853
Net impairments	25	-
Increase/(decrease) in provision for impairment of receivables	136	(258)
Increase/(decrease) in other provisions	413	-
Audit fees payable to the external auditor		
Audit services	61	79
Other auditor remuneration	12	20
Internal audit expenditure	-	100
Clinical negligence	10,742	9,765
Legal fees	453	373
Insurance	188	176
Research and development	80	92
Education, training and conferences	1,982	758
Rentals under operating leases	5,169	4,552
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,037	1,029
Hospitality	23	32
Other	5,418	4,398
Total	310,068	305,157
Of which:		
Related to continuing operations	310,068	305,157
Related to discontinued operations	-	-

Note 5.1 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	3
2. Audit-related assurance services	12	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	5
Total	12	20

The external audit fee paid to the auditors was £51,075 + VAT. The fee paid for non-audit services was £10,000 + VAT.

Note 5.2 Limitation on auditor's liability

The contract signed on 27/09/17 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	25	-
Other	-	-
Total net impairments charged to operating surplus / deficit	25	-
Impairments charged to the revaluation reserve	119	-
Total net impairments	144	-

Note 7 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	171,508	150,367
Social security costs	17,266	18,147
Apprenticeship levy	844	-
NHS Pension costs	20,314	20,369
Termination benefits	587	49
Temporary staff (including agency)	9,355	33,289
Total gross staff costs	219,874	222,221
Less: recoveries in respect of outward secondments (where treated net)	-	-
Total staff costs	219,874	222,221
Of which		
Costs capitalised as part of assets	872	888

In line with the GAM, employee benefits should be shown in the accounts note in a single column for all categories of staff, which matches those shown for employee benefits in the staff costs disclosure in the Staff Report part of the annual report. See paragraphs 5.32 - 5.36 in the GAM for more detail.

See the "Staff report tables" tab for the disclosure that is now required in the Staff Report section of the annual report.

Note 7.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£159k in 2016/17).

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

Note 8 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation to be carried out is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 The Whittington Health NHS Trust as a lessor

This note discloses income generated in operating lease agreements where The Whittington Health NHS Trust is the lessor.

Arrangements are related to leasing areas of the hospital and community sites for catering and other services.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	875	904
Total	875	904
	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	875	869
- later than one year and not later than five years;	3,500	-
- later than five years.	-	-
Total	4,375	869

Note 9.2 The Whittington Health NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Whittington Health NHS Trust is the lessee.

The Trust has a number of operating leases for premises (buildings) for which the full leases are currently being negotiated. The premises are mainly properties owned by NHS Property Services Ltd or Community Health Partnerships. The premises are used in the provision of community services. Other operating leases are for medical and surgical equipment.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	5,169	4,552
Total	5,169	4,552
	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	4,868	4,910
- later than one year and not later than five years;	18,849	2,074
- later than five years.	34,795	1,361
Total	58,512	8,345
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	28	20
Other finance income	16	-
Total	44	20

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	530	-
Other loans	-	550
Overdrafts	-	-
Finance leases	197	207
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	1,513	1,517
Contingent finance costs on PFI and LIFT scheme obligations	923	888
Total interest expense	3,163	3,162
Unwinding of discount on provisions	-	18
Other finance costs	-	-
Total finance costs	3,163	3,180

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(28)	(7)
Total gains / (losses) on disposal of assets	(28)	(7)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	(28)	(7)

Note 13.1 Intangible assets - 2017/18

	Intangible assets		
	Software licences	under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	11,394	-	11,394
Transfers by absorption	-	-	-
Additions	1,054	1,292	2,346
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Gross cost at 31 March 2018	12,448	1,292	13,740
Amortisation at 1 April 2017 - brought forward	7,409	-	7,409
Transfers by absorption	-	-	-
Provided during the year	2,187	-	2,187
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to / from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2018	9,596	-	9,596
Net book value at 31 March 2018	2,852	1,292	4,144
Net book value at 1 April 2017	3,985	-	3,985

Note 13.2 Intangible assets - 2016/17

	Intangible assets		
	Software licences £000	under construction £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	10,142	-	10,142
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2016 - restated	10,142	-	10,142
Transfers by absorption	-	-	-
Additions	1,252	-	1,252
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2017	11,394	-	11,394
Amortisation at 1 April 2016 - as previously stated	5,556	-	5,556
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	5,556	-	5,556
Transfers by absorption	-	-	-
Provided during the year	1,853	-	1,853
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2017	7,409	-	7,409
Net book value at 31 March 2017	3,985	-	3,985
Net book value at 1 April 2016	4,586	-	4,586

Note 14.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	47,896	150,284	1,054	2,426	28,745	12,127	93	242,625
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	2,267	-	-	3,981	1,463	43	7,754
Impairments	-	985	-	(1,147)	-	-	-	(162)
Reversals of impairments	-	18	-	-	-	-	-	18
Revaluations	-	4,919	62	-	-	-	-	4,981
Reclassifications	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(180)	-	-	(180)
Valuation/gross cost at 31 March 2018	47,896	158,473	1,116	1,279	32,546	13,590	136	255,036
Accumulated depreciation at 1 April 2017 - brought forward	-	2,394	15	-	22,423	8,423	14	33,269
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	2,598	17	-	2,151	1,402	20	6,188
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(152)	-	-	(152)
Accumulated depreciation at 31 March 2018	-	4,992	32	-	24,422	9,825	34	39,305
Net book value at 31 March 2018	47,896	153,481	1,084	1,279	8,124	3,765	102	215,731
Net book value at 1 April 2017	47,896	147,890	1,039	2,426	6,322	3,704	79	209,356

Note 14.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	42,459	138,368	938	2,602	26,683	10,793	70	221,913
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	42,459	138,368	938	2,602	26,683	10,793	70	221,913
Additions	-	3,274	11	335	150	963	-	4,733
Revaluations	5,437	10,426	116	-	-	-	-	15,979
Reclassifications	-	(1,784)	(11)	(511)	1,912	371	23	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2017	47,896	150,284	1,054	2,426	28,745	12,127	93	242,625
Accumulated depreciation at 1 April 2016 - as previously stated	-	-	-	-	20,111	7,020	-	27,131
Prior period adjustments	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	-	-	-	20,111	7,020	-	27,131
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	2,394	15	-	2,312	1,403	14	6,138
Accumulated depreciation at 31 March 2017	-	2,394	15	-	22,423	8,423	14	33,269
Net book value at 31 March 2017	47,896	147,890	1,039	2,426	6,322	3,704	79	209,356
Net book value at 1 April 2016	42,459	138,368	938	2,602	6,572	3,773	70	194,782

Note 14.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018								
Owned - purchased	47,896	75,207	1,084	1,279	6,663	3,765	89	135,983
Finance leased	-	4,465	-	-	1,441	-	-	5,906
On-SoFP PFI contracts and other service concession arrangements	-	72,894	-	-	-	-	-	72,894
PFI residual interests	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-
Owned - donated	-	915	-	-	20	-	13	948
NBV total at 31 March 2018	47,896	153,481	1,084	1,279	8,124	3,765	102	215,731

Note 14.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017								
Owned - purchased	47,896	79,078	1,039	2,426	3,500	3,704	79	137,722
Finance leased	-	3,880	-	-	2,822	-	-	6,702
On-SoFP PFI contracts and other service concession arrangements	-	64,932	-	-	-	-	-	64,932
PFI residual interests	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-
Owned - donated	-	-	-	-	-	-	-	-
NBV total at 31 March 2017	47,896	147,890	1,039	2,426	6,322	3,704	79	209,356

Note 15 Donations of property, plant and equipment

Assets totalling £138k were donated by the Whittington Hospitals NHS Charitable Funds (Registered Charity 1056452). There were no restrictions placed on their use.

Note 16 Revaluations of property, plant and equipment

Land, buildings and dwellings were last valued by qualified valuers Cushman and Wakefield as at 31 March 2018. The assets were revalued on a fair value basis.

In line with the current valuation methodology, buildings have been recategorised as 'blocks' and the various components within each block grouped as one block. Each block is then considered as an individual item and depreciated over its estimated useful economic life.

Note 17 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,171	1,341
Work In progress	-	-
Consumables	43	66
Energy	26	26
Other	114	269
Total inventories	1,354	1,702
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £12,670k (2016/17: £12,800k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	18,999	23,457
Capital receivables (including accrued capital related income)	-	-
Accrued income	11,020	-
Provision for impaired receivables	(2,177)	(2,806)
Deposits and advances	-	-
Prepayments (non-PFI)	758	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	16	-
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	1,746	1,092
Corporation and other taxes receivable	-	-
Other receivables	-	3,747
Total current trade and other receivables	30,363	25,490
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	656	626
Total non-current trade and other receivables	656	626
Of which receivables from NHS and DHSC group bodies:		
Current	22,461	16,519
Non-current	-	-

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	2,806	3,064
Prior period adjustments	-	-
At 1 April - restated	2,806	3,064
Transfers by absorption	-	-
Increase in provision	136	(258)
Amounts utilised	(765)	-
Unused amounts reversed	-	-
At 31 March	2,177	2,806

Note 18.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	2,177	-	2,806	-
Total	2,177	-	2,806	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,747	-	-	-
30-60 Days	1,268	-	-	-
60-90 days	350	-	2,151	-
90- 180 days	1,579	-	1,252	-
Over 180 days	1,088	-	5,144	-
Total	6,032	-	8,547	-

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.

	2017/18	2016/17
	£000	£000
At 1 April	3,161	2,597
Prior period adjustments	-	-
At 1 April (restated)	3,161	2,597
Transfers by absorption	-	-
Net change in year	890	564
At 31 March	4,051	3,161
Broken down into:		
Commercial banks and cash in hand	64	57
Government Banking Service	3,987	3,104
Deposits with National Loans Fund	-	-
Other short term investments	-	-
Total cash and cash equivalents as in SoFP	4,051	3,161
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	4,051	3,161

Note 19.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March	31 March
	2018	2017
	£000	£000
Bank balances	6	-
Monies on deposit	-	-
Total third party assets	6	-

Note 20.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	18,345	19,132
Capital payables	4,903	-
Accruals	8,010	12,493
Receipts in advance (including payments on account)	-	-
Social security costs	2,507	-
VAT payables	-	-
Other taxes payable	-	137
PDC dividend payable	95	307
Accrued interest on loans	55	51
Other payables	3,062	2,997
Total current trade and other payables	36,977	35,117
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	9,167	16,977
Non-current	-	-

Note 20.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-
- outstanding pension contributions	-	-	-	-

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	320	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	320	-
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	-	-

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	18,490	164
Other loans	-	-
Obligations under finance leases	655	655
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,050	1,026
Total current borrowings	20,195	1,845
Non-current		
Loans from the Department of Health and Social Care	11,192	29,682
Other loans	-	-
Obligations under finance leases	1,667	2,804
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	25,589	27,626
Total non-current borrowings	38,448	60,112

Note 23 Finance leases

Note 23.1 The Whittington Health NHS Trust as a lessee

Obligations under finance leases where The Whittington Health NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	4,390	5,532
of which liabilities are due:		
- not later than one year;	981	981
- later than one year and not later than five years;	2,782	3,924
- later than five years.	627	627
Finance charges allocated to future periods	(2,068)	(2,073)
Net lease liabilities	2,322	3,459
of which payable:		
- not later than one year;	655	655
- later than one year and not later than five years;	1,482	2,619
- later than five years.	185	185
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

The Trust leases the Stroud Green Health Centre. The lease started in 1993 and is scheduled to last for 125 years. The Trust's main finance lease is for imaging equipment with our Managed Equipment Service contractor, Asterol. This arrangement started in 2007 and is currently scheduled to run until 2027.

Note 24.1 Provisions for liabilities and charges analysis

	Early departure costs £000	Legal claims £000	Re- structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	1,215	41	-	-	-	-	984	2,240
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	37	-	-	-	-	395	432
Utilised during the year	(197)	(11)	-	-	-	-	(212)	(420)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	(19)	-	-	-	-	-	(19)
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2018	1,018	48	-	-	-	-	1,167	2,233
Expected timing of cash flows:								
- not later than one year;	176	-	-	-	-	-	1,167	1,343
- later than one year and not later than five years;	704	-	-	-	-	-	-	704
- later than five years.	138	48	-	-	-	-	-	186
Total	1,018	48	-	-	-	-	1,167	2,233

Other provisions include:

1. estimated employer's liability in relation to pending negligence claims with NHS Resolution.
2. ongoing and potential employment tribunal cases. The employment tribunal provision represents management's estimate (and that of our legal advisers) of liability based on experience.
3. potential dilapidations from the transfer of leased estates back to the lessor.
4. potential liability in the event that the Trust is unable to achieve a range of greenhouse gas reduction targets.

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £99,506k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Whittington Health NHS Trust (31 March 2017: £75,726k).

Note 25 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(18)	(15)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(18)	(15)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(18)	(15)
Net value of contingent assets	-	-

Note 26 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	365	2,666
Intangible assets	3,530	207
Total	3,895	2,873

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Blocks A and L of the Trust's site are provided under a PFI arrangement and were brought onto balance sheet in 2007.

Note 27.1 Imputed finance lease obligations

The Whittington Health NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	40,299	43,779
Of which liabilities are due		
- not later than one year;	2,465	2,492
- later than one year and not later than five years;	10,040	9,883
- later than five years.	27,794	31,404
Finance charges allocated to future periods	(13,660)	(15,127)
Net PFI, LIFT or other service concession arrangement obligation	26,639	28,652
- not later than one year;	1,050	1,026
- later than one year and not later than five years;	4,966	4,569
- later than five years.	20,623	23,057

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	94,173	99,435
Of which liabilities are due:		
- not later than one year;	5,285	5,261
- later than one year and not later than five years;	21,815	21,497
- later than five years.	67,073	72,677

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	5,261	5,214
Consisting of:		
- Interest charge	1,513	1,517
- Repayment of finance lease liability	1,089	1,084
- Service element and other charges to operating expenditure	1,037	1,029
- Capital lifecycle maintenance	699	696
- Revenue lifecycle maintenance	-	-
- Contingent rent	923	888
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	5,261	5,214

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs 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 the financial reporting standards mainly apply. 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 facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	27,881	-	-	-	27,881
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	4,051	-	-	-	4,051
Total at 31 March 2018	31,932	-	-	-	31,932

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	23,457	-	-	-	23,457
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	3,161	-	-	-	3,161
Total at 31 March 2017	26,618	-	-	-	26,618

Note 28.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	29,682	-	29,682
Obligations under finance leases	2,322	-	2,322
Obligations under PFI, LIFT and other service concession contracts	26,639	-	26,639
Trade and other payables excluding non financial liabilities	34,470	-	34,470
Other financial liabilities	-	-	-
Provisions under contract	1,215	-	1,215
Total at 31 March 2018	94,328	-	94,328

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	29,846	-	29,846
Obligations under finance leases	3,459	-	3,459
Obligations under PFI, LIFT and other service concession contracts	28,652	-	28,652
Trade and other payables excluding non financial liabilities	31,625	-	31,625
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2017	93,582	-	93,582

Note 28.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	55,879	31,853
In more than one year but not more than two years	2,791	18,899
In more than two years but not more than five years	4,499	2,292
In more than five years	31,159	40,538
Total	94,328	93,582

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	12	11	12	9
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	104	123	34	104
Stores losses and damage to property	-	-	-	-
Total losses	116	134	46	113
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	118
Extra-contractual payments	-	-	-	-
Ex-gratia payments	-	-	1	35
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	-	-	2	153
Total losses and special payments	116	134	48	266
Compensation payments received		-		-

Note 30 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust.

Dr Greg Battle is both Executive Medical Director for Integrated Care for the Trust and a GP with Goodinge Group Practice and Wish Health, which provides a service to the Trust's Urgent Care Centre.

In 2017-18, the Trust paid £22k to Goodinge. There were no balances outstanding. The Trust also paid £588k to Wish Health, of which £96k was outstanding at 31 March 2018.

The Department of Health is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department. For example material income was received from the following such entities:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
Islington CCG	105,838	0	4,056	221
Haringey CCG	85,055	0	1,402	40
NHS England	43,135	0	6,661	0
Health Education England	16,932	16	382	3
Camden CCG	10,646	0	376	0
Barnet CCG	10,730	0	558	53
Enfield CCG	4,894	0	50	0
City and Hackney CCG	5,500	0	456	0

Material expenditure was incurred with the following other entity within the NHS:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
NHS Resolution (formerly NHS Litigation Authority)		10,903		

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of the material transactions have been with:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
London Borough of Haringey	8,394		167	
London Borough of Islington	7,798	1,509	411	

Another key related party is the Trust's linked charity. However, there have been no material transactions between the Trust and the Charity during the year.

Note 31 Events after the reporting date

The Trust has considered whether there are any material post balance sheet events to disclose. We have concluded that there is nothing to disclose here.

Note 32 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	88858	130706	80447	116494
Total non-NHS trade invoices paid within target	80109	119606	72365	105876
	<u>90.15%</u>	<u>91.51%</u>	<u>89.95%</u>	<u>90.89%</u>
NHS Payables				
Total NHS trade invoices paid in the year	7019	19622	6514	17446
Total NHS trade invoices paid within target	2541	5660	2181	4310
Percentage of NHS trade invoices paid within target	<u>36.20%</u>	<u>28.85%</u>	<u>33.48%</u>	<u>24.70%</u>

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

Note 33 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	-748	7088
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	<u>(748)</u>	<u>7,088</u>
External financing limit (EFL)	<u>-716</u>	<u>8,000</u>
Under / (over) spend against EFL	<u>32</u>	<u>912</u>

Note 34 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	10,100	5,985
Less: Disposals	(28)	-
Less: Donated and granted capital additions	(166)	(138)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	<u>9,906</u>	<u>5,847</u>
Capital Resource Limit	11,314	7,869
Under / (over) spend against CRL	<u>1,408</u>	<u>2,022</u>

Note 35 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	5,432
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	<u>5,432</u>

Note 36 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		139	508	1,120	3,614	1,165	(7,342)	(14,788)	(3,670)	6,158
Breakeven duty cumulative position	3,971	4,110	4,618	5,738	9,352	10,517	3,175	(11,613)	(15,283)	(9,126)
Operating income		176,853	186,300	278,212	281,343	297,397	295,007	294,211	309,255	323,394
Cumulative breakeven position as a percentage of operating income		2.32%	2.48%	2.06%	3.32%	3.54%	1.08%	-3.95%	-4.94%	-2.82%