Royal Free London NHS
NHS Foundation Trust

Annual Report and Accounts
2013/14

The Royal Free London NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2013/14

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)

(a) of the National Health Service Act 2006

Contents

A word from our chairman and chief executive

Our aspiration is to provide our patients with world class care and expertise. We do this through a continual focus on improving against our five governing objectives.

1. Excellent outcomes in clinical services, research and teaching

On what is perhaps the single most important indicator of outcomes, mortality rates, we remain among the best in the country, continuing an outstanding record since 2001. We have also continued our excellent infection control record, with no attributable methicillin resistant staphylococcus aureus (MRSA) cases during 2013/14, meaning that by the year end we had been free of MRSA for 18 consecutive months. On Clostridium difficile (C. difficile), while we did not meet the threshold set for the year, cases were down 30% on last year.

We have continued to invest in our clinical, research and teaching facilities, opening the second phase of our £11.8million intensive care unit, two new operating theatres, a positron emission tomography (PET) scanner and a refurbished medical simulation centre as well as renovating much of the teaching space in the medical school.

During the past year we have trained more students than ever before and broken new ground in the world of research, opening the pioneering UCL Institute for Immunity and Transplantation – the first of its kind in the UK – becoming the first place in the world to conduct research into the use of photodynamic therapy in primary breast cancer and carrying out the world's first clinical trials involving transplant organs grown from stem cells.

2. Excellent experience for our patients and staff

We have continued to develop our World Class Care programme, designed to ensure our patients and staff have the very best experience and we have renewed our focus on safety with a new patient safety programme.

Through the national friends and family test, the vast majority of our patients are telling us they are likely to recommend our services. The latest figures show that 87.1% of in-patients and 85.7% of accident and emergency (A&E) patients are 'extremely likely' or 'likely' to recommend the trust to family and friends who needed similar care or treatment. We need to improve this even further over the coming year so that as many of our patients as possible feel they have the care they would want for their friends and family.

We have examined the recommendations of the Francis report on Mid Staffordshire NHS Foundation Trust to see where we can learn lessons. In addition to the recommendations set out in this report, there have been two further reviews undertaken or published nationally in the last 12 months about complaints in the NHS and we have looked at these closely to ensure that we can learn from best practice to continually improve our service.

Another national survey, this time of NHS staff, placed us in the top 20% of trusts for staff engagement and showed improvements in the percentage of staff having structured appraisals and those reporting good communication between senior management and staff.

David Sloman, chief executive (left) and Dominic Dodd, chairman

We are committed to ensuring these improvements continue and to addressing areas where we fall short. Our council of governors has been particularly keen to help us to improve in areas such as patient transport, avoidable delays to discharge and improving staff facilities.

3. Excellent financial performance

We have achieved all our financial targets and reported a surplus of £8.1million, which is in line with our plan. Our financial performance has enabled us to make the investments in our clinical, teaching and research facilities described above, bringing significant benefits to patients.

However, some parts of the trust have struggled to achieve budgets for the year and our plans to make efficiency savings through the quality innovation productivity and prevention (QIPP) programme were £4.5million behind plan. The position improved significantly in the second half of the year after implementing financial recovery plans and we intend to build on this improved performance in the new financial year.

4. Safe and compliant with our external duties

During the year we had two unannounced inspections by the Care Quality Commission (CQC) and met all their standards. We were rated amber green for quarter one and then green for quarters two to four by Monitor, the regulator of foundation trusts.

At a time when there has been increased pressure on A&E departments, we have been able to maintain performance and were the fourth best performing teaching trust in the country on the four-hour waiting time standard.

We also performed better than the national targets on waiting times for patients referred to us with cancer symptoms. These national standards

require 93% of patients urgently referred by their GP to be seen within two weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving their first definitive treatment within 62 days of referral. We were the second best performing English teaching hospital for the two-week waiting time measure, the fourth best for 31-day waits and the best performing in relation to the 62-day target.

5. Continual development of a strong and highly capable organisation

This is our second year as a NHS foundation trust and we have continued to develop as an organisation through the delivery of our clinical strategy, investing in key services such our new intensive care unit, theatres, the institute, a high dependency renal unit, a planned investigation and treatment unit and Tottenham Hale kidney and diabetes centre. We have also found innovative ways of delivering care which are better for patients, such as our post acute care enablement and triage rapid elderly assessment team services which help to reduce unnecessary admissions and allow patients to receive care at home rather than in hospital where appropriate.

We are now at a key turning point as we consider the acquisition of Barnet and Chase Farm (BCF) Hospitals NHS Trust. We believe that as one larger organisation we would be able to deliver better quality healthcare nearer to patients' homes, plan services more effectively, so that patients are always treated in the right places at the right time by the right people and use our resources more efficiently. Final decisions on this are expected in June 2014.

We have made good progress on all of our five governing objectives over the past year and we would like to take this opportunity to thank all our staff for the hard work, dedication and care which has made this possible.

Dominic Dodd
Chairman

David Sloman
Chief executive

At a glance – the highlights of the year

2012

Our patron His Royal Highness The Duke of York opened our new Institute for Immunity and Transplantation. The institute - the first of its kind in the UK - is one of only five such centres in the world and the first outside the USA. Researchers and clinicians work closely to develop new treatments and improve the care of patients with an immune-related disease.

Our menu was given a celebrity makeover by TV chef James Martin as part of a national campaign to transform NHS hospital food. The trust took part in the BBC1 series 'Operation Hospital Food', an initiative backed by HRH Prince of Wales to improve hospital food and provide patients with quality and nutritionally balanced meals.

A comedy night featuring a host of top comedians was one of many fundraising events by the Royal Free Charity. The evening featured performances from the great and good of the comedy world - including Rowan Atkinson, Jo Brand and Julian Clary – to raise essential funds towards our £47 million charity appeal to complete the second phase of the Institute for Immunity and Transplantation.

Our new intensive care unit is ensuring the best service and facilities for patients. The £11.8 million facility centralises the department in a spacious and modern environment, where patients at the Royal Free can benefit from the latest treatments and high quality care.

We unveiled a new PET scanner which will benefit up to 1,500 patients a year.

Two new operating theatres and five recovery bays are enabling patients needing surgery to be cared for in a modern environment by highly experienced teams. The extra capacity brings the total number of operating theatres at the trust to 19 and is helping reduce waiting times for patients.

We scooped the emergency and critical care award at this year's Nursing Times awards. Meanwhile, one of our junior staff nurses was shortlisted in the Student Nursing Times' mentor of the year category for her outstanding work with our students.

2013

"I qualified as a teacher. Two days later I had a kidney transplant at the Royal Free."

Meet Joseph

Joseph Adams thinks the staff on the acute renal unit are brilliant.

Now 29, Joseph needed a life saving kidney transplant two years ago – and the Royal Free found his mum to be his most compatible match.

"As a child, I suffered from ill health and lost a lot of schooling. My parents took me frequently to my GP and were always told that I had a virus and that they were over-anxious! I never had any investigations.

"When I was 17, I developed a pilonidal sinus and my parents took me to a private hospital. Following pre-assessment tests for surgery, it was discovered that I had renal problems. This was my saving grace.

"It came as a shock to find out I had a solitary pelvic kidney and that I had renal failure. The kidney continued to deteriorate.

"After further investigations at UCLH, I had an operation for reflux and continued to be monitored for years. The kidney deteriorated quickly and I was referred to the Royal Free for tissue typing. Both my parents were compatible but my mother was the perfect match. This meant that the transplant could take place before the need for dialysis.

"Surgeons removed my kidney, harvested one of my mother's kidneys and transplanted it to me at the same time. Obviously, I was worried for her health, but she sailed through it without any complications.

"I proved to be a big challenge as I had numerous complications including recurrent urinary tract infections and cytomegalovirus.

"I have spent most of the time since the transplant under the care of the staff on the acute kidney unit. It has been an immense privilege to have been treated by such professional staff. I consider the standards to be of the utmost quality. Nothing has ever been too much trouble; they make you feel important and as if you are part of their family.

"Recently I have been under the care of the out-patient team. Annette and Moses were absolutely amazing. They explained my procedure in full and gave me the confidence to give myself intravenous antibiotics at home."

The strategic report

The purpose of this strategic report – as set out in the annual reporting guidance for NHS foundation trusts – is to inform users of the accounts and to help them assess how our directors have performed in promoting the success of our foundation trust.

Further information is published throughout our annual and quality reports.

About us

A long tradition

For 186 years, the Royal Free has been providing the highest standards in NHS treatment, research, education and care.

It was founded in 1828 by William Marsden, a newly qualified surgeon who was shocked that he could not help a penniless young woman he found collapsed on the steps of a London church. Without a special letter entitling her to treatment, no hospital would care for her and she died. Four months later, with the help of 27 friends, he opened the first London hospital to provide treatment and care on the basis of need rather than the ability to pay. History was made.

In 1837, Queen Victoria awarded the hospital its royal status after it was the only hospital in London to stay open during a series of cholera epidemics. For many years it was the only hospital in London to train women doctors, beginning a long association with the London School of Medicine for Women which later became known as the Royal Free Hospital School of Medicine.

Our mission

Our mission is to deliver world class care and expertise in research, treatment, teaching and education.

Making a difference today

Today, we are renowned for the quality of our nursing care, pioneering research and world class services including accident and emergency, maternity, general surgery, critical care, cancer services, infectious diseases and blood disorders.

Based in Hampstead, London, with a network of services in other hospitals and centres across north London and Hertfordshire, we are a regional centre for kidney and liver diseases and a major centre for liver and kidney transplants.

We are the vascular and haemophilia 'hub' for north London and the Royal Free Hospital has one of two heart attack centres in the area. We provide a national centre of excellence for facial re-animation surgery, are the only centre in the UK specialising in amyloidosis, we have the country's largest myeloma clinic, are a European centre of excellence for neuroendocrine tumours and one of only six designated units for patients with lysosomal storage disorders.

We are one of the UK's leading teaching trusts, welcoming more than 700,000 patients through our doors every year from all over the world.

In 2012, we were proud to become an NHS foundation trust, giving us a much greater say in the way we deliver our services for the benefit of patients. During the year we were compliant with our regulators' standards and maintained our enviable record for having some of the lowest mortality rates in the country.

Leading the way in ground breaking research and education

The Royal Free is a founder member of UCLPartners, one of the world's leading centres of medical discovery, healthcare innovation and education, giving our patients access to leading specialists and the latest drugs and treatments.

In the past five years, UCLPartners has established itself as a leading academic health science partnership that supports a healthcare system serving around 10% of the country's population. Together, its member organisations in higher education and the NHS form one of the world's leading resources of medical discovery, healthcare innovation and education, creating measureable benefits for patients and populations.

This year we were delighted to unveil phase one of our Institute of Immunity and Transplantation. This unique partnership with UCL and the Royal Free Charity is working to swiftly translate discoveries in laboratories and clinical research into treatments for disease.

Among its current research projects, experts hope to cure chronic conditions such as diabetes with a one-off treatment, bringing lifesaving transplants to patients in months rather than years and by using gene therapy to ensure that transplant patients no longer need to take a cocktail of anti-rejection drugs.

We play an essential role in educating the NHS specialists of the future. Each year we carry out training for around 600 students.

Our strategy

The Royal Free's strategy is made up of five key governing objectives:

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KEY GOVERNING OBJECTIVES

- Excellent outcomes in clinical services, research and teaching
- Excellent experience for our patients and staff
- Excellent financial performance and value for taxpayers' money
- Safety and compliance with our targets
- Continual development of a strong and highly capable organisation.

These objectives provide the structure for all that we do: setting annual corporate objectives, planning, strategic risk management and operational delivery.

All of our staff are expected to operate according to our World Class Care values.

The values expect us to be:

- Positively welcoming
- Actively respectful
- Clearly communicating
- Visibly reassuring

There are six development themes which encapsulate our strategy in both service and financial terms:

6
DEVELOPMENT THEMES

- Extending the role of a major acute provider
- Being a network and system leader and the surgical hub
- Being a leader in the academic health science system
- Being experts in integrated care
- Reducing unit costs
- Gaining new markets and income sources.

Our key developments

During the past year, detailed planning for our proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust has taken place. In June 2014 Monitor is due to report on its three-month assessment of the risks of the acquisition and our council of governors and board will consider its findings at their June meetings. If approved by the secretary of state, we expect the expanded organisation to come into being on 1 July 2014. An enlarged organisation will be able to deliver even better care to local people in north London. The expanded trust is being designed by the clinicians of both existing trusts, closely working with commissioners, local GPs and representatives from our local population. The overriding aim is for the joining of the two trusts to build upon the best of both organisations.

We unveiled our new Institute of Immunity and Transplantation to swiftly translate discoveries in laboratories and clinical research into new treatments.

We opened a new intensive care unit.

We introduced a new PET scanner.

We opened two new operating theatres, five recovery bays and our newly refurbished medical simulation centre.

We opened a new infusion suite at Finchley Memorial hospital and a new community ophthalmology service in Barnet.

We carried out a range of clinical research trials for the benefit of patients.

We trained more students than ever before and introduced a new degree programme.

We improved our student facilities.

Our performance

During our second year as an NHS foundation trust we have met all but one of the quality targets set for us by Monitor, the independent regulator.

At a time when there has been increased pressure on accident and emergency departments, we have been able to maintain performance against our waiting time targets.

We continue to record some of the lowest mortality rates in the country.

It is 18 months since we last had a case of MRSA and we have made significant progress in our control of Clostridium difficile infection, cases falling from 50 in 2012/13 to 35 this year.

Further details about our performance can be found in our quality report which starts on page 130.

We continue to develop our World Class Care programme, which is designed to improve patient and staff experience. We have renewed our focus on safety by launching a new patient safety programme.

Employee matters

The success of the Royal Free in delivering high quality patient care is attributed to the commitment of our motivated and forward thinking staff who aim to put patients at the centre of everything they do.

We employ over 5,400 staff of whom 800 are doctors and around 1,400 are nursing and midwifery staff.

We have embedded at the Royal Free a set of core values – known as our World Class Care values. These values were developed from listening events involving our patients and staff.

Discussions with staff focused on how improvements could be made to improve the patient experience and therefore the staff experience.

During 2013, our corporate induction and recruitment, probation and appraisal policies and procedures were reviewed to ensure they align with the values and apply its principles.

The annual national staff survey results placed the Royal Free in the top 20% of trusts for staff engagement and shows continuing improvement in this area.

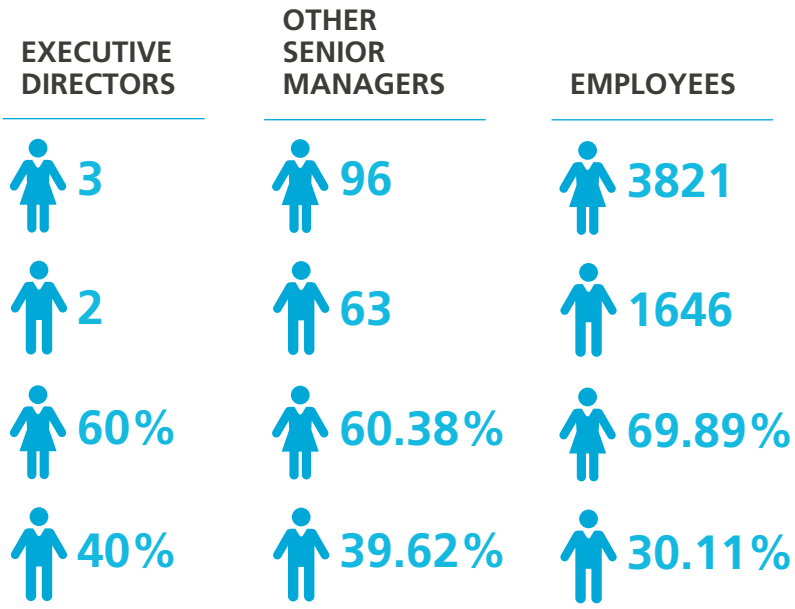
Our response rate was 54% – which is above the average 49% for trusts in England. The results help us review and improve staff experience so that staff can provide better patient care.

During 2013/14 we introduced further systems, processes and forums aimed at proactively encouraging and promoting equality of opportunity across the organisation.

Our annual equality diversity report illustrates the practices adopted to endorse the workforce equality and diversity agenda. It demonstrates how equality is embedded within all employment policies and procedures within the organisation to help to eliminate inequality of access and promote a rich and diverse workforce.

Further information about our workforce and employee matters – and details about updates to our staff policies - can be found in the 'Supporting our dedicated staff' section of the annual report.

As at 31 March 2014, the number of male and female:



Environmental matters

The trust prides itself on its maintainance of a clean environment for its patients, visitors and staff.

Patient-led assessments of the care environment – or PLACE – is the new measure and the annual assessment is more reliant on patient input and scrutiny.

During 2013, PLACE monitored our cleanliness, food, privacy, dignity, well being and condition, appearance and maintenance. The trust performed well compared to other similar trusts.

A complete smoking ban was reinforced across all our sites from March 2014. Patients, visitors and staff have not been permitted to smoke anywhere on the trust site since 2005 and a number of processes have been put in place to improve compliance.

Our carbon reduction strategy reflects the ambition for the NHS to help drive change towards a low carbon society. Since it was introduced in 2008, the Royal Free has reduced its annual carbon emissions by about 4,500 tonnes to 27,300 tonnes.

Our updated strategy will take the trust through to 2020 and reduce a further 5,116 tonnes of carbon emissions each year. This equates to a financial saving of £444,000 over the same period and reflects our corporate responsibility to lead by example in the community we serve.

During 2013/14, we took part in National Climate Week, NHS Sustainability Day and launched a Switch Off For Christmas Campaign, which demonstrated that a three per cent saving in electricity could be achieved.

The trust set up a sustainability development management group and collaborated in a joint initiative to use waste heat to heat around 1,500 local homes.

We won an energy efficiency funding bid to upgrade central plant heat, recovery of waste heat, improve the controls over hospital cooling, improve the energy efficiency of our steam distribution system and to install energy efficient LED lighting and occupancy sensors. We increased secure bicycle parking and installed two electric vehicle charging points.

Social, community and human rights issues

We have continued to develop relationships with our local community health and social care teams to allow us to work together to deliver innovative solutions to improve patient care.

An example of this is our post-acute care enablement service. Many patients who in the past would have needed to stay in hospital can now instead receive care at home, while remaining under the care of their hospital consultant.

There have been positive investments in community services that we have been able to access which have also reduced the need for hospital admission.

To assist with best use of community beds, the Royal Free opened an enablement ward in 2013/14 to support patients whilst they wait for rehabilitation beds.

We are actively working with community and social care partners who we have not traditionally linked with before. Specific developments have included timely discharge planning and escalation pathways. Considerable work continues to address feedback from GPs.

Other examples of how we work together with community providers are included in the 'Playing our part in the local NHS' section of the annual report.

Financial review

Statement as to disclosure to auditors

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

Income from health services

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

The income the trust receives from the provision of goods and services for any other purposes is generated from capacity within the organisation; it is not generated by depriving users of the health service from receiving that service. Such activities are undertaken only where they can demonstrate a positive impact for the trust, such as a financial contribution to the trust which can be invested for the purposes of healthcare, or as part of a wider clinical benefit analysis.

Countering fraud and corruption

The trust has a fraud policy and, through accountancy and advisory firm RSM Tenon, has a local counter fraud service in order to prevent and detect fraud. The local counter fraud officer reports to the audit committee at each of its meetings on the work undertaken. The trust also participates in the national fraud initiative data matching exercise.

Financial risk management

The financial risk management objectives and policies of the trust, together with its exposure to financial risk, are set out in note 23 of the accounts.

Pensions, retirement benefits and remuneration

The accounting policies for pensions and other retirement benefits are set out in note 5.7 to the accounts. Details of senior employees' remuneration can be found in the remuneration report. The number of and average additional pension liabilities for individuals who retired early on ill-health grounds during the year are set out in note 5.5 to the accounts.

Better payments practice code

The code requires the trust to aim to pay 95% of undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. It is designed to promote good practice in the payment of debt from NHS organisations. Details of compliance with the code are given in note 6 of the accounts.

Prompt payment code

The trust has registered with the prompt payment code. The details of the code are shown below:

Pay suppliers on time

- within the terms agreed at the outset of the contract
- without attempting to change payment terms retrospectively
- without changing practice on length of payment for smaller companies on unreasonable grounds

Give clear guidance to suppliers

- providing suppliers with clear and easily accessible guidance on payment procedures
- ensuring there is a system for dealing with complaints and disputes which is communicated to suppliers

- advising suppliers promptly if there is any reason why an invoice will not be paid on the agreed terms

Encourage good practice

- by requesting that lead suppliers encourage adoption of the code throughout their own supply chains

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

There were no interest charges paid in accordance with this act in 2013/14 or 2012/13.

Cost allocation and charging

The trust has complied with the cost allocation and charging requirements set out in guidance from HM Treasury and the Office of Public Sector Information.

Income

Overall the trust operating income in 2013/14 was above plan by £28.8million or 5.1% (2012/13: above plan by £16.9million or 3.0%). Income from clinical activities was above plan by £10.3million or 2.1% (2012/13: above plan by £3.9million (0.8%). Significant amounts of other income include monies from manufactured pharmacy sales.

Surplus

The trust earnings before interest, tax, depreciation and amortisation (EBITDA) were 5.5% of operating income at £32.6million (2012/13: 5.7% or £32.5million). This compares to a planned EBITDA of 5.4% or £30.6million of budgeted operating income.

Our reported deficit of £22.0million (2012/13: deficit of £16.4million) includes an impairment charge (the expense related to the reduction in value of the trust estate) of £30.1million (2012/13: £28.4million). Excluding that impairment the surplus of £8.1million (2012/13: £12.0million) is £0.2million better than plan (2012/13: £0.1million better than plan).

Revaluation and impairment

During the year the trust appointed new estates advisers and valuation experts. Due to the specialised nature of the trust estate there is no active market upon which to base a valuation, ie the estate value is not linked to the housing property market.

Instead, the valuation is based on the current cost of its replacement with a modern equivalent, less any deductions for physical deterioration. This methodology therefore considers whether, if rebuilding the estate, it would be in the same location and the same layout, as well as the current cost of purchasing the necessary materials and services.

While the buildings cost index (the published guides which note how expensive it is to build in any given area) has risen, a number of other factors have caused the estate value to fall, notably:

- Remaining lives have been reassessed - this is the estimated length of time that the buildings are expected to be used for
- The value of land owned by the trust but leased to others has been reviewed in light of the lease length
- Satellite sites have considered whether they are site specific or could be located in a cost optimal setting.

Reference costs

The trust reference cost index, ie the expenditure incurred in providing one unit of healthcare, continues to reduce, from 101 to 97. Coupled with a reduction in the prices charged and an increase in earnings before EBITDA, the overall message is that the trust is becoming more efficient.

Balance sheet

Our balance sheet remains in a strong position, with a cash balance at the end of the year of £61.7million (2012/13: £82.7million), net current assets of £21.6million (2012/13: £7.3million) and taxpayers' equity of £242.7million (2012/13: £285.7million). The land and buildings of the trust were revalued as at 31 March 2014 and resulted in an overall decrease in their value of £55.0million (2012/13: £30.6million decrease).

The trust had an agreed overdraft facility of £42million during 2013/14 and 2012/13 which has been extended to 31 March 2015. We did not need to draw down on those funds in either year.

In March 2014 the trust did draw down £20million of a £30million pre-approved loan. This has been used to support the significant investment the trust is making in its premises and equipment to support clinical services.

Quality innovation productivity programme

The quality innovation productivity programme (QIPP) is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs. The savings made are reinvested to support frontline services.

There has been an even greater focus within the trust on its QIPP programme. Many of the "easy win" savings have been realised and we are now seeking further opportunities by changing the way our services are organised. We successfully delivered £17.8million of cost savings in the year against a plan of £22.3million (2012/13: £22.1million against a plan of £24.4million).

The shortfall in QIPP was due to slippage against the implementation of a number of complex schemes.

The full annual accounts can be found from page 83 onwards.

Future prospects, risks and uncertainties facing the trust

During the year we have undertaken detailed planning for the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust from 2014.

The operating environment for the combined trust would have the following features:

- Reduced real terms public spending, minimal (formally 0.1% a year) or no growth in NHS spending and the need for real terms cost reductions
- A continuing marked increase in population in Barnet and Enfield, with lower, but still significant, increases elsewhere in the combined catchment
- A continuing significant increase in the number of people aged 85 and older, meaning a greater need for complex, acute care and the effects of demand management
- Expectation by the public and the health regulators of higher standards and lower tolerance of poor service or outcomes.

The financial position of Barnet clinical commissioning group (CCG), and Enfield CCG to a lesser extent, remains challenging, confirming that we must continue our strategy of helping local commissioners to reduce costs and achieve their savings programmes in ways which also improve the outcomes and experience for patients.

NHS England will consult on a new strategy during 2014, partly in order to address the still-increasing demand for specialised services. Meanwhile those CCGs without such serious current financial challenges instead face reductions in their spending power in the years ahead as allocations change.

Directors' responsibilities statement and going concern

The directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The secretary of state, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS foundation trust and of the income and expenditure of the NHS foundation trust for that period. In preparing those financial statements, the directors are required to:

Apply on a consistent basis accounting policies laid down by the secretary of state with the approval of the Treasury.

- Make judgements and estimates which are reasonable and prudent.
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

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

The directors are required to make a statement on whether or not the financial statements have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

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

The strategic report has been approved by the directors of the trust.

David Sloman
Chief executive

29 May 2014

Setting the pace... in patient care

Trust unveils first centre of its kind in the UK

We received the royal stamp of approval when our patron His Royal Highness The Duke of York visited the Royal Free to unveil our pioneering Institute of Immunity and Transplantation.

The pioneering institute - the first of its kind in the UK - is one of only five such centres in the world and the first outside the USA with researchers and clinicians working closely to develop new treatments and improve the care of patients with an immune-related disease.

Experts hope to cure chronic conditions such as diabetes with one-off treatments rather than years of therapy, bring life-saving transplants to patients in a matter of months rather than years and use gene therapy to ensure that transplant patients no longer need to take a cocktail of anti-rejection drugs.

Patients with cancer, leukaemia and chronic infections including HIV and tuberculosis, auto-immune diseases such as diabetes and other rare conditions such as haemophilia will benefit from ground breaking treatments at the institute.

Leading the way in intensive care

Our new intensive care unit opened its doors during the year.

The £11.8million purpose-built facility brings the department together on one floor in a spacious and modern environment.

Increased in capacity to 34 beds, the unit allows more patients to have access to treatment such as complex surgery. It includes 14 side rooms and a specialised ventilation system to prevent the spread of infection.

Virtual reality simulators put surgery in the spotlight

Professor Sir Bruce Keogh, NHS England's medical director, opened our newly refurbished medical simulation centre.

The centre provides medical training on virtual reality simulators.

Simulators help trainee surgeons to develop and perfect their skills by virtually replicating real-life procedures including endovascular surgery, laparoscopic (keyhole) surgery, gastrointestinal and endoscopy. Learning from the centre is shared with other hospitals.

Care closer to home thanks to new partnerships

Cancer patients are benefiting from a brand new infusion suite, which is bringing care closer to home.

The new facility at Finchley Memorial hospital is a joint project between the Royal Free and Barnet and Chase Farm Hospitals NHS Trust.

Patients can receive chemotherapy and supportive treatments in the purpose-built suite instead of having to travel to the Royal Free, Barnet or Chase Farm hospitals, making this more convenient for some patients who retain the expertise of highly trained oncology nurse specialists.

Meanwhile, plans for a new Royal Free service for kidney and diabetes patients in Tottenham were unveiled.

The new Tottenham Hale Kidney and Diabetes Centre, which opened in April, is the largest dialysis unit outside a hospital: with 48 dialysis stations, it can treat 270 patients.

Royal Free consultants will run clinics at the centre, focusing on self-care, home dialysis and home therapies. The new centre will replace the dialysis service at the North Middlesex University Hospital.

Boost for surgery

The Royal Free opened two new operating theatres and five recovery bays in a £3.6million development.

Now increased to 19 operating theatres, our world class surgeons provide a broad range of general and complex surgery for the benefit of patients requiring surgical care.

We are a specialist centre for a range of disciplines including vascular, plastics and transplantation.

More and more highly specialised operations are being performed, which due to their complexity take longer to carry out than more routine operations. This trend is likely to continue and the new theatres provide the extra capacity to allow for this and will reduce waiting times for patients.

Successful pilot leads to new service

A new community ophthalmology service has been launched in Barnet following a successful pilot.

The new service, at clinics in Edgware Community Hospital, Barnet Hospital and Visioncare opticians in East Finchley, provides an accessible local service and is aimed at reducing waiting times for patients with non-complex eye problems.

Previously, patients in Barnet joined a waiting list which included patients with more complex or urgent problems and they would be seen according to priority.

The new community service offers additional clinics at convenient locations which concentrate solely on patients with non-complex eye problems. This allows patients to be seen more quickly and means other hospital clinics can concentrate on more complex cases.

Improvements to patient transport

Many patients are eligible for non-emergency patient transport to and from their hospital appointments and ensuring a punctual and convenient service is key to improving our patients' experience.

During 2013/14 our patient experience committee has been committed to delivering long term patient transport service (PTS) improvements.

Work is being carried out by the patient experience governors' sub-group, with a requirement to complete a tender exercise to secure a new PTS partner to deliver non-emergency patient transport.

As part of this, the patient governors shared their first hand experiences and worked with staff to find new ways to make innovative improvements.

A new 'total hours in both systems' indicator has been introduced, which measures the length of time patients spend travelling and waiting for transport and also the time they spend in hospital.

New ways to alert patients of their transport's imminent arrival are being considered and work is underway in clinics to ensure that patients are treated promptly before their transport returns them home as quickly and conveniently as possible.

These new ways of working have already achieved significant results.

On average, just over an hour has been reduced from the patient's day and further improvements are expected to be made.

Developments in dementia care

Dementia is one of the biggest health and social care problems facing society.

At the Royal Free, a number of initiatives have been introduced to improve our services for patients. One involves 30 volunteers who have signed up to provide support and social interaction to patients on the wards, providing activities, befriending and emotional support.

Many activities focus on improving conversation with patients and by evoking past memories, encouraging patients to talk about personal and public events which were important to them. To help with this work touchscreen units are used, allowing patients to interact, as well as newspapers and 'my life' story books.

New carer focus groups identify key issues in dementia care and provide a forum for carers and people with an interest in developing dementia care with an opportunity to discuss ideas and get support.

Questionnaires distributed to carers are giving us valuable feedback on how we are doing and being used to further develop our dementia services.

A dementia specialist re-ablement service for Camden starts therapeutic intervention while patients are in hospital and accompanies and supports discharge.

This new project helps patients who have previously been resistant to care and who would otherwise be at risk of deterioration or placement. The re-ablement team starts to build a relationship with patients while they are in hospital and accompanies and supports the discharge with continuing care.

Launched in April 2013, another project for discharging patients with dementia is providing a proactive case management model of care alongside safe, sustainable and timely discharges for patients.

Known as My Discharge Project, and led by a specialist occupational therapist, it provides a single point of contact for patients and multidisciplinary staff by making assessment of complex needs and following up with patients after their discharge.

Within the first nine months, using a comparison group of 100 patients with dementia from the previous year, the project has shown:

- An impact on length of stay by at least 1.9 days
- 85% of patients discharged home (94% directly, 6% into respite care or rehabilitation)
- Reduced re-attendance at A&E by 26%
- 34% of patients at risk of permanent placement were helped to return home.

Approximately

1,700 staff

have been trained in dementia care since March 2013

Setting the pace... in research

New treatment could avoid the need for breast surgery.

World first trial for breast cancer patients

Research at the Royal Free hopes to deliver a new breast cancer treatment which could eradicate the need for surgery in some patients.

Believed to be a world first, researchers are using an established treatment already available for skin (non-melanoma), head, neck, lung and oesophageal cancers – known as photodynamic therapy (PDT) – in patients with primary breast cancer.

As part of the new two-year clinical study, PDT gives patients an infusion of a drug which makes cancer cells sensitive to light. A beam of light is then targeted to the area through a needle to destroy the cancer cells.

Novel pump transforms treatment

Patients being treated for liver disease are having their lives transformed thanks to a simple pump that is implanted in the abdomen.

The pioneering 'alfapump' controls the debilitating symptoms of liver failure and can allow the liver to partially recover preventing the need for a liver transplant, previously the only treatment option.

New insights into how the kidney works

A team of leading researchers has discovered a new mechanism which may help treatment of patients with a rare kidney disease, but also sheds new light onto how the kidney works.

The multi-disciplinary University College London (UCL) research team, based at the Royal Free hospital, comprising renal doctors, geneticists, bioinformaticians, computer scientists, cell and molecular biologists and physiologists –focused on the study of autosomal dominant renal Fanconi syndrome, a disease which affects the kidneys of both children and adults.

The ground breaking research, published in the world's leading medical journal, has led to the discovery of a completely novel disease mechanism. It found an enzyme that, when altered (mutated), changes the way that kidney cells behave. Understanding the cause of this inherited disease may lead to new treatments for patients with this kidney disease.

Ground breaking trial to change lives

The world's first clinical trials involving transplant organs grown from stem cells have been launched thanks to a £2million grant awarded to scientists at the Royal Free.

The technology is transforming the lives of patients needing new airways and allows a trachea (windpipe) transplant to be carried out without the need for anti-rejection drugs. The trials are being carried out in the hospital's pioneering new Institute of Immunity and Transplantation.

The stem cells are taken from the patient receiving the transplant and used to populate a trachea scaffold taken from a donated trachea. The trachea is stripped of its original cells and the new stem cells are grown into it in a specialised laboratory at the institute.

Because the stem cells used to repopulate this scaffold will be cells from the recipient patient there will be no need for immuno-suppressant drugs. The breakthrough also removes the need to find a donor trachea which matches a recipient, so patients are less likely to face a lengthy wait for a suitable organ to become available.

Lead centre for acute lymphoblastic leukaemia clinical trials

The Royal Free continues to be the lead centre in the UK for clinical trials in adult acute lymphoblastic leukaemia (ALL).

We have been able to offer numerous patients from all over the UK the chance to receive innovative unlicensed investigational agents.

The UK biobank for ALL is based at the trust and a UCL lab on the Royal Free campus receives specimens from UK-wide trials such as UKALL14 and UKALL60+.

Adult patients with ALL from all over the UK are having their treatment monitored and directed by the minimal residual disease test, a very specialised and sensitive test that detects tiny amounts of leukaemia not detected by standard techniques, carried out only at the Royal Free.

Use of patient's own cells avoids need for immuno-suppressants.

Setting the pace... in education

- Largest number of students in our history
- New and innovative degree programme
- New student facilities
- Improved funding transparency and incentives
- Excellent student feedback.

The Royal Free is proud of its strong tradition in education and as a campus of UCL Medical School we are at the forefront of medical education of international status.

Each year we carry out training for around 600 students - with about 200 on site at the Royal Free at any one time - mainly in years four to six of the curriculum.

We also host a significant amount of earlier years medical student teaching. Most clinical departments have a commitment to teaching and for some this is substantial.

Of the three central teaching locations for UCL Medical School – the Royal Free hospital, UCL hospital and the Whittington hospital – the Royal Free is particularly well placed to provide a full range of teaching in tertiary and secondary care as well as integrated care with the community.

At a glance

In 2013/14 especially good feedback about departmental teaching was received from students in cardiology, rheumatology, vascular surgery, neurology, endocrinology and health of older people.

Due to our expertise in these areas, the teaching of renal medicine and vascular surgery for the whole medical school is based at the Royal Free.

We are leading on a 'preparation for practice' module in year four, which concentrates on particular skills identified by the General Medical Council as important for newly-qualified doctors - prescribing, assessment of the acutely unwell and understanding of integrated care pathways – to ensure our future doctors have a good understanding of seamless patient care.

This means the number of students at the Royal Free has increased in comparison to previous years.

New degree programme

Preparation is well underway for the introduction of a new UCL degree programme from the summer of 2014.

The new degree in applied medical science will be an innovative programme for students who wish to pursue careers allied to medicine – for instance in the pharmaceutical industry, medical research and related careers in the NHS.

It is anticipated that this will bring several hundred more students to the Royal Free campus every year.

Improving our teaching facilities

This year has seen the refurbishment of much of the teaching space in the medical school.

Lectures theatres and tutorial rooms have been developed and of particular importance to the student experience is a large new student informal learning and social space, known as the Hub.

New offices for administrative staff have allowed the concentration of staff previously based at the Whittington into purpose-built accommodation.

Improved transparency and incentives

The system for NHS trusts being paid for undergraduate teaching changed in 2013 to a more transparent 'money follows the student' process.

Each year a student based at the Royal Free brings approximately £43,000 into the trust. A major new project has been to ensure distribution of this funding to service lines to improve transparency and incentivise high quality teaching.

The scheme will incorporate an element of an educational CQUIN - an incentive scheme based on specific educational targets - with clear targets around job planning, feedback and timetabling and goes live at the beginning of 2014/15.

Meet Lynn

Lynn Steblecki was diagnosed with systemic scleroderma, a rare auto-immune disease which sees the body attacks its own connective tissues.

The condition causes scarring and hard, thickened areas of tissue. There is currently no cure. For patients with systemic scleroderma, the disease often starts in the skin, resulting in loss of flexibility, spreading throughout the body and hardening key organs such as the lungs, heart, gut and kidneys. For Lynn, formerly a business woman and model, this has brought about mobility difficulties and many other health problems.

"My original diagnosis was a shock at a time when information was scarce", explains Lynn, who was born in Yorkshire and spent many years in Zimbabwe before returning to the UK in 1996.

"It was very scary. I was working in London at the time and had gone to my GP with painful swollen hands which were tender to touch and I was very tired all the time. Originally I was sent away but I knew something wasn't right and after six months I finally ended up at the Royal Free – which is the national centre for scleroderma - where I was diagnosed and treated.

"I'm in and out of the hospital. Every three months I'm picked up from my home in the New Forest and spend a week on 11 west ward for in-patient treatment. I'm given a powerful intravenous infusion of drugs to help manage the disease.

In my case, the drug has to be given continuously for five days but many patients I know have this treatment in the out-patient clinic. The Royal Free has been part of my life for a long time and my experience has been good.

"My condition is very complicated and has brought me into contact with many departments and areas across the hospital. I have regular echocardiograms, my lung function also needs to be monitored. My hands are rigid and I've had operations to help with that and stem cells have been inserted into my face to help with facial movement.

"As a woman, I have found the effects on my facial features devastating. Last year, along with a group of specialists, I was invited with Professor Peter Butler to give a talk at Downing Street about the condition and its treatment. I'm also involved with the Royal Free Charity to raise vital funds for research into reconstructive surgery and scarring."

Over the past few years, Lynn has found a new passion – writing - and has been taking courses. She has almost completed her first novel, a thriller set in Africa, inspired by real life events.

"Everyone knows me at the Royal Free. I've been everywhere. Every department I think: rheumatology, dermatology, plastics, orthopaedics, out-patients, lung function, cardiology, gynaecology, the breast clinic...the list goes on."

Continuous improvements to quality

"The nurses are wonderful. They make sure he is okay each day."

"If the nurses don't know an answer they will go and find someone who does. Nothing is too much trouble. Staff have a sense of humour no matter what time, day or night."

Meeting our standards - Monitor

Monitor is the regulator for health services in England. Its job is to protect and promote the interests of patients.

The Royal Free has completed its second year as an NHS foundation trust and we have met all but one of the quality objectives set for us by Monitor.

Our performance is measured against 15 national performance targets.

We have also made significant progress in our control of *Clostridium difficile* (C. difficile) infection, focusing on the way we use antibiotics that can cause this infection. On C. difficile, while we did not meet the threshold set for the year, cases were down 30% on last year (falling from 50 in 2012/13). We recorded 35 cases against an annual target of 33.

In common with other hospitals, we have been finding the C. difficile threshold a challenge. From April to September 2013 we recorded 25 C. difficile infections and between October to March 2014 we recorded ten.

This is a reduction of 60% between the first and second halves of the year and means we have achieved our monthly target for five successive months.

Mortality rates

We are still recording some of the lowest mortality rates in the country.

Mortality rates are measured against two indicators, the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI).

The most recent data on HSMR shows that for the 12 months to the end of December 2013 we recorded the third lowest relative risk of mortality of any acute English NHS trust with a relative risk of mortality of 72.5, which is 27.5% below (statistically significantly better than) expected.

Looking at SHMI, for the 12 months to the end of June 2013 (the most recent data available) we have the eighth lowest relative risk of mortality of any acute English NHS trust with a relative risk of mortality of 80.7 – 19.3% below (significantly better than) expected.

MRSA

We did not record any cases of MRSA during 2013/14 and have been free of MRSA for 18 consecutive months.

Emergency care

Despite increased pressure on our accident and emergency department, we have maintained our performance against the waiting times targets.

On March 31, a total of 328 patients attended A&E, the highest number ever recorded.

Especially during periods of high attendances and admissions a key objective is to continue to maintain good bed flow.

This includes ensuring discharged patients are able to go home early in the day and making sure every patient has an estimated discharge date. This enables us to maintain capacity for both our planned and emergency patients.

The table below shows our A&E performance for each month and quarter.

Time period	Attendances	Performance
April 2013	7,778	92.88%
May 2013	8,112	96.50%
June 2013	7,734	97.85%
Q1 2013/14	**23,624**	**95.75%**
July 2013	8,229	97.69%
August 2013	7,459	96.43%
September 2013	7,469	96.45%
Q2 2013/14	**23,157**	**96.89%**
October 2013	7,883	96.30%
November 2013	7,626	97.40%
December 2013	7,755	95.53%
Q3 2013/14	**23,264**	**96.40%**
January 2014	7,754	96.40%
February 2014	7,290	95.01%
March 2014	8,491	96.30%
Q4 2013/14	**23,535**	**95.93%**
2013/14 total	**93,580**	**96.24%**

Meeting our Care Quality Commission standards

The Royal Free is registered with and licensed by the Care Quality Commission (CQC) - the independent regulator of health and adult social care services in England.

We are required to demonstrate compliance with the CQC's 16 essential standards across every service we provide.

This year we had two inspections. In October 2013, the CQC undertook a re-inspection of the Royal Free hospital site following the implementation of actions to ensure the safe storage of medicines.

The inspection confirmed that we were compliant with all 16 essential standards.

Inspectors found that our patients rated our care and services very highly and enjoyed attending for their care with us.

The second inspection in February 2014 saw nine inspectors visit a number of wards and departments as part of a routine unannounced inspection.

The trust met all seven standards being assessed, including consent to care and treatment, care and welfare of the people who use our services, cleanliness and infection control and supporting staff. With regards to the care and welfare of those who use our services, the report included patient feedback. Comments included:

"The nurses are wonderful. They make sure he is okay each day."

"If the nurses don't know an answer they will go and find someone who does. Nothing is too much trouble. Staff have a sense of humour no matter what time, day or night."

The report also included observations from the inspectors.

"During the inspection we saw many examples of compassionate care that met people's needs… We saw many examples of staff helping patients in a kind and considerate manner."

Although we met the standard for nutritional needs, areas for improvement were identified. The report stated that patients "were supported to be able to eat sufficient amounts to meet their needs".

Other standards achieved included staff being properly trained and supervised, with the chance to develop and improve their skills, and that people have their complaints listened to and acted on.

An overview of the performance against national targets is included below.

Monitor Risk Assessment Scorecard April 2013 - March 2014

	2013/14					
Monitor indicators of Governance Concerns - October 2013 - March 2014	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Weighting**
A&E: 95% of patients admitted, transferred or discharged within 4 hours	95.8%	96.9%	96.4%	96.0%	>=95%	1.0
C difficile: number of cases against plan	12	13	5	5	Q4<=8	1.0
Maximum time of 18 weeks from point of referral to treatment in aggregate for admitted patients	92.4%	92.4%	92.4%	90.7%	>=95%	1.0
Maximum time of 18 weeks from point of referral to treatment in aggregate for non-admitted patients	97.6%	96.5%	96.9%	97.0%	>=95%	1.0
Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways	92.0%	92.1%	92.0%	92.1%	>=95%	1.0
All Cancer: 31-day second or subsequent treatment: surgery drug radiotherapy	 98.5% 100% 100%	 100% 100% 100%	 99.2% 100% 100%	 98.8% 100% 100%	 >=94% >=98% >=94%	1.0
All Cancers: 62-day wait for first treatment: from urgent GP referrals from a screening service	 90.6% 100%	 92.5% 100%	 89.0% 100%	 86.6% 100%	 >=85% >=90%	1.0
All cancers: 31-day wait from diagnosis to first treatment	98.6%	99.7%	89.9%	98.7%	>=96%	1.0
Cancer: two-week wait from referral to date first seen: All cancers Symptomatic breast patients	 97.7% 96.6%	 97.2% 95.0%	 96.8% 96.0%	 98.0% 97.2%	 >=93% >=93%	1.0
Compliance with requirements regarding access to healthcare for people with learning disabilities	Compliant	Compliant	Compliant	Compliant	Meeting the 6 criteria	1.0
Monitor overall governance thresholds: Trust rating: Green: a service performance score of ?4.0 and <3 consecutive quarters' breaches of a single metric Weighting: Red: a service performance score of >=4.0 and >=3 consecutive quarters' breaches of a single metric	Amber - green 1	Green 1	Green 1	Green 1		

For further information

Quality governance, quality and our improvement priorities are discussed in more detail in the annual governance statement on page 76 and within our quality report (from page 130 onwards).

Regulatory ratings report – template commentary and table of analysis

	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the compliance framework				
Financial risk rating	4	4		
Governance risk rating	Amber-green	Green		
Under the risk assessment framework				
Continuity of services rating			4	4
Governance risk rating			Green	Green
	Q1 2012/13	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**
Under the compliance framework				
Financial risk rating	4	4	4	4
Governance risk rating	Amber-green	Amber-green	Amber-green	Green

"During the inspection we saw many examples of compassionate care that met people's needs… We saw many examples of staff helping patients in a kind and considerate manner."

We have developed a new menu for our in-patients.

The continuity of services risk rating states Monitor's view of the risk facing a provider of key NHS services. There are four rating categories ranging from one, which represents the most serious risk, to four, representing the least risk. A low rating does not necessarily represent a breach of the trust's licence. Rather, it reflects the degree of financial concern Monitor may have about a provider and consequently the frequency with which it will monitor it.

This new continuity of services risk rating (CSRR) is not calculated and used in the same way as the financial risk rating (FRR) that was applied to NHS foundation trusts through Monitor's Compliance Framework. Whereas the FRR was intended to identify breaches of trusts' terms of authorisation on financial grounds, the CSRR will identify the level of risk to the continuing availability of key services.

The continuity of service risk rating reflects the trust's maintenance of a strong position against a backdrop of increasing patient demand and financial constraints.

Monitor will predominately use the governance rating, incorporating information across a number of areas, to describe its views of the governance of the trust. The rating is generated by considering a range of information including:

- Performance against selected national access and outcomes standards
- CQC judgements on the quality of care provided
- Relevant information from third parties
- A selection of information to reflect quality governance at the organisation
- The degree of risk to continuity of services and other aspects of risk relating to financial governance

Trusts are rated green if no issues of concern are identified and red where Monitor is taking enforcement action.

Listening to and learning from our patients

Patient engagement

We continue to develop ways to engage and listen to our patients, collecting views, comments, ideas and suggestions for improvements from patients, their families and carers to inform our plans.

This year, a new and immediate way of gaining feedback from patients about the care being received was launched at the Royal Free through a new national initiative - the friends and family test, known as FFT.

Under the FFT scheme, every adult patient attending A&E and the wards is phoned within 48 hours of their discharge and asked 'How likely are you to recommend the Royal Free to friends and family if they needed similar care or treatment?'

Patients respond either 'extremely likely', 'likely', 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely'.

During 2013/14 we received over 28,000 responses:

- A&E patients: 85.7% responded 'extremely likely' or 'likely' (14.3% responded 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely')
- in-patients: 87.1% responded 'extremely likely' or 'likely' (12.9% responded 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely').

We also asked each patient the reason for their response. Their comments and the FFT weekly scores are then fed back to departments and wards for staff to review.

Positive comments provide a morale boost for hard working staff and negative comments are used to identify themes or particular issues so that improvements or changes can be made.

In A&E, for example, waiting times can be an issue and we continue to look at ways to improve communication with patients to reduce anxiety while waiting to be treated.

Plans are underway to use the plasma screens in A&E to display waiting times and other useful information for patients.

Looking ahead, the FFT score and comments will be used to track patient experience and help us to respond to the issues that really matter to patients.

FFT scores for 2013/14

ROYAL FREE	Score		Response rate		Satisfaction	
Month	In-patients	A&E	In-patients	A&E	In-patients	A&E
Apr 13	54.1	-26.0	6.5%	7.5%	84%	37%
May 13	54.8	35.3	6.8%	27.5%	85%	80%
Jun 13	43.5	41.1	10.1%	49.2%	81%	88%
Jul 13	40.3	35.7	10.5%	44.6%	82%	86%
Aug 13	44.6	39.0	46.6%	44.5%	87%	88%
Sep 13	45.7	39.7	45.5%	44.7%	89%	87%
Oct 13	47.7	36.4	41.1%	38.3%	88%	86%
Nov 13	46.0	40.9	42.8%	42.8%	88%	88%
Dec 13	42.5	37.8	42.3%	41.0%	88%	86%
Jan 14	48.3	39.5	45.2%	43.7%	88%	88%
Feb 14	38.2	35.4	46.0%	40.7%	86%	85%
Mar 14	38.5	33.3	49.5%	43.6%	86%	85%

The FFT score is calculated as follows: percentage of extremely likely to recommend scores minus percentage of neither likely nor unlikely, minus percentage of unlikely, minus percentage of extremely unlikely to recommend. The percentage of likely to recommend scores is not included in the FFT score.

Comments were received about food sometimes being served cold by the time patients received it on the wards.

In response, we have started serving soup in flasks and one ward is trialling the use of lids for plates prior to serving.

Another comment concerned noise on the wards at night. In response, we have made changes to the main door-closing mechanism, we close four-bedded bays at night, make sure that bins are closed at night and provide ear plugs for patients on request.

Response **extremely** likely –

"The waiting time was a lot less than I expected, very quick and I was kept updated. The staff were very friendly and kept me at ease."

(December 2013)

Response **extremely** likely –

"Staff were so efficient, so sympathetic. I couldn't have wished for anything better."

(February 2014)

Response **likely** –

"All the staff were marvellous and looked after me very well."

(October 2013)

Response **likely** –

"My needs were attended to well and quickly. I felt safe."

(October 2013)

Response **unlikely** –

"I came really early and no-one was waiting. Had to wait two hours at 7am and was told that it would only be half an hour."

(August 2013)

Response **extremely** unlikely –

"Long waiting time."

(August 2013)

Response **extremely** unlikely –

"When I explained my situation I was told I was not considered an emergency. I was given a prescription and asked to leave."

(January 2014)

World class care for everyone

Last year marked the launch of our World Class Care values.

This is our promise to deliver world class care, every one of us, to patients and colleagues, every day.

A year on, these values are now part of our focus for recruitment, induction, yearly appraisals and continued development.

The leadership foundation for junior doctors and managers, the nurse preceptorship programme – mentoring and guidance for qualified nurses who are new to the trust - as well as nurse induction and training, all now include these World Class Care values as a basis for developing and promoting a caring attitude in the workplace.

Treating our staff with the same values as we treat our patients is crucial to embedding these values in all aspects of our daily duties.

Both our patient improvement plans and staff improvement plans are closely linked and monitored by our patient and staff experience committee. Staff who are well treated and feel appreciated at work are likely to provide a better experience for the patients they care for.

NHS Change Day

NHS Change Day saw hundreds of our staff, medical students and patients making pledges to do something different to improve the patient experience through 'thousands of single actions, one enormous difference'.

Pledges from the Royal Free, Whittington and University College London hospitals were displayed at UCL, where medical students who had taken on a Change Day 'ask one question' project presented their patient stories.

Staff displayed their pledges for NHS Change Day on 3 March 2014

Patient surveys and focus groups

The year has seen a number of national surveys at the hospital, including of cancer, maternity and in-patient services.

They help us focus on what really matters to patients to improve their hospital stay.

In the national in-patient survey, the Royal Free scored higher than the national average on the following:

- 95% of respondents said they did not need to share a bath/shower facility (national average 88%)
- 84% of patients felt they were given the correct amount of information on their condition or treatment (national average 80%)
- 83% of patients received copies of letters between hospital doctors and GPs (national average 69%).

Improvements since last year's survey – we scored higher than in 2012 on:

- 64% of patients agreed that from the time they arrived at hospital, they felt that they were given a bed on the ward in good time. This had improved from 51% in 2012 (national average 67%).

The in-patient survey highlighted a number of areas where the trust will seek ways to improve the patient experience:

- 48% of patients said they definitely were involved as much as they wanted in decisions about their care and treatment (against an average of 55%)
- 65% of patients said they were always given enough privacy when discussing their condition (average 73%).

In 2013, 80% of Royal Free patients rated their overall experience as 7/10, the same as the previous year.

Patient engagement has continued with regular patient focus groups, including one with the radiology department, which has made a number of improvements as a result.

Appointment and reminder letters have been revised as a result of patients' perception that they could be improved and face-to-face bookings have been introduced to eliminate the reliance on postal systems, reducing the number of non-attendances.

Self-check-in kiosks have also been introduced, with patients reporting this makes the reception booking in system quicker and simpler.

New mothers brought in their babies to discuss their antenatal care and birth experiences with our midwife supervisors. This has led to better patient representation on the maternity services liaison committee.

The kidney transplant team gave a presentation to patients on rejection, medication and planned future services. The feedback from this meeting is being used to plan further support groups and meetings for kidney transplant patients who continue to have long-term care.

Patient feedback at the touch of a button

A new way to collect patient feedback has been introduced using bedside TVs.

The in-patient survey is now available on bedside TVs and can be used by patients to tell us what they think of the care they receive and how they rate the cleanliness of the environment.

Each ward is able to see the anonymous feedback from their patients on a weekly basis - similarly to the FFT comments - and so can respond much more rapidly to any concerns raised.

The patient and staff experience committee - formerly the user experience committee - meets quarterly to monitor and advise on developments in patient engagement and the actions and outcomes of improvements to the patient and staff experience. It is chaired by one of the trust's non-executive directors.

Listening to what patients tell us

Feedback from patients, relatives and carers provides us with an essential insight into people's experiences of our healthcare and helps us improve our services.

We receive many thousands of compliments, letters of thanks and other plaudits from our patients and their carers every year. The number of complaints we received during 2013/14 represented 0.08% of the number of patients we saw (652 complaints from 772,260 in-patient and out-patient attendances).

Information about how to make a complaint and about our patient advice and liaison service, is available on our website.

An easy-to-read leaflet 'Comments, concerns and complaints', explains how to raise concerns, make comments or give feedback and is available in wards and departments throughout the trust. Information is also included in the patient bedside guide.

All comments help us improve our services. The executive lead for the trust's complaints process is the director of nursing.

Our PALS: patient advice and liaison service

During 2013/14, our patient advice and liaison service (PALS) continued to be the first point of contact for questions, concerns and suggestions about our services.

Our dedicated PALS team offers help and support and tries to answer questions and resolve concerns quickly and informally in line with the enquirer's wishes.

The service is based at the front of the hospital, next to main reception, to ensure that it is as visible and accessible as possible.

Examples of changes made as a direct result of feedback through our PALS include:

- Introducing a new electronic system to track patients' transport following the end of an appointment in the ophthalmology department at Barnet hospital where we hold some clinics
- Rescheduling the timing of patient review meetings in the myeloma clinic to ensure clinics start on time
- Correcting a computer error which was not transferring contact information across to the letter templates for our ophthalmology appointments run at the Whittington hospital.

Dealing with complaints

Formal complaints continued to be dealt with by our patient experience department to ensure that any matters raised were investigated thoroughly and responded to in line with trust procedures.

Systems are in place to systematically review complaints and PALS cases and to ensure that investigations are undertaken appropriately, in line with legislation and good practice, and escalated within the trust as necessary.

Data collected is used to inform reports, disseminated among divisional teams and used to further improve the patient experience.

Examples of changes made following complaints are:

- Pre-operative assessments have been introduced for all urology patients who are due to have radiology procedures
- The nursing team in the intensive care unit has been given additional training and guidance on the use of syringe drivers to administer painkillers
- We have invested in additional information technology resources to enable the viewing of eye test images in all clinical rooms to reduce waiting times for patients
- Staff in the haemophilia department changed the wording of letters about missed appointments after a patient found the content abrupt
- A new patient information leaflet for endoscopy patients aims to help avoid confusion and anxiety about fasting before procedures
- We are working with WHSmith to launch a three-month pilot scheme after comments were received about healthy eating options in its shop and on the patient snack trolley.

We value all the feedback we receive and aim to respond to concerns openly, thoroughly and efficiently, using the information we receive to improve health services and the care that our patients receive.

A new development involves sending out questionnaires to patients to gain feedback on the way their cases were handled and is used to make further quality improvements.

Improving our environment

The trust prides itself on its performance to maintain a clean environment for its patients, visitors and staff.

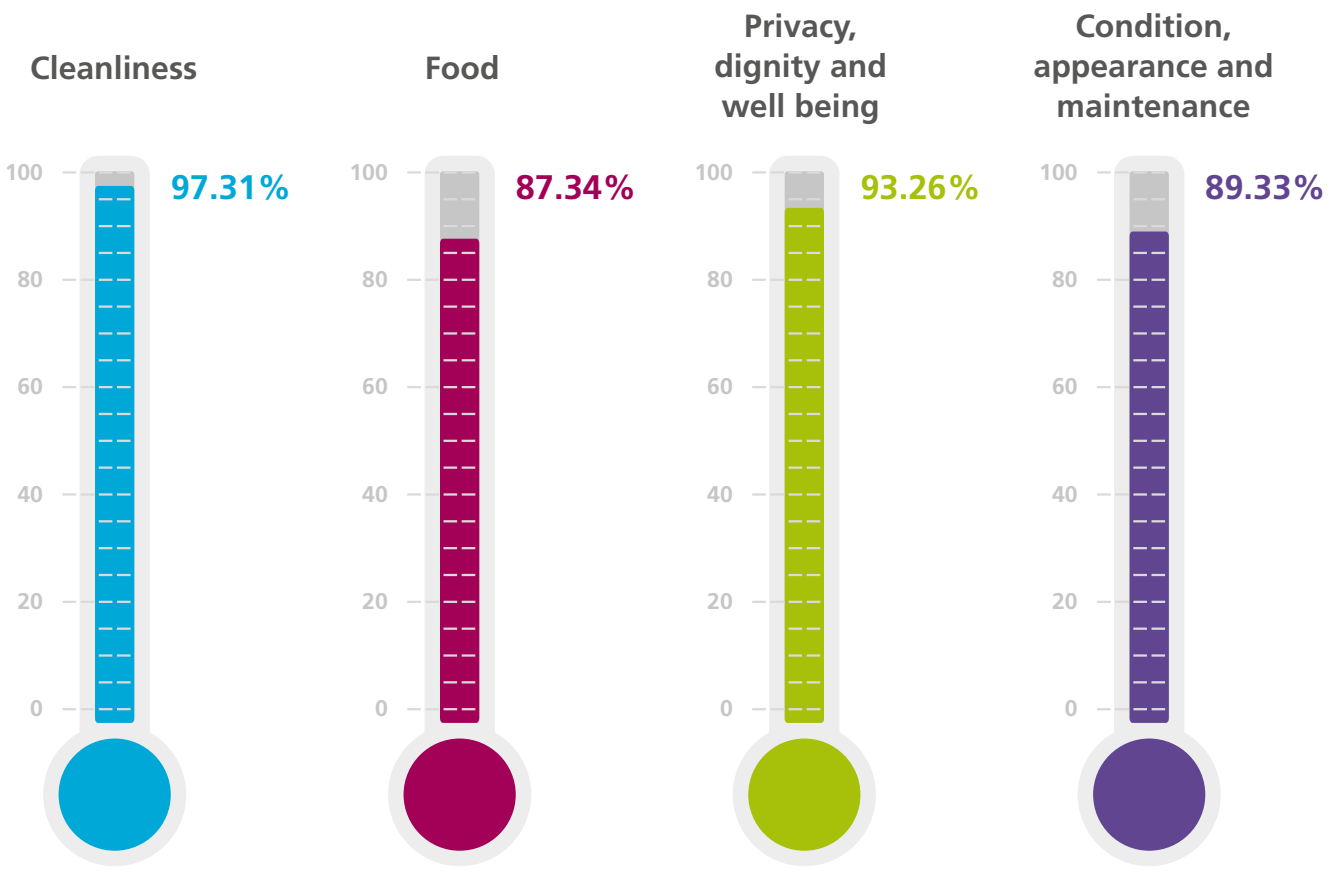
During 2013, the Patient Environment Action Team (PEAT) - which has monitored cleaning, catering and privacy and dignity since 2001 – was changed to put a greater focus on becoming patient-led.

Patient-led assessments of the care environment - or PLACE - is the new measure and the annual assessment is more reliant on patient input and scrutiny.

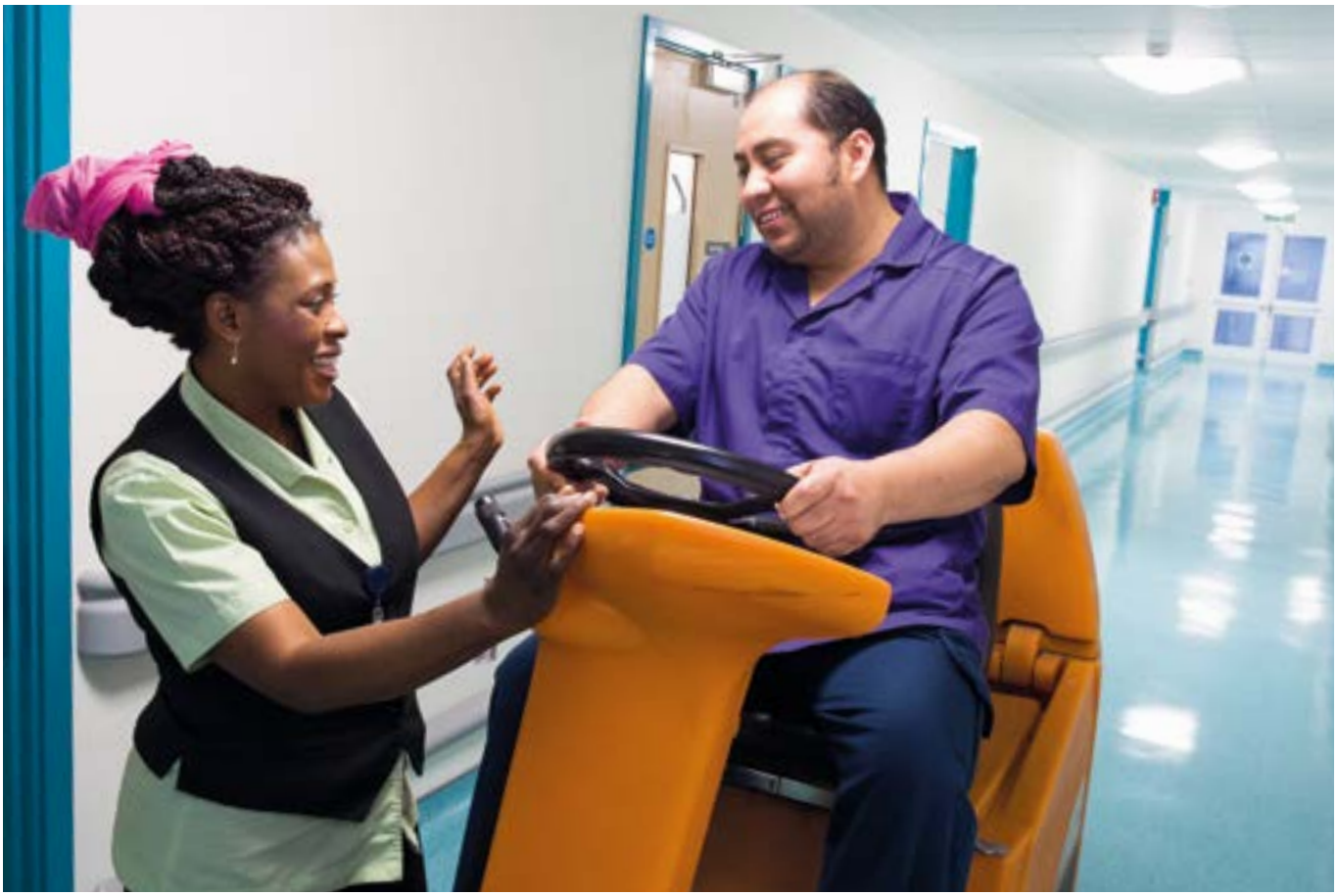
Three measures have become four, with the trust performing well compared to other similar trusts on cleanliness, food, privacy, dignity, well being and condition, appearance and maintenance.

The national average scores for each of the categories was cleanliness 95.75%, food 85.41%, privacy, dignity and well being 88.90% and condition, appearance and maintenance 88.78%.

The Royal Free performed better than average across all categories in the first annual round of PLACE.



The Royal Free performed well against the new PLACE targets



A breath of fresh air at the Royal Free

A complete smoking ban was reinforced across all our sites from March 2014. Patients, visitors and staff have not been permitted to smoke anywhere on the trust site since 2005 and a number of processes have been put in place to improve compliance.

We prepared for a re-launch of the policy with new signage, clear demarcation of site boundaries and a deep clean of the grounds.

A leaflet campaign informed patients, visitors and staff. Details of our smoke-free vision were published on the website and included an online survey to feed back views.

Food for thought

The media spotlight was on the Royal Free when work continued with celebrity chef James Martin to refresh our hospital menu.

The celebrity host of *Saturday Kitchen* worked alongside our in-house catering team to launch a new range of fresh soups and salads for patients, visitors and staff.

Series three of the BBC's *Operation Hospital Food* returned to the Royal Free to review progress and patient feedback, which was excellent.

Jeremy Sharp, our director of facilities joined James Martin at a special Royal College of Nursing event to talk about the project with more than 140 other hospital trusts, sharing good practice at the Royal Free across the NHS.

Making the environment a priority

Our carbon reduction strategy reflects the ambition for the NHS to help drive change towards a low carbon society.

Since the strategy was introduced in 2008, the Royal Free has reduced its annual carbon emissions by about 4,500 tonnes to 27,300 tonnes. Our updated strategy will take the trust through to 2020 and reduce our emissions by a further 5,116 tonnes. This equates to a financial saving of £444,000 over the same period and reflects our corporate responsibility to lead by example in the community we serve.

During 2013/14 we:

- Collaborated on a district heating system in a joint initiative with energy management company MITIE and Camden Council. The first phase of this scheme uses waste heat from our heat and power plant to heat around 1,500 local homes and is projected to reduce carbon emissions in the borough of Camden by about 2,800 tonnes each year
- Won an energy efficiency funding bid to upgrade central plant heat recovery of waste heat and improve the controls over hospital cooling, improve the energy efficiency of our steam distribution system and to install energy efficient light emitting diode (LED) lighting and occupancy sensors
- Increased secure bicycle parking with the help of Transport for London
- Installed two electric vehicle charging points
- Took part in National Climate Week and NHS Sustainability Day by communicating our carbon awareness themes
- Launched a 'Switch Off For Christmas' campaign, which demonstrated that a 3% saving in electricity could be achieved
- Set up a sustainability development management group, chaired by Caroline Clarke, the deputy chief executive, consisting of decision makers from across the trust.

Emergency planning – resilience and response

We continue to take steps to help us prepare for an emergency and cope if a major incident happens.

We have built upon on the considerable work undertaken with our partners across the capital for the 2012 London Olympic games.

Highlights of 2013/14 have included a new training programme for staff likely to act as an incident commander in an emergency.

Training harnesses the knowledge of specialists within the trust, as well as the knowledge of more experienced incident commanders and covers the areas on which decisions need to be made, whether in reaction to internal issues such as infrastructure, infection control or staffing or external issues such as a major incident in the community.

A new e-learning framework for emergency planning training was introduced to provide a measurable record of learning across all staff.

It includes details on how to react during an incident - such as access to local plans - and advice on what to do if a major incident occurs.

Major incident exercises

We ran a number of major incident exercises - including three large-scale hospital exercises – at a level above and beyond that expected by national guidelines.

In the final exercise, our performance rated highly against national standards and in comparison with other major incident receiving hospitals.

We trained a further wave of potential future commanders and carried out a number of smaller scale exercises, including a potential loss of community electricity supply, the security lockdown of the hospital site, links to Barnet hospital and training around intensive care.

We introduced a new policy to look at how we will meet the standards in emergency planning required by clinical commissioning groups through our annual contracts, the new international standard on societal security and the NHS England core standards.

It also allows directors and other stakeholders, such as fellow responders, to be appraised on progress and future plans and names the executive director of operations as the trust director-level lead: a post known under NHS guidance as the accountable emergency officer.

We worked with stakeholders through the local authority-led borough resilience forums in Camden and Barnet, the Barnet CCG-led urgent care working group and the submission of evidence against the NHS England core standards for this area of activity.

Plans into action

We put our plans into action during the London-wide response to the Apollo Theatre ceiling collapse.

We assisted by treating patients not involved in the incident to relieve pressure on the other hospitals taking the casualties.

We continually review and learn from our experiences to improve emergency plans for the future and are well placed to make a positive contribution to the safety of the wider London community.

Playing our part in the local NHS

Plans for a new, enlarged trust

During the past year, detailed planning for our proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust has taken place.

In June 2014 Monitor is due to report on its three-month assessment of the risks of the acquisition and our council of governors and board will consider its findings at meetings in early June. If approved by the secretary of state, we expect the expanded organisation to come into being on 1 July 2014.

An enlarged organisation would be able to deliver even better care to our patients.

The expanded trust is being designed by the clinicians of both existing trusts, closely working with commissioners, local GPs and representatives from our local population. The overriding aim is for the joining of the two trusts to build upon the best of both organisations.

Social and community matters

We have continued to mature and develop productive relationships with our local community health and social care teams to allow us to work together to deliver innovative solutions to improve patient care.

An example of this is our post-acute care enablement (PACE) service which has continued to flourish this year.

This integrated team brings together staff from five organisations: the Royal Free, Central London Community Healthcare NHS Trust, Central and North West London NHS Foundation Trust and Barnet and Camden councils.

We work together to ensure patients who in the past would have been admitted to hospital can instead receive that care at home, while still remaining under the care of their hospital consultant.

Regardless of employer, PACE team members view themselves as one team, working to deliver excellent care to patients along seamless pathways.

The service has been further enhanced in 2013/14 through our partnership with the Royal Voluntary Service to provide befriending and transitional support to patients as they move from hospital to their home.

Other examples of how we work together with community providers are included in 'our partners', the next section of this report.

The inevitable challenges that we all face as a result of the economic climate continue. The changes in the community health and social care sector have had an impact on our ability to pursue gold standard pathways of care in all areas.

We have accessed investments in community services to reduce the need for hospital admission. These services take time to develop and their actual impact is still to be determined.

We have continued to face challenges with availability of community based in-patient beds, meaning some patients stay in hospital after their main treatment has been completed.

An enlarged organisation would deliver even better care.

This is coupled with an increase in patients being admitted for social care reasons, when they are no longer able to cope at home. The hospital becomes the place of safety for these patients although it is not necessarily the optimal environment for them.

To assist with best use of community beds, the Royal Free opened an enablement ward in the latter part of 2013/14 to help patients stay as fit as they are able while they wait for rehabilitation beds.

Early indications are that some patients improved enough on the ward to enable them to go home with support rather than move to a community bed. This is much preferred by patients and saves money.

It is clear patients who used to use other hospitals are now choosing the Royal Free and we are developing new relationships with community and social care partners who we have not worked with before to further improve the care of our patients.

Specific developments have included timely discharge planning and escalation pathways.

Our partners

We want to ensure that our services are arranged around the patient and deliver good value for taxpayers' money.

We cannot do this without building strong relationships with our partner organisations in north central London, including CCGs, specialist commissioners, other hospitals, mental health trusts, GPs, social care and voluntary sector organisations.

In addition to a wide range of integrated pathways designed and implemented across Barnet we have continued to play a key role in the development of the Camden integrated care service (CICS), a partnership between Camden CCG and the main clinical and social care providers in Camden.

Key services that we are actively involved with through CICS include:

- diabetes
- frailty – including a consultant-led team approach to case management of patients (which has also been implemented in Barnet) as well as community consultant geriatrician clinics
- chronic obstructive pulmonary disease
- heart failure.

An early evaluation of the impact of the services has been positive with clear improvements in reductions of unplanned care and multiple appointments for frail patients.

The portfolio will continue to be expanded and developed through business cases in partnership with other Camden providers.

Further integrated care pathways

Our focus on integrated pathways across organisational boundaries has been further demonstrated through our work on 'my discharge,' a scheme governing the discharge of patients with dementia.

This service brings together eight partner organisations in a single pathway of care for one our most vulnerable groups of patients. By providing a personalised service in partnership with the patient, their carer and health, social and voluntary organisations, we are able to discharge patients in a safe, personalised and dignified way and prevent re-admission.

The evaluation of the first nine months has shown demonstrable reductions in unplanned admissions and the amount of time patients spend in hospital. In addition, more patients with dementia are being supported at home.

This service has received recognition for its innovative approach to quality and safety with an award from the Health Foundation.

Working together with GPs

Considerable work continues to address the feedback by our GP colleagues received during practice visits.

Electronic discharge summaries and radiology results are now sent to most Barnet and Camden GP practices as well as many practices in Enfield, Haringey and Islington.

We have a dedicated email account, website and phone number for GPs. All these forms of communication are increasingly being used to address queries immediately, finding solutions to problems faster.

This work is supported by Dr Mike Smith, our clinical director for primary care, a local GP working with us on service improvement.

We have continued to receive positive feedback from both Barnet and Camden GPs about how things are working between us.

Engagement with our communities

As we have seen above, strong relationships with our partners and the local community are vital to providing high quality care for patients.

This year we have seen a major engagement programme and more communication with our communities and stakeholders than ever before.

As outlined earlier, one focus of work has been the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust, in which the best of both organisations will be built upon for the benefit of local people.

Senior clinicians and managers at both trusts have been working closely together to establish the benefits to patients of creating an expanded trust.

We believe that our acquisition of Barnet and Chase Farm would bring the Royal Free expertise closer to patients, improve our research programme and enable us to better prepare the clinicians of tomorrow.

We have attended numerous meetings to share information about future developments, explain our plans and gather valuable feedback, including local overview and scrutiny committees, health and well being boards and meetings of the independent consumer champion Healthwatch.

Local residents

Listening to the views of local residents is key to the future of the Royal Free.

We have focused on consulting widely for the opening of our new Institute of Immunity and Transplantation and this will increase as we plan for phase two of the pioneering centre and a major refurbishment of our A&E.

There will be meetings with residents' associations to discuss plans and developments throughout the institute planning application process and we will keep patients closely informed about our plans for A&E.

We seek the views of our patients through our patient user experience committee, regular workshops and special events and information is regularly updated on our website, through leaflet campaigns and displayed on information screens around the hospital.

As a foundation trust, we work in close partnership with our council of governors, elected by our members. We have a well-attended programme of events for our members, enabling them to stay up to date with clinical developments and give their views on our plans for services.

Environment liaison group

The bi-annual environment liaison group has gone from strength to strength.

Our trust chairman meets with local residents' associations to discuss matters of local interest with our neighbours. During 2013/14, this has included phase two of our new institute and the planned major refurbishment of A&E.

Supporting our dedicated staff

Our success in delivering high quality patient care is attributed to the commitment of our motivated and forward thinking staff who aim to put patients at the centre of everything they do.

We employ more than 5,400 staff, including 800 doctors and 1,400 medical and midwifery staff.

Our World Class Care values

At the Royal Free, our ambition is simple: to offer our staff and patients world class care and expertise.

Our World Class Care (WCC) values were devised by our patients and staff and are used to help ensure that we deliver world class care to every patient, every colleague, every day. They are to be positively welcoming, actively respectful, clearly communicating and visibly reassuring with every one of our patients.

The values were developed in 2011 by involving patients in listening events - called 'in your shoes' - and members of staff.

Discussions with our staff focused on how improvements could be made in the patient experience or our services and also the staff's own experience.

When we launched our World Class Care values 1,700 members of staff attended briefing sessions on launch day.

Training sessions introduced the values to teams and 3,181 members of staff – 63% of the workforce - attended. Staff then took the actions from the half-day session back to their areas of work for discussion and implementation.

Embedding the values

During 2013, our corporate induction and the recruitment, probation and appraisal policies and procedures have been reviewed to ensure they aligned with the ethos.

In recruitment, new staff are now selected based on whether they meet our World Class Care values as well as their knowledge, skills and experience.

Work continues to ensure that potential candidates are aware of and endorse the values, helping to make the Royal Free a fair, diverse and desirable place to work.

Our corporate induction is now built around the World Class Care values, giving all new starters an insight into what they mean and how they were developed and are applied. The programme has shifted its focus to welcoming and reassuring new staff rather than only meeting mandatory and statutory training requirements.

The appraisal process has also been updated to ensure that all staff are appraised against the values in addition to work objectives. Documentation makes this more user friendly and staff are given more relevant training in the new process.

We reviewed the probation process to include our values as part of the performance measures against which new starters are measured. The values are now included in the first formal review and final review.

Our quarterly World Class Care awards acknowledge and celebrate the work being done by both individuals and teams.

Staff are nominated for this award based on how they improve patient care through the values.

Workshops were held as part of our 'licence to lead and manage programme' to ensure that managers adopted appropriate management styles to support the values. These workshops were rolled out in targeted areas across the trust where bullying and harassment was highlighted as an issue.

CELEBRATING
THE ACHIEVEMENTS OF OUR STAFF

We celebrated the achievements of staff at our annual staff achievement awards.

Linked to our World Class Care values, staff were nominated for an award by their colleagues and a special event was held to celebrate and recognise their hard work and continued commitment.

- One of our specialist dementia occupational therapists was awarded for her work for dementia patients and helping with training volunteers in dementia awareness.
- One of our clinical nurse specialists acts as the point of contact for all lung cancer patients as well as being the liaison between general practice, thoracic surgery, thoracic medicine and oncology. She ensures that all patients being investigated for cancer have a realistic idea of how long the process will take and that all the investigations are completed in a timely manner.
- A manager in organisational development operates an open door policy even though this means she is constantly disturbed; she is always positive and fair to all. She keeps staff morale high and is an inspirational manager.
- The A&E nursing team ensures the patient experience is as positive as possible, while ensuring performance indicators are being met in the most demanding environment in the trust.
- The deep clean team is vital in the fight against hospital acquired infection and always provides an excellent planned and reactive service to meet the demands of the trust.

Engaging with our staff

Staff engagement is essential if we are to ensure excellence in patient care.

The national staff survey placed the Royal Free in the top 20% of UK acute trusts for staff engagement and shows continuous improvement in this area.

We have a staff engagement policy which sets out in detail how we engage with staff to ensure a positive experience for patients and staff. The policy:

- Actively encourages a two-way dialogue on improving organisational performance with clearly set goals, targets and current challenges
- Engages staff in organisational, service and individual changes which may affect them
- Provides effective management support and personal development to support staff performance
- Supports staff so they remain healthy and safe.

We communicate with staff regularly through a variety of key channels such as:

- Freemail – a weekly bulletin sent to all staff via email
- Freepress – a quarterly staff magazine distributed to all sites
- Chief executive briefings – a monthly face-to-face brief from the chief executive open to all staff which is then also communicated through video and written channels on the intranet
- Team brief – a two-way messaging system encouraging team meetings to hear and give feedback on the key messages in the chief executive's briefing
- Freenet – the intranet available to staff across all sites which is updated daily.

The Royal Free actively encourages two-way communication. Our communications staff have affiliations with each of the key divisions to provide continuity and immediate support.

Each division and department has been involved in a series of listening events to hear from staff about their experiences of working at the Royal Free. This is in direct response to the Francis report, an independent report into the quality failures in Mid Staffordshire. Action plans are drawn up by each department to implement agreed actions and make any service improvements. These were reported at the annual members meeting by the medical director and director of nursing as part of the trust's response to the Francis report.

NHS staff survey

The annual national NHS staff survey was conducted between September and December 2013.

The 2013 survey marked the 11th annual national survey of NHS staff and was responded to by 203,000 NHS staff nationwide.

The survey was distributed to a sample group of 850 staff across all divisions, directorates and staff groups at the Royal Free.

The response rate was 54%, which matched the response rate for 2012 and is above the national average of 49% for trusts in England.

Summary of our results

The national staff survey results placed the Royal Free in the top 20% of trusts for staff engagement with a score of 3.87 (out of a possible 5) against a national average of 3.74 and shows continuous improvement from the 2012 position of 3.82.

The engagement score is calculated using three key question outcomes around staff ability to contribute towards improvement, staff recommendation of the trust as a place to work and staff motivation at work. The trust scored in the highest 20% for the first two questions and above average for the third.

Our results continued to improve with this year seeing positive movement in the following areas:

- The percentage of staff appraised rose from 78% in 2012 to 91% in 2013 (national average 84%), although it should be noted that actual achievement for staff appraisals was 76%.
- The percentage of staff receiving health and safety training in the past 12 months rose from 66% in 2012 to 76% in 2013 (national average 76%)
- The percentage of staff reporting good communication between senior management and staff rose from 29% in 2012 to 36% in 2013 (national average 29%).

There were a number of areas that improved on the previous year, however improvement was not significant enough to position the trust to be better than the national average as follows:

- The percentage of staff suffering work related stress in the past 12 months reduced by 2% from 40% in 2012 to 38% in 2013 (national average 37%)
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months reduced by 6% from 38% in 2012 to 32% in 2013 (national average 29%)
- The percentage of staff experiencing harassment, bullying or abuse from staff in the past 12 months decreased by 4% from 38% in 2012 to 34% in 2013 (national average 24%)
- The percentage of staff feeling pressure in the past three months to attend work when unwell reduced by 3% from 33% in 2012 to 30% in 2013 (national average 28%)
- The percentage of staff believing the trust provides equal opportunities for career progression or promotion increased by 2% from 78% in 2012 to 80% in 2013 (national average 88%)
- The percentage of staff experiencing discrimination at work in the past 12 months decreased by 2% from 23% in 2012 to 21% in 2013 (national average 11%).

Areas for improvement 2013 to 2015

Results of the staff survey suggest that we are having a positive impact on staff experience, but further work is needed.

Our staff experience improvement plan (SEIP) was developed following the 2012 staff survey results and has provided a clear focus for effort and resources to address the most prominent findings from the survey. It focuses on four work streams: appraisal, bullying and harassment, health and well being and world class care.

This year's survey results would suggest the plan is having a positive impact on staff experience at work.

The key areas for improvement will continue to support improvements in the required areas identified by the survey. In addition we will focus on equal opportunities for career progression or promotion and scrutinising data by division to tackle identified hotspots.

NHS staff survey – summary of performance

	2013		2012		Our improvement/ deterioration
Response rate	Royal Free	National median	Royal Free	National median	
	54%	49%	54%	50%	Unchanged

	2013		2012		Our improvement/ deterioration
Top four ranking scores	Royal Free	National median	Royal Free	National median	
Staff agreeing that their role makes a difference to patients	95%	91%	93%	89%	2% improvement
Staff feeling satisfied with the quality of work and patient care they are able to deliver	85%	79%	84%	78%	1% improvement
Staff having a well structured appraisal in the past 12 months	46%	38%	42%	36%	4% improvement
Staff experiencing physical violence from patients, relatives or the public in the past 12 months	12%	15%	11%	15%	1% deterioration

	2013		2012		Our improvement/ deterioration
Bottom four ranking scores	Royal Free	National median	Royal Free	National median	
Staff experiencing harassment, bullying or abuse from staff in the past 12 months	34%	24%	38%	24%	4% improvement
Staff experiencing discrimination at work in the past 12 months	21%	11%	23%	11%	2% improvement
Staff saying hand washing materials are always available	43%	60%	37%	60%	6% deterioration
Staff believing the trust provides equal opportunities for career progression or promotion	80%	88%	79%	80%	1% improvement

Promoting equality and diversity

Our priority is to develop a culture which values each person for the contribution they can make to our services for patients.

Our equality and diversity policy, agreed by our board and unions, aims to ensure that 'no present or future employee or job applicant receives less favourable treatment (whether actual or perceived) or on the grounds of an association with someone who may fall under a protected characteristic'.

Our approach is mindful of the nine protected characteristics – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) and sexual orientation.

During 2013/14 we introduced further enabling systems, processes and forums aimed at proactively encouraging and promoting equality of opportunity across the organisation.

Our annual equality diversity report highlights our progress and illustrates the practices adopted to endorse the workforce equality and diversity agenda. It demonstrates how equality is embedded within all employment policies and procedures within the organisation to help to eliminate inequality of access and promote a rich and diverse workforce.

Equality and diversity training at the Royal Free is mandatory at induction. Our compliance rate during 2013/14 was 87%.

Equal opportunities

The trust takes equal opportunities very seriously in its recruitment and is clear in its policies and procedures that no job applicant should receive less favourable treatment on the grounds of their sex, sexual orientation, marital status, race, religion, age, creed, colour, nationality, national origin, ethnic origin or disability, nor be disadvantaged by any conditions or requirements which cannot be shown to be justified.

We give a guaranteed interview to disabled candidates under the Positive About Disabled People 'two-ticks' scheme. We are also a Stonewall Champion promoting lesbian, gay, bisexual and transgender diversity. Policies and procedures are in place to combat any discrimination in employment too.

For members of staff who develop a disability during their employment, there are appropriate arrangements for support from our safe effective quality occupational health service (SEQOHS) accredited occupational health, including advice and assistance on any appropriate work readjustment.

Our equality objectives

In line with the Department of Health's equality delivery system, we have agreed - in partnership with our unions – to focus on the following key objectives for 2013 to 2015, which build on the valuable foundations already in place at the Royal Free:

- To provide a working environment that is free from abuse, harassment, bullying or violence
- To ensure that staff are aware of the appropriate mechanisms for raising concerns
- To eliminate discrimination in all aspects of an employee's working life.

During the past year, the equal opportunities monitoring group, consisting of managers and staff side representatives, has also been established and now meets quarterly to monitor the implementation of the equality delivery system and the related workforce equality objectives.

Our 2013 staff survey results indicate we are starting to head in the right direction in relation to the first objective. However, we recognise there is much more work to do in the year ahead to embed the pathway and review practices to help support achievement of both objectives.

Special events

To celebrate with our vibrant and diverse workforce, we took part in Black History Month during which our different food vendors supplied a range of traditional foods.

To mark International Day for People with Disabilities we held a session with employment law experts on how to work with staff who are disabled.

We celebrated the achievements of lesbian, gay, bisexual and transgender (LGBT) people during national LGBT month by launching a new network for staff. We have plans to embed the network in 2014/15.

Further details about our equality and diversity work can be found in our equality report on the hospital's website.

Employment matters

We held a well being day to promote the availability of support for staff at the Royal Free. Around 500 members of staff attended this event, which included:

- Health and work centre for occupational health and psychological interventions
- Care First - our employee assistance programme
- A mediation service - co-ordinated by Care First.

We reviewed our whistle-blowing policy for staff. This highlights the legal protections that apply to staff who have concerns to raise about the safety of their working environment or about an employee's professional behaviour.

In order to support this work, awareness of fraud and staff security is included as part of the mandatory training programme. This is completed during the Royal Free's induction for all new members of staff.

Revising our workforce policies

We revised our bullying and harassment policy during the year, introducing a new pathway to support staff and four ways of helping staff to deal with behaviour that they felt constituted either bullying or harassment.

Our workforce department held 20 briefing sessions during 2013/14 to promote the policy across the organisation, with nearly 1,000 staff attending.

Our maternity leave policy was revised to make the procedure clear for expectant mothers and our special leave policy was amended to comply with legislative changes, in particular to reflect the changes to parental leave.

In anticipation of the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust, a joint partnership group consisting of union and management representatives has been formed.

The group is responsible for reviewing and harmonising key workforce policies. Best practice between the two organisations has been shared and adapted for the new organisation.

During the year, the managing attendance and sickness absence policy and the appraisal and pay progression policy have been harmonised, with many others in progress.

Strong leadership for a successful future

Strong leadership is critical to the success of our organisation and responsibility is shared at all levels, from the board through to the wards.

A total of 108 managers attended the Royal Free's licence to lead and manage programme in 2013/14. This provides skills and knowledge that enable managers to lead, manage and coach their teams to support or deliver patient care.

A wide range of subjects is covered, which staff can choose from depending on their own developmental needs or those identified with their manager.

Helping managers to lead, manage and coach their teams.

This is supplemented by an online leadership toolkit, developed to provide tools and techniques to help those with responsibility for leading others carry out their role more effectively. London Leading for Health Partnership has adopted the toolkit and it will appear on their website from April 2014.

Foundation year two doctors and managers from other staff groups participate in an Introduction to Leadership in the NHS programme, which includes a series of taught sessions and culminates with multi-disciplinary groups presenting a service improvement project that they have delivered during the programme.

We have piloted two paired-learning leadership programmes in 2013/14, the first of which was presented at a London-wide event by the Royal Free's organisational development department.

The second programme is due to finish in June 2014 and is made up of foundation year one doctors and staff from other staff groups embarking on their leadership journey. It also includes delivery of a service improvement project.

Currently, 11 staff are supported by the organisation in undertaking the NHS Leadership Academy Mary Seacole programme – leading care I and two staff members are undertaking the Nye Bevan - leading care III programme, both of which are highly competitive.

For senior leaders there are quarterly leadership forum meetings to explore key, strategic topics and the clinical directors' development programme is aimed specifically at maximising the skills of the clinical directors in the divisions.

This programme aims to support clinical directors in operating strategically, to lead complex change, negotiate with senior managers and across the NHS community, work across disciplines and manage clinical and non-clinical staff. It offers them an opportunity to consider the leadership challenge in the context of the current climate in the NHS and to explore options for service improvement.

In addition the trust holds monthly Schwartz Centre Rounds® for all staff, both clinical and non-clinical. these were developed in the United States to improve relationships between clinical caregivers and their patients. They accomplish this by providing support to caregivers, developing their insight into non-clinical aspects of care and enhancing communication and teamwork among caregivers.

A management conference for sisters and charge nurses was attended by 60 staff and covered a range of management and leadership topics in both plenary and break-out sessions. Due to its popularity, it is proposed to run this twice a year in future.

Occupational health at work

During 2013/14, our health and work centre (HaWC) concluded its work towards gaining the SEQOHS accreditation.

We met the standards and received our accreditation in the third quarter of 2013/14.

A new policy on managing sickness absence was introduced, to increase the support given to staff who are unwell by ensuring that more regular and rigorous reviews of sickness absence are carried out by managers.

The HaWC has ensured that the demand for increased numbers of sickness absence referrals has been responded to.

There were 971 referrals in 2013/14, a significant increase from 730 referrals during the previous year.

This is a direct result of more proactive management support to encourage those absent to return to work if occupational health felt it appropriate.

Staff at the centre continued to be involved in supporting work to address the high reported levels of bullying and harassment and has proactively helped to establish the new offer of facilitated conversations. Requests have been rising month on month since summer 2013.

Our team has assisted in identifying areas with higher reporting of these problems and has ensured that our employee assistance programme providers are integrated into all initiatives to support staff. A total of 132 staff contacted our employee assistance programme in the first eight months of the year.

Once again, we co-ordinated the flu vaccination programme for staff across the trust. Despite one of the warmest winters in recent memory, over 50% of staff were vaccinated.

We have reviewed our approach to pre-employment health screening to ensure that staff are screened and cleared as fit for work faster than ever before.

Together with work undertaken in the workforce recruitment teams, this has seen the time needed for pre-employment checks significantly reduce from a high of 41 days to a new average of 13 days (in quarter 4), delivering safe, competent staff to the wards where they can better serve the needs of our patients.

The centre is leading on the review of the existing well being policy to address and support staff working additional hours in a safe way.

A new strategy is being prepared, and together with the public health team, we have commissioned an external review of our health and well being approach to ensure that we are able to continue to make improvements in this area.

Bullying and harassment in the workplace

Everyone should be treated with dignity and respect at work and we have worked extensively to ensure staff and aware of our bullying and harassment pathway, introduced last June.

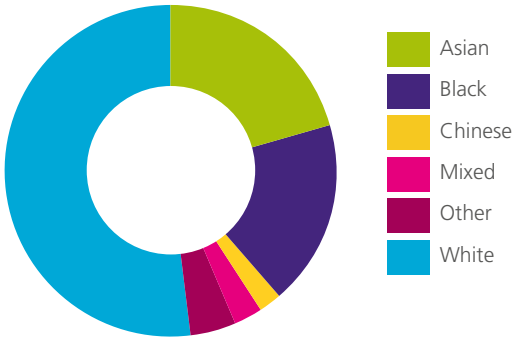
Our staff experience and improvement plan SEIP aims to reduce the percentage of staff experiencing bullying and harassment to no more than the national average by 2014.

Results from the 2013 annual staff survey showed an improvement, with the percentage of staff experiencing harassment, bullying or abuse falling by 4% from 38% in 2012 to 34% in 2013 against a national average of 24%.

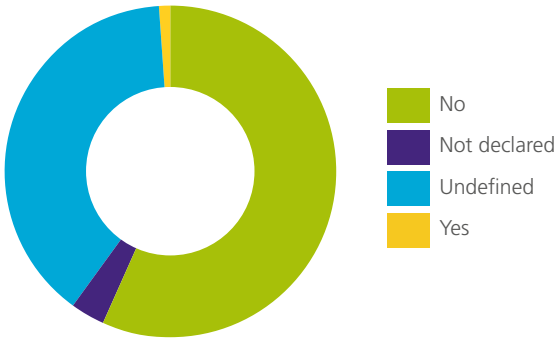
Everyone should be treated with dignity and respect at work.

Our workforce as at 31 March 2014

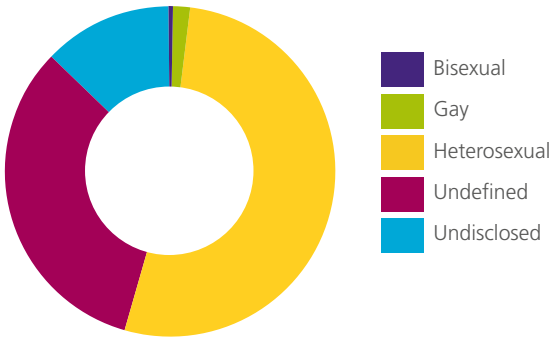
Gender	Trust total	% of trust total
Female	3821	69.89%
Male	1646	30.11%
Total	5467	100%



Ethnic origin	Trust total	% of trust total
Asian	1132	20.71%
Black	990	18.11%
Chinese	113	2.07%
Mixed	152	2.78%
Other	255	4.66%
White	2825	51.67%
Total	5467	100%

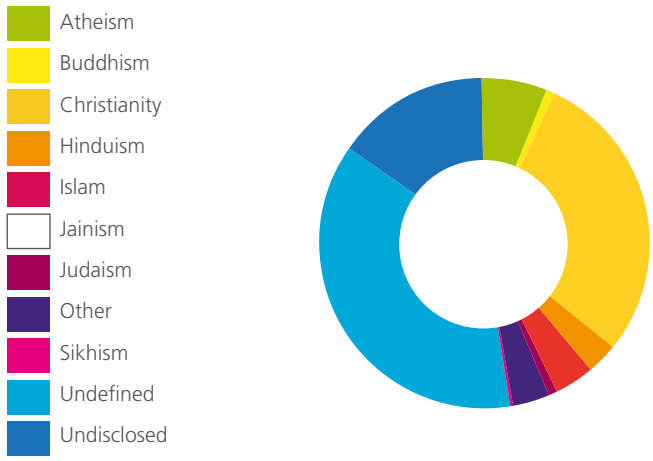


Disability	Trust total	% of trust total
No	3113	56.94%
Not declared	172	3.15%
Undefined	2123	38.83%
Yes	59	1.08%
Total	5467	100%

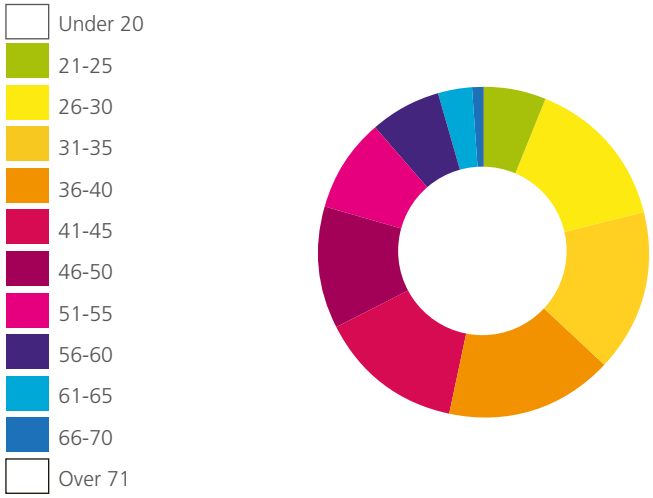


Sexual orientation	Trust total	% of trust total
Bisexual	25	0.46%
Gay	93	1.70%
Heterosexual	2871	52.52%
Undefined	1792	32.78%
Undisclosed	686	12.55%
Total	5467	100%

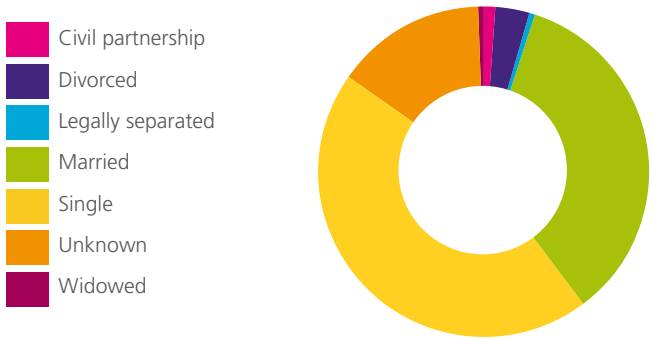
Religion/belief	Trust total	% of trust total
Atheism	343	6.27%
Buddhism	41	0.75%
Christianity	1590	29.08%
Hinduism	161	2.94%
Islam	214	3.91%
Jainism	4	0.07%
Judaism	47	0.86%
Other	192	3.51%
Sikhism	16	0.29%
Undefined	2026	37.06%
Undisclosed	833	15.24%
Total	5467	100%



Age profile	Trust total	% of trust total
Under 20	8	0.15%
21-25	339	6.20%
26-30	813	14.87%
31-35	868	15.88%
36-40	896	16.39%
41-45	780	14.27%
46-50	651	11.91%
51-55	503	9.20%
56-60	374	6.84%
61-65	184	3.37%
66-70	39	0.71%
Over 71	12	0.22%
Total	5467	100%



Status	Trust total	% of trust total
Civil partnership	69	1.26%
Divorced	177	3.24%
Legally separated	28	0.51%
Married	1901	34.77%
Single	2461	45.02%
Unknown	803	14.69%
Widowed	28	0.51%
Total	5467	100%



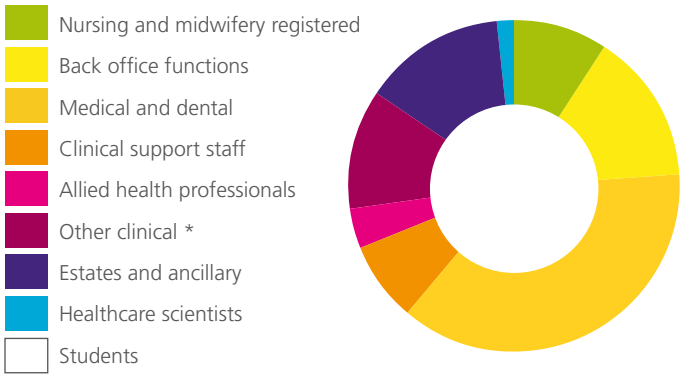
Length of Service with Royal Free	Trust total	% of trust total
Less than 1 year	1247	22.81%
1 to 2 years	515	9.42%
2 to 5 years	1184	21.66%
5 to 10 years	1193	21.82%
More than 10 years	1328	24.29%
Total	5467	100%

Employees on maternity leave	Trust total	% of trust total
Nursing and midwifery registered	43	28.86%
Medical and dental	25	16.78%
Back office functions	24	16.11%
Allied health professionals	17	11.41%
Clinical support staff	16	10.74%
Other clinical*	15	10.07%
Healthcare scientists	8	5.37%
Estates and ancillary	1	0.67%
Students	0	0.00%
Total	149	100%

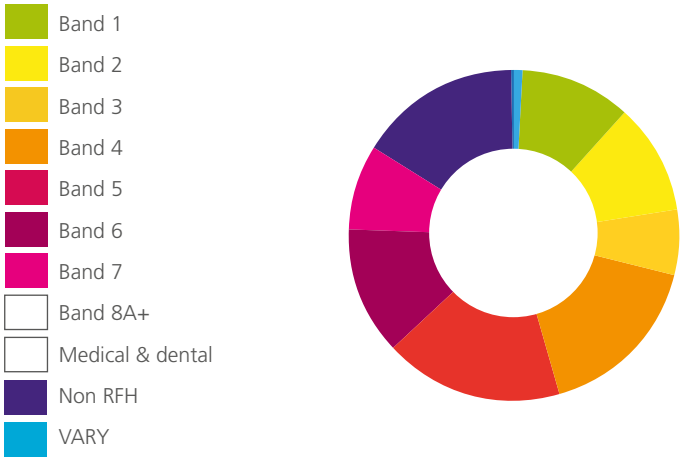
Part time female employees	Trust total	% of trust total
Nursing and midwifery registered	237	29.15%
Back office functions	193	23.74%
Medical and dental	102	12.55%
Clinical support staff	97	11.93%
Allied health professionals	79	9.72%
Other clinical *	42	5.17%
Estates and ancillary	38	4.67%
Healthcare scientists	25	3.07%
Students	0	0.00%
Total	813	100%

* Includes chaplains, clinical Psychologists, optometrists, pharmacists, practitioners, psychotherapists, social workers & technicians

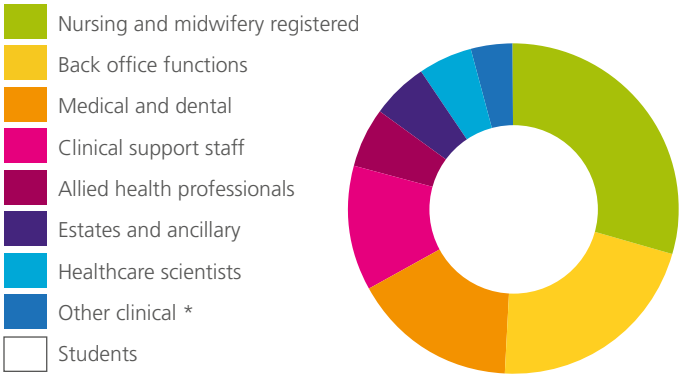
Part time male employees	Trust total	% of trust total
Nursing and midwifery registered	12	9.30%
Back office functions	19	14.73%
Medical and dental	48	37.21%
Clinical support staff	10	7.75%
Allied health professionals	5	3.88%
Other clinical *	15	11.63%
Estates and ancillary	18	13.95%
Healthcare scientists	2	1.55%
Students	0	0.00%
Total	129	100%



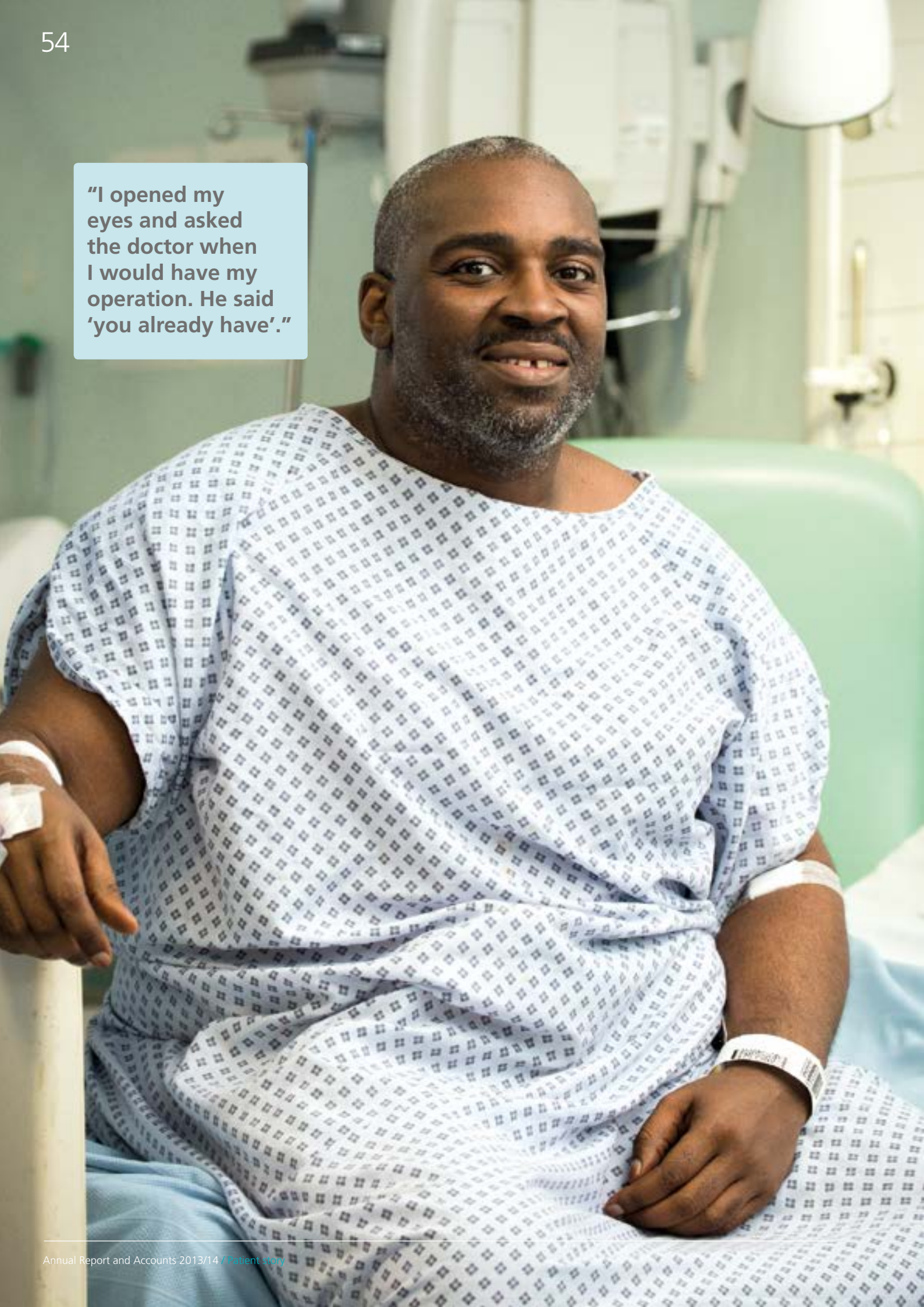
Band	Trust total	% of trust total
Band 1	59	1.08%
Band 2	590	10.79%
Band 3	583	10.66%
Band 4	359	6.57%
Band 5	901	16.48%
Band 6	958	17.52%
Band 7	685	12.53%
Band 8A+	452	8.27%
Medical & dental	875	16.08%
Non RFH	0	0.00%
VARY	1	0.02%
Total	5467	100%



Staff group	Trust total	% of trust total
Nursing and midwifery registered	1623	29.69%
Back office functions	1165	21.31%
Medical and dental	879	16.08%
Clinical support staff	664	12.15%
Allied health professionals	324	5.93%
Estates and ancillary	301	5.51%
Healthcare scientists	287	5.25%
Other clinical *	221	4.04%
Students	3	0.05%
Total	5467	100%



* Includes chaplains, clinical Psychologists, optometrists, pharmacists, practitioners, psychotherapists, social workers & technicians



"I opened my eyes and asked the doctor when I would have my operation. He said 'you already have'."

Meet Ukpong

Ukpong Anderson was a youth worker in Islington, where he lives, before he was diagnosed with an aggressive form of bowel cancer on Good Friday last year.

"I had acute stomach pain and didn't think anything more of it at the time. Of course, now looking back, I had been lethargic for a couple of months but just got on with things. Then on Good Friday 2013 I was diagnosed with stage four bowel cancer, an aggressive form of the disease.

"I had surgery at UCH followed by nine months of chemotherapy. Since then, the cancer has spread to my liver and I have come to the Royal Free for surgery to remove the growths."

Ukpong's surgery took place in the hospital's new operating theatres, opened this year, together with a new intensive care unit (ICU). Ukpong spent two days in intensive care after a five-hour operation to remove the growths from his liver.

"My experience at the Royal Free has been positive and I have had really good one-to-one nursing care in ICU since my operation. There is good communication between the nursing staff assigned to me. I'm moving to 9 west ward later today."

Meet the trust board and our council of governors

A broad coverage of knowledge and skills strengthens the effectiveness of the board.

The trust board

The trust board consists of the chairman, five non-executive directors and five executive directors, including the chief executive. They are collectively responsible for the performance of the trust. The general duty of the trust board and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

All current non-executive directors have been in post since the trust became a foundation trust and were appointed in accordance with the constitution as part of the foundation trust assessment process. The council of governors is now responsible for the appointment of non-executive directors. During 2013/14 the council voted to further extend the term of one non-executive director by a further three months and has appointed a new non-executive director who will commence in post in 2014/15 for a term of three years.

Executive directors are full-time employees who manage the daily running of the trust, but the entire board takes collective responsibility for setting our strategic direction and for holding the executive to account for the trust's performance. The board is also accountable for upholding high standards of governance and probity. The chair and non-executive directors in particular provide strategic and board level guidance and support. The council of governors holds the board to account. The Health and Social Care Act 2012 introduced amendments to the council's role, much of which came into force in April 2013.

The members of the trust board boast a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. The skills portfolio of the directors, both executive and non-executive, is wide ranging and includes international strategy, healthcare management, audit, accountancy and social care. This broad coverage of knowledge and skills strengthens the effectiveness of the board of directors, giving the trust confidence that the board is balanced, complete and appropriate to supporting the organisation in meeting its objectives.

Our directors

Non-executive directors

Mr Dominic Dodd Chairman

Appointed as non-executive director in 2006 and as the chair of the trust in July 2010.

Dominic Dodd was an executive director of the Children's Investment Fund Foundation, one of the world's largest private foundations, which funds projects to improve the lives of children living in poverty in developing countries. Before that he was a managing partner of Marakon Associates, an international strategy consulting firm, where he advised the chief executives and top management of some of the best-known companies in the UK and continental Europe.

In his capacity as chairman he is also a director of UCLPartners, Europe's largest academic health science system, of which the Royal Free is a founder member. He was appointed to the board of Permanent TSB PLC in October 2012 and to the board of Permanent TSB Group Holdings PLC in December 2012.

Mr Danny Bernstein Vice chair and senior independent director

Appointed as a non-executive director in May 2005 and vice chair of the trust board in 2009

Danny Bernstein is a chartered accountant and a former chairman of Monarch Airlines, having served as managing director and chairman from 1991 to 2009. He is also a former chairman of the Airline Group Ltd and the immediate past chairman of the British Air Transport Association.

His areas of special interest include finance, administration and elderly patients' welfare.

The council of governors voted to further extend his tenure as a non-executive director by a further three months, up to 30 June 2014.

Mr Stephen Ainger

Appointed as a non-executive director in November 2011

Stephen Ainger has had a career in energy and not-for-profit financial services and is currently chief executive officer of Partnerships for Renewables (PfR), a company which develops, constructs and operates renewable energy projects on public sector land.

Mr Ainger started his career with BP Exploration, where he worked for 24 years in the UK and overseas including postings in Brazil, Colombia, Spain, Kuwait and Venezuela. He left BP in 1999 to join the BG Group as a main board director of Transco and, latterly, group director of strategy and business development for the Lattice Group PLC (when the company was formed on demerger from the BG Group). He left Lattice in 2002 to take up the role of chief executive officer of the Charities Aid Foundation (CAF), one of the principal providers of financial services to UK charities and donors in the UK and overseas. He was CEO of CAF until 2006 and is currently a trustee of Artsadmin, an East End arts charity.

Ms Deborah Oakley

Appointed as a non-executive director in April 2011

Deborah Oakley has been involved with the NHS since 2007 as a non-executive director of NHS Camden, where she chaired the audit committee for three years. She also served as a non-executive board member of the Health Protection Agency until March 2013. She was appointed to the board of the Medicines and Healthcare Products Regulatory Agency (MHRA) in September 2012 as a non-executive director and sits on its risk and audit committee.

Deborah's career has been in the financial services industry. She worked for 20 years at Newton Investment Management as a senior fund manager and company director. She now works at Veritas Investment Management looking after private client portfolios. She combines this with her public service positions.

Deborah has been involved in a voluntary capacity with a variety of community-based organisations in Camden. Most recently she has been chair of a school parent teacher association and also works as a helper in a homeless night shelter.

Ms Jenny Owen CBE

Appointed as a non-executive director in October 2010

Jenny Owen was the deputy chief executive and executive director of adults, health and community well being at Essex County Council until the end of March 2012. Her responsibilities included deputising for the chief executive, leading on commissioning for people, partnership working for the council and specifically adult social care, libraries and adult learning. She had worked in Essex since 2004 and has 34 years' experience of working in social care.

Jenny is a past president of the Association of Directors of Adult Social Services and she co-chaired the national dementia strategy in 2009/10. She worked for 12 years at the Department of Health including as director for social care for the east of England. She is a non-executive director of the housing and care association Housing 21, where she is deputy chair of the governance committee and a member of the audit committee. She is also a member of the King's Fund advisory board.

Professor Anthony Schapira

Appointed as a non-executive director in December 2009

Anthony Schapira was appointed a consultant neurologist at the Royal Free Hospital and the National Hospital for Neurology and Neurosurgery in 1988 and was appointed to the University Chair of Clinical Neuroscience at the UCL Institute of Neurology in 1990. He is vice dean of University College London (UCL) Medical School and director of the Royal Free campus.

His research interests focus on neurodegenerative disease with special emphasis on Parkinson's disease and other movement disorders. He is one of the principal investigators on the Medical Research Council (MRC) and Wellcome Trust programme for neurodegenerative diseases (£5.9million) and is the principal investigator of a MRC centre of excellence in neurodegeneration (COEN) award.

During his career he has won various awards for his research and was elected a fellow of the Academy of Medical Sciences in 1999. He was appointed to the board of the Ministry of Justice, Office of the Public Guardian, in 2012.

Length of appointments

Name	Date appointed	Termination of appointment
Dominic Dodd	Non-executive director – 2006 Chair – July 2010	Second term (as non-executive director) ends 7 July 2014
Danny Bernstein	Non-executive director – May 2005 Vice chair – 2009	Second (extended) term ends 30 June 2014
Stephen Ainger	Non-executive director – November 2011	First term ends 31 October 2015
Deborah Oakley	Non-executive director – April 2011	First term ends 31 March 2015
Jenny Owen	Non-executive director – October 2010	First term ends 30 September 2014
Anthony Schapira	Non-executive director – December 2009	Second term ends 30 November 2016

Executive directors

Mr David Sloman
Chief executive

David Sloman has been chief executive for nearly four years. He was formerly chief executive of the Whittington Hospital NHS Trust and before that he was chief executive of NHS Haringey. He has spent his career in healthcare management, most of it in the NHS, although he worked for a number of years in the private healthcare sector.

David is a member of the UCLPartners executive team and the North Central and East London Local Education and Training Board and is the chair of the Central and East London Comprehensive Local Research Network.

Ms Caroline Clarke
Director of finance and deputy chief executive

Caroline Clarke was formerly director of strategy at NHS North Central London. Prior to that she was an associate partner in KPMG's health strategy team. She has spent most of her career in NHS finance, having been director of finance at the Homerton University Hospital NHS Foundation Trust and City and Hackney Primary Care Trust. In 2012, she was made the finance director of the year by the Healthcare Financial Management Association.

She is currently a trustee of the Foundation for Nursing Studies and also of Circus Space.

Professor Stephen Powis

Medical director

Stephen Powis is professor of renal medicine at University College London. He joined the Royal Free Hospital in 1997 as a consultant, becoming the trust's medical director in 2006. His main clinical interest is renal transplantation.

He is the chairman of the Association of UK Universities Medical Directors' Group and a board member of Merton Clinical Commissioning Group. He is a past non-executive director of North Middlesex University Hospital NHS Trust, including a period of eight months as acting chairman. He is a past chairman of the Joint Royal Colleges of Physicians Training Board specialty advisory committee for renal medicine and a former board member of Medical Education England. He was director of postgraduate medical and dental education for UCLPartners from 2010 to 2013.

Ms Deborah Sanders

Director of nursing

Deborah Sanders has worked for the trust since 1994 and before that worked at St Bartholomew's Hospital and the London Chest Hospital. She trained at the Royal Free.

She is also a board member of the Royal Free Hospital Nurses' Home of Rest Trust.

Ms Kate Slemeck

Executive director of operations

Kate Slemeck was most recently the director of operations at the Whittington Hospital NHS Trust for five years and before this deputy director of operations.

She has a total of 20 years' NHS management experience, mainly in acute trusts (including Northwick Park Hospital and the Royal Hospital for Neuro-disability).

She originally trained as an occupational therapist.

Directors' attendance at board meetings

The trust board meets regularly throughout the year and is chaired by a non-executive director, usually the chairman. The following table records the attendance of each director at these meetings. Five public board meetings were held in the reporting period. Where confidential matters need to be discussed, the board also meets in closed session.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Dominic Dodd - chairman	11 out of 12
Danny Bernstein	10 out of 12
Stephen Ainger	11 out of 12
Deborah Oakley	12 out of 12
Jenny Owen	12 out of 12
Anthony Schapira	11 out of 12
Executive directors	
David Sloman	10 out of 12
Caroline Clarke	9 out of 12*
Stephen Powis	11 out of 12
Deborah Sanders	11 out of 12
Kate Slemeck	12 out of 12

*Ms Clarke took a period of special leave from November to January 2014

The trust is required to hold and maintain a register of details of company directorships and other significant interests held by directors which may conflict with their management responsibilities. This register is required to be made available to the public; it is available on our website at www.royalfree.nhs.uk. The board considers that all its non-executive directors are independent in character and judgement, although it notes that Professor Anthony Schapira, as an appointee of University College London Medical School, brings its views to the trust board. All non-executive directors bring a breadth of expertise to the board and are independent of the executive and thus able to provide an objective and balanced opinion on matters relating to the trust's business.

The board is satisfied 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 and training programmes in place ensure that the non-executive directors have appropriate experience and skills. The board has the capability and experience necessary to deliver the trust's business plan. The governance structure the board has in place is appropriate to deliver the trust's business plan.

The board development programme has been largely incorporated into the normal working of the board to ensure that the development is relevant and applicable to its responsibilities.

The objectives of the development programme are to ensure that the board:

- is fit to govern a foundation trust
- is able to set performance standards (informed by research into high performing boards) in all its areas of responsibility
- has an annual process for reviewing performance against these standards that informs individual and collective development needs
- operates as a unitary function and is aware of, and successfully manages, competing priorities and future challenges against the trust's five governing objectives
- advocates a culture of inquiry and improvement through reflective practice that is modelled from the top, including clarity about the values and expected behaviours of the board, and thus the whole organisation
- can assure itself on all aspects of quality in clinical services.

A robust process for evaluating the performance of the chairman and non-executive directors has been developed by the nominations committee on behalf of the council of governors. Members of the board undertake personal development and collectively the board holds periodic development sessions during the year, which for the reporting period have mainly focused on the trust's acquisition of Barnet and Chase Farm Hospitals NHS Trust.

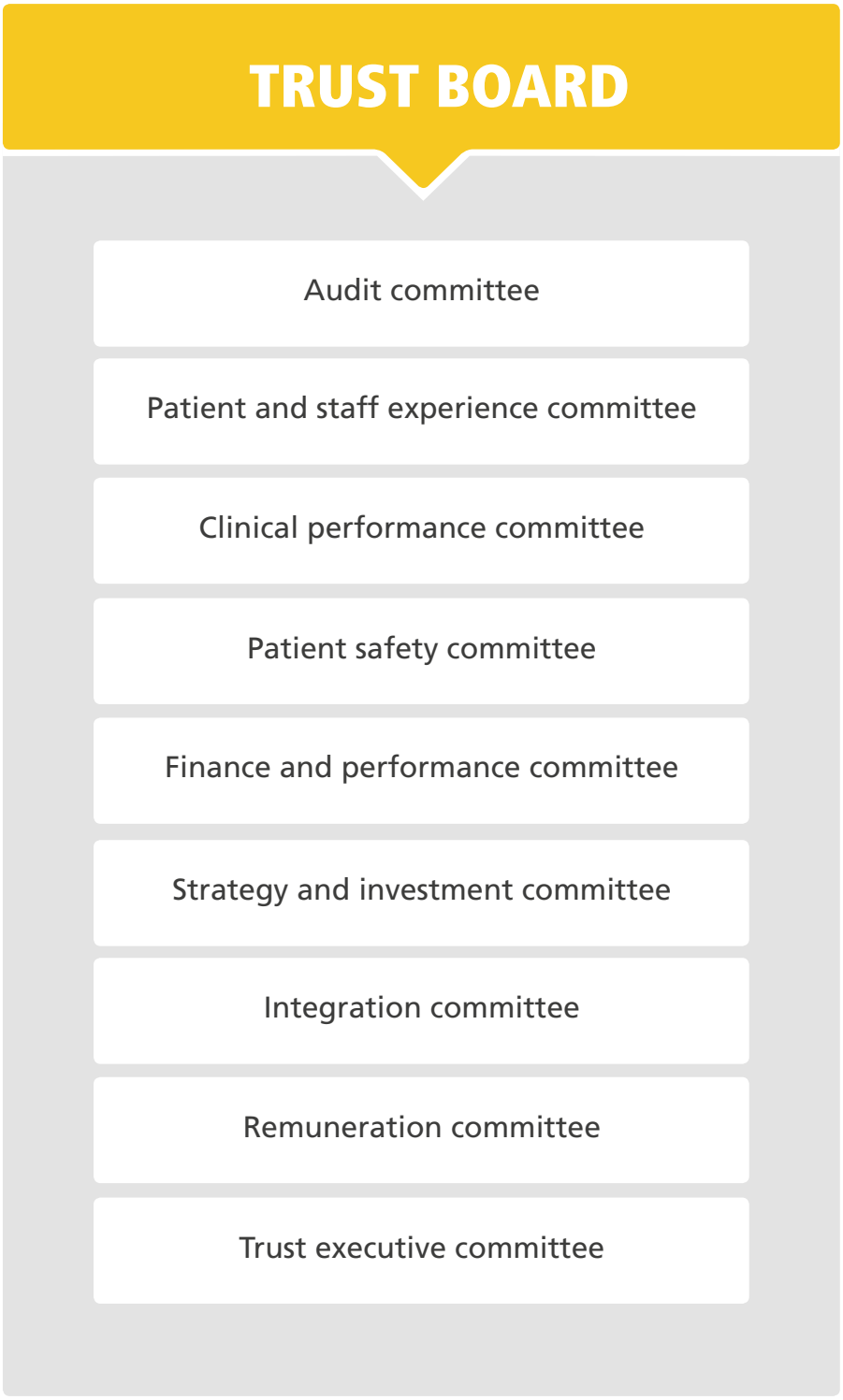
Removal of a non-executive director requires a resolution by a governor, which must be supported by no fewer than five governors and requires the resolution to be approved by three-quarters of the members of the council of governors.

The performance of the executive directors is reviewed by the chief executive and considered by the remuneration committee. All executive and non-executive directors have an annual appraisal and a personal development plan which forms the basis of their individual development.

Board committees

A number of changes were made to board committees during 2013/14. The board now has a total of nine committees which meet regularly and, with the exception of the trust executive committee, each is chaired by a non-executive director. A number of board responsibilities are delegated either to these committees or individual directors.

The board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely report to the board showing how they are fulfilling their duties as required by the board. The audit committee, as the senior independent committee of the board, undertakes a yearly self-assessment of effectiveness and provides an annual report on its performance to the board. In addition to regularly reporting to the trust board, audit committee minutes are a standing item on each trust board agenda.



Audit committee

The audit committee is the senior independent non-executive committee of the trust board. It is responsible for monitoring the externally reported performance of the trust and providing independent and objective assurance on the effectiveness of the organisation's governance, risk management and internal control; the integrity of the trust's financial statements, in particular the trust's annual report and accounts; and the work of internal and external audit and local counter fraud providers and any actions arising from that work.

The committee met five times during the year. It is chaired by Deborah Oakley and comprises the non-executive directors listed in the table. The internal and external auditors and providers of local counter fraud services attend all meetings of the committee in addition to the director of finance, although they are not members of the committee. The chief executive and other members of the trust board and executive team attend meetings by invitation. The broad coverage of knowledge and skills of the members and attendees ensures that the committee is effective. The trust is satisfied that the committee is sufficiently independent.

During 2013/14, the committee has remained observant of the key financial, operational and strategic risks facing the trust through regular review of the board assurance framework and through internal sources of assurance and validation by way of triangulation with the risk governance and regulation committee, patient safety committee and clinical performance committee.

The committee has reviewed progress reports and evaluated the major findings of internal and external audit work, focusing on the implementation of agreed objectives and recommendations. In association with this, the committee has sought greater assurance in a number of areas, including around the controls and mechanisms in place for liver transplants and learning from serious incidents.

As part of its responsibility for assuring other functions, the committee has received annual assurance that the clinical audit functions and the overall quality of care provided by the trust was satisfactory. It has supported, in particular, a patient safety campaign to embed a culture where patient safety is inherent across the trust, as well as a proposal for an exercise in validating consultant-level performance data.

The committee has received regular reports on counter-fraud activity at the trust, ensuring appropriate action in matters of potential fraudulent activity and financial irregularity and sought assurance that the trust's whistle-blowing policy was fit for purpose and contained an adequate level of independence. It has also fulfilled its oversight responsibilities with regard to monitoring the integrity of financial statements and the annual accounts, including the annual governance statement before submission to the board.

The committee submitted a 2012/13 annual report to the board in July 2013 and will prepare one for 2013/14 for submission to the board and the council of governors.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Deborah Oakley - chair	5/5
Stephen Ainger	5/5
Danny Bernstein	5/5
Jenny Owen	5/5

During the reporting period, the trust's external audit services have been provided by PricewaterhouseCoopers LLP (PwC). The committee has received and reviewed progress reports from PwC in delivering its responsibilities as the trust's external auditor, together with other matters of interest.

Review of effectiveness of the trust's external auditors

The audit committee reviews the effectiveness of the trust's external auditors on an annual basis.

This is particularly important in a foundation trust because the governors appoint the external auditor and the audit committee and finance staff conduct the evaluation on their behalf.

Committee members and senior finance managers were asked to rate 14 statements related to behaviours and processes in the following areas: quality control process, audit team, audit scope, audit fee, audit communications, quality account and audit governance. An additional rating was also sought from the trust's medical director specifically on the quality account statement.

The chair of the audit committee presented the results, which were positive, to the council of governors in January 2014.

Independence of external auditor

As external auditors of the trust, PwC is required to be independent of the trust in accordance with the ethical standards established by the Auditing Practices Board (APB).

As part of its external audit plan, PwC has disclosed those relationships that, in its professional judgement, may reasonably be thought to bear on its independence; the audit committee has accepted these disclosures noting the safeguards in place. PwC has also communicated in reference to relationships and investments that senior officers of the trust should not seek or receive personal financial or tax advice from PwC. Non-executives who receive such advice from PwC (perhaps in connection with employment by a client of the firm) or who also act as director for another audit or advisory client of the firm should notify PwC so that they can put appropriate conflict management arrangements in place.

Remuneration committee

On behalf of the trust board, the committee is responsible for all decisions concerning the remuneration and terms of service of executive directors. The committee met twice during the reporting period.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Dominic Dodd – chairman	2 out of 2
Deborah Oakley	2 out of 2
Stephen Ainger	2 out of 2
Danny Bernstein	2 out of 2
Jenny Owen	2 out of 2
Anthony Schapira	2 out of 2

Clinical performance committee

The committee is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board. Our aim is to be in the top 10% of our relevant peers. The committee met four times during 2013/14. Two governors attend this committee as observers.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Anthony Schapira - chairman	4 out of 4
Deborah Oakley	4 out of 4
Executive directors	
David Sloman	3 out of 4
Professor Stephen Powis	4 out of 4
Deborah Sanders	4 out of 4

Finance and performance committee

The committee is responsible for seeking and securing assurance that the trust achieves the high levels of financial performance expected by the board. Our aim is to be in the top 10% of our relevant peers. The committee met 11 times during the reporting period. Two governors attend this committee as observers.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Danny Bernstein - chairman	11 out of 11
Stephen Ainger	11 out of 11
Executive directors	
David Sloman	8 out of 11
Caroline Clarke	10 out of 11
Kate Slemeck	8 out of 11

Risk, governance and regulation committee (until January 2013)

The committee is responsible for ensuring that the trust is fully compliant with all its legal and regulatory duties and for ensuring that all material risks to trust objectives are understood and appropriately addressed. The committee met four times during 2013/14.

Following a review of the trust's governance structure in late 2013, the board agreed to dissolve the risk, governance and regulation committee and replace it with a patient safety committee in order to reflect our renewed emphasis on safety and the changes in external regulation

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Stephen Ainger - chairman	4 out of 4
Dominic Dodd	3 out of 4
Deborah Oakley	3 out of 4
Executive directors	
Stephen Powis	3 out of 4
Kate Slemeck	2 out of 4
Deborah Sanders	4 out of 4

Patient safety committee

The patient safety committee was established in February 2014. It is an assurance committee of the trust board and is responsible for reviewing systems of control and governance in relation to patient safety, specifically those incidents that can cause 'harm'. The committee's aims are in line with the trust's governing objective 'to be safe and complaint with our external duties'.

The committee has met once in the reporting period. Two governors attend this committee as observers.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Stephen Ainger - chairman	1 out of 1
Deborah Oakley	1 out of 1
Executive directors	
Stephen Powis	1 out of 1
Deborah Sanders	1 out of 1

Strategy and investment committee

The committee is responsible for ensuring that the trust's strategy and investment decisions support the achievement of its governing objectives by directly taking investment decisions under £3 million and making recommendations to the board for those over £3 million. The committee met 10 times during the reporting period.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Dominic Dodd - chairman	10 out of 10
Danny Bernstein	9 out of 10
Deborah Oakley	9 out of 10
Stephen Ainger	10 out of 10
Jenny Owen	9 out of 10
Anthony Schapira	10 out of 10
Executive directors	
David Sloman	9 out of 10
Stephen Powis	6 out of 10
Caroline Clarke	8 out of 10
Kate Slemeck*	7 out of 10
Deborah Sanders*	8 out of 10

*Became members of the committee in May 2013

Integration committee

Following a review of the trust's governance structure in late 2013, the trust board agreed to implement an integration committee to oversee the integration effort associated with the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust to ensure it is implemented effectively and in a timely manner. The committee has met twice in the reporting period.

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Dominic Dodd - chairman	2 out of 2
Danny Bernstein	2 out of 2
Executive directors	
David Sloman	2 out of 2
Caroline Clarke	2 out of 2

User experience committee/ patient and staff experience committee

The user experience committee was responsible for seeking and securing assurance that the trust's services are delivered to its customers (patients and commissioners) so as to achieve the high levels of performance expected of them by the board. Our aim is to be in the top 10% of our relevant peers.

Following a review of the governance structure in late 2013, the user experience committee was renamed the patient and staff experience committee. Its terms of reference

Membership and attendance

	Attendance at meetings (actual/possible)
Non-executive directors	
Jenny Owen - chairman	4 out of 4
Danny Bernstein	3 out of 4
Executive directors	
David Sloman	3 out of 4
Deborah Saunders	4 out of 4
Kate Slemeck	3 out of 4

were strengthened to highlight the committee's remit of seeking and securing assurance on performance in relation to the experience of patients and staff, to monitor performance in relation to key outcomes set by the Care Quality Commission and to ensure that there is a clear performance and governance framework against these, which is linked to clear consequences for both good and poor performance.

The committee met four times during 2013/14. Two governors attend this committee as observers.

Trust executive committee

The committee supports and advises the chief executive in running the trust, in meeting the requirements of the operating framework and the regulator Monitor's compliance framework and on strategic priorities and objectives. It is the only committee that is not chaired by a non-executive director. The committee meets weekly.

The trust board interacts regularly with the council of governors to ensure that it provides the council with appropriate information, allows for good debate between board and council members and understands the council's views. Meetings of the council of governors' working groups are also attended by non-executive directors.

The arrangements for resolving any disputes between the board and the council are described in the trust constitution (paragraph 45.5) which is available at the Royal Free website at www.royalfree.nhs.uk.

Council of governors

The over-riding role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public. Other statutory roles include:

- representing the interests of members and the public
- amending the constitution
- approving the appointment of the chief executive
- appointing and removing the chair and other non-executive directors
- appointing and removing the NHS foundation trust's external auditor
- receiving the NHS foundation trust's annual accounts and annual report
- preparing the forward plan
- taking decisions on significant transactions
- taking decisions on non-NHS income.

The trust maintains a register of interests for its governors, which is available to the public on the trust website www.royalfree.nhs.uk.

During the second year as a foundation trust, the council of governors has:

- received updates on and engaged with the trust's consideration of the acquisition of Barnet and Chase Farm Hospitals NHS Trust
- engaged with the business planning process
- received updates from non-executive directors on the performance of board committees
- appointed a non-executive director
- extended the term of office of a non-executive director
- extended the term of office of those governors with a two year tenure.

Governor elections

There have been no elections in the reporting period.

Governor constituencies, terms of office and attendance at council of governors' meetings

Elected	Constituency	Term of office began	Term of Office ends	Attendance (actual/ possible)
Judy Dewinter	Patient	1 April 2012	31/3/2015	6/6
Valerie Bynner	Patient	1 April 2012	31/3/2015	6/6
Peter Woodford	Patient	1 April 2012	31/3/2015	6/6
Sara Shaw	Patient	1 April 2012	31/3/2015	5/6
Gerry Bacon	Patient	1 April 2012	30/9/2014	6/6
David Myers	Patient	1 April 2012	30/9/2014	6/8
Peter Atkin (lead governor)	Patient	1 April 2012	30/9/2014	5/6
Barbara Alden	Public	1 April 2012	31/3/2015	5/6
Stephen Cameron	Public	1 April 2012	31/3/2015	5/6
Linda Davies	Public	1 April 2012	31/3/2015	5/6
Richard Lindley	Public	1 April 2012	31/3/2015	6/6
Anthony Isaacs	Public	1 April 2012	30/9/2014	6/6
Arthur Brill	Public	1 April 2012	30/9/2014	6/6
Alex Clarke	Staff	1 April 2012	31/3/2015	6/6
Michael Jacobs	Staff	1 April 2012	31/3/2015	6/6
Sheldon Stone	Staff	1 April 2012	31/3/2015	2/8
Dave Thomas	Staff	1 April 2012	31/3/2015	5/6
Paul Hayler	Staff	1 April 2012	31/8/2013	2/2
Jude Bayly Appointed	Staff	1/9/2013	31/3/2015	4/4
Peter Christian	Enfield, Haringey and Islington clinical commission group (CCG)	1 April 2012	31/3/2015	6/6
Helena Hart	London Borough of Barnet	1 April 2012	31/3/2015	5/6
Don Williams	London Borough of Camden	1 April 2012	31/3/2015	3/6
Richard Mendall	Camden CCG	1 April 2012	31/3/2015	4/6
David Riddle	Barnet CCG	1 April 2012	31/3/2015	3/6
Hans Stauss	University College London	1 April 2012	31/3/2015	6/6

Governors also attended a number of joint meetings with board members, and briefing meetings relating to the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust. We also have a continuing development seminar programme covering areas of specific interest to governors.

Nominations committee

The nominations committee is responsible for determining and administering the selection process for the appointment and remuneration of the chair and non-executive directors of the trust; recommending the preferred candidate to the council of governors for appointment; and monitoring their performance.

The members of the committee are detailed in the table below and met seven times in the reporting period.

In April 2013 the committee agreed a revised objective setting and appraisal system for the chairman and non-executive directors, which was noted by the council in May 2013. During much of the year the committee considered and agreed the process for re-appointment to a non-executive position and appointed Russell Reynolds to support the recruitment process. Interviews were held in March 2014 and the council approved the recommendation made by the nominations committee to appoint Dean Finch at its meeting on 19 March 2014.

The council also approved the committee's recommendation to further extend the term of office (to 30 June 2014) for Danny Bernstein.

Arrangements for those non-executive directors whose tenure will expire in the coming months will be discussed by the committee.

Membership and attendance

Members		Attendance at meetings (actual/possible)
Dominic Dodd	Chairman	7/7
Peter Atkin	Elected patient governor	7/7
Sara Shaw	Elected patient governor	5/7
Don Williams	Appointed governor	5/7
Hans Stauss	Appointed governor	7/7

Governors have also been invited to sit on three board committees (the patient and staff experience committee, the patient safety committee and the clinical performance committee) and provide regular feedback to the council of governors. Details of these committees are included in the previous section.

Working groups

The governors have set up sub-groups to concentrate on specific priorities for improvement agreed by the council of governors. The council takes into account feedback from its constituents when deciding on its areas of focus. The sub-groups report back to the council of governors who ratify any decisions made. Each sub-group consists of four governors, an executive lead in the relevant area and a non-executive director.

Patient experience sub-group: has focused on non-emergency transport and hospital discharge processes. The trust has recognised that this added attention has helped provide real improvement to the existing patient experience. Governor involvement in the proposed patient transport service has added useful challenge for the prospective providers.

Staff experience sub-group: has focused on both improvements to staff facilities and a reduction in staff experiencing bullying and harassment.

With the added emphasis from the governors, the trust has now committed to a rolling programme of improvement to staff toilets and changing facilities. The sub-group's commitment to the way in which the trust is addressing bullying and harassment issues within the trust has been welcomed by staff and their message is included in staff training and has led to an article in the staff newsletter.

Clinical outcomes sub-group: has focused on the fractured neck of femur pathway of care for patients, where the trust had been struggling to reduce the time taken to get patients to the ward and then to theatre quickly. With the support of the governors, progress has been achieved, ensuring that patients are transferred with the minimum of delay, which means that patients' experience is improved, outcomes are improved and they are able to go home more quickly.

Membership engagement sub-group: continues to develop strategies to canvass the views of the public, patients and staff to recruit new members and to inform members and the public at large about the vision and performance of the trust. It led on the annual governors' report, a members' event in January 2014 and has developed a revised membership strategy ready for the proposed acquisition of the Barnet & Chase Farm Hospitals NHS Trust.

The trust held a members' meeting in July 2013. The chairman, chief executive and director of finance gave an overview of the annual accounts and achievements for the first year of being a foundation trust. Governors provided an update on their work within the trust and provided members with the opportunity to ask questions. The medical director and director of nursing gave a presentation on the trust's response to the Francis report, which was written as a result of the failings at Mid Staffordshire NHS Foundation Trust.

Our membership

The trust's membership is essential to help guide our work, decision making and adherence to the NHS values. It provides one of the ways in which the trust communicates with patients, the public and staff. Membership is free and open to anyone in the following categories:

Public - anyone who is 16 years old or over and lives within the London boroughs of Camden or Barnet.

Patient - anyone who is 16 years old or over and lives outside Camden and Barnet but has been a patient of the Royal Free in the past five years, or has been the carer of a patient under 16 of the Royal Free in the past five years.

Staff - all staff of the trust who have contracts of at least 12 months are automatically members unless they choose to opt out.

The total number of public and patient members at year end was 11,076. This total includes 6,852 (2011/12: 6,690) from the public constituency and 4,224 (2011/12: 4,102) from the patient constituency.

The trust continues to work hard to ensure that its membership is representative of the local community and takes steps to ensure that membership is accessible to all who are eligible, irrespective of age, sex, race or social background.

Membership recruitment

Recruitment for the period has been steady with a net increase of 154 members in 2013/14, an increase of 1.5% in total membership.

We continue to have a number of regular initiatives to involve members with the trust's activities including:

- a monthly members' e-briefing which keeps members informed about key developments and trust news
- monthly 'medicine for members' talks
- focus groups to engage with members about specific areas within the trust
- a members' area on the trust's website which includes information on what it means to be a member as well as profiles of our governors.

Recruitment methods have included:

- mail-outs to recent patients encouraging them to become members
- promoting membership at regular focus groups and medical lectures as well as at the annual general meeting
- making membership boxes available in key areas of the trust.

Remuneration report

Remuneration for the trust's most senior managers, including directors, executive directors and the chief executive, is determined by the trust's remuneration committee, comprising the trust chairman and non-executive directors.

The remuneration committee is informed by executive salary surveys, periodic assessments conducted by independent remuneration consultants and benchmarking salary awards and terms and conditions applying to other NHS foundation trusts. The benchmarking comparisons indicated that no reviews were required this year.

Senior managers are employed on contracts of service and are substantive employees of the trust. Their contracts are open ended employment contracts which can be terminated by either party with six months' notice. Compensation in the event of early termination would be in accordance with contractual entitlements as set out in the 'Agenda for Change' national terms and conditions. The trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct.

The following table sets out the expenses of the governors and directors (NOT SUBJECT TO AUDIT)

	2013/14			2012/13		
	Total in office	Total receiving expenses	Aggregate sum of expenses paid	Total in office	Total receiving expenses	Aggregate sum of expenses paid
	Number	Number	£00	Number	Number	£00
Governors	25	1	29	24	1	7
Directors	11	5	71	11	4	74

Salaries and allowances (audited)

	2013/14						2012/13					
	Salary and fees	Taxable benefits	Annual performance-related bonuses	Long-term performance-related bonuses	Pension–related benefits	Total	Salary and fees	Taxable benefits	Annual performance-related bonuses	Long-term performance-related bonuses	Pension–related benefits[2]	Total[2]
	(in bands of £5,000)	(total to the nearest £100)	(in bands of £5,000)	(in bands of £5,000)	(in bands of £2,500)	(in bands of £5,000)	(in bands of £5,000)	(total to the nearest £100)	(in bands of £5,000)	(in bands of £5,000)	(in bands of £2,500)	(in bands of £5,000)
Dominic Dodd	55-60	-	-	-	-	**55-60**	55-60	-	-	-	-	**55-60**
Stephen Ainger	10-15	-	-	-	-	**10-15**	10-15	-	-	-	-	**10-15**
Danny Bernstein	10-15	-	-	-	-	**10-15**	10-15	-	-	-	-	**10-15**
Jenny Owen	10-15	-	-	-	-	**10-15**	10-15	-	-	-	-	**10-15**
Deborah Oakley	10-15	-	-	-	-	**10-15**	10-15	-	-	-	-	**10-15**
Anthony Schapira	10-15	-	-	-	-	**10-15**	10-15	-	-	-	-	**10-15**
David Sloman	215-220	-	-	-	17.5-20.0	**235-240**	215-220	-	-	-	262.5-265.0	**480-485**
Caroline Clarke	165-170	-	-	-	22.5-25.0	**185-190**	165-170	-	-	-	100.0-102.5	**265-270**
Stephen Powis[1]	195-200	-	-	-	32.5-35.0	**230-235**	190-195	-	-	-	(20.0)-(22.5)	**170-175**
Deborah Sanders	135-140	-	-	-	2.5-5.0	**140-145**	135-140	-	-	-	172.5-175.0	**310-315**
Kate Slemeck	135-140	-	-	-	7.5-10.0	**140-145**	135-140	-	-	-	102.5-105.0	**240-245**

[1]Stephen Powis' salary includes a national clinical excellence award. He is employed by UCL Medical School and his salary is recharged to the trust.

[2]The requirement to include the pension related benefit is new for 2013/14 and so the 2012/13 comparative has been restated. The pension related benefit is calculated as:

Increase/(decrease) = ((20 x PE) +LSE) – ((20 x PB) + LSB) - employee pension contributions

Where

- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Pay multiples

The banded remuneration of the highest paid director in the Royal Free London NHS Foundation Trust in the financial year 2013/14 was £215-220,000 (2012/13: £215-220,000). This was 7.8 times (2012/13: 7.5 times) the median remuneration of the workforce, which was £27,901 (2012/13: £29,202). In 2013/14, no employees (2012/13: no employees) received remuneration in excess of the highest paid director.

Annualised remuneration ranged from £2,000 to £220,000 (2012/13: £120 to £220,000).

Pension benefits of executive directors (audited)

	Title	Real increase/ (decrease) in pension at age 60 (bands of £2,500)	Real increase/ (decrease) in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2014 (rounded to the nearest £000)	Cash equivalent transfer value at 31 March 2013 (rounded to the nearest £000)	Real increase/ (decrease) in cash equivalent transfer value (rounded to the nearest £000)
		£000	£000	£000	£000	£000	£000	£000
David Sloman	**Chief executive**	0.0-2.5	5.0-7.5	80-85	245-250	1,587	1,473	81
Caroline Clarke	**Director of finance and deputy chief executive**	0.0-2.5	5.0-7.5	35-40	115-120	605	547	46
Stephen Powis	**Medical director**	2.5-5.0	7.5-10.0	70-75	215-220	1,421	1,302	90
Deborah Sanders	**Director of nursing**	0.0-2.5	2.5-5.0	35-40	110-115	626	580	33
Kate Slemeck	**Executive director of operations**	0.0-2.5	2.5-5.0	25-30	75-80	431	391	32

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

A 'cash equivalent transfer value' (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which 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 additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. It must be noted that the figures taken at 31 March 2012 have been revised as per the December 2011 government actuarial data. Therefore they do not use the common valuation factors, as described above, for the beginning and end of the period.

Off-payroll engagements disclosure requirements

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

Table 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months.

No. of existing engagements as of 31 March 2014	**7**
Of which...	
No. that have existed for less than one year at time of reporting.	6
No. that have existed for between one and two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

The trust has now put in place contracts which contain contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations.

Of the four individuals for whom assurance has not been received, two left the trust before providing their evidence. The two remaining individuals are in continuing dialogue to provide such assurance.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	**13**
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	**-**
No. for whom assurance has been requested	**13**
Of which...	
No. for whom assurance has been received	9
No. for whom assurance has not been received	4
No. that have been terminated as a result of assurance not being received.	-

An interim appointment was made during 2012 to the post of director of workforce and organisational development due to a long-term absence. Recruitment took place during the year to appoint the post holder permanently to the post and began in the role during March 2014. The interim post holder remains at the trust to support it through the Barnet and Chase Farm Hospitals NHS Trust transaction.

Table 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	**1**
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	**1**

Further information on the employee benefits costs to the trust can be found in note 5 of the annual accounts.

David Sloman
Chief executive

Date: 29 May 2014

Statement of the chief executive's responsibilities as the accounting officer of the Royal Free London NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust.

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

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

In preparing the accounts, the accounting officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the accounts direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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

David Sloman
Chief Executive

29 May 2014

Annual governance statement

The trust has strengthened governance with the addition of the patient safety committee.

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on processes designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Free London NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal Free London NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board brings together the corporate, financial, workforce, clinical, information and research governance risk agendas. The board assurance framework ensures that there is clarity over the risks that may impact the trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

The trust has reviewed Monitor's NHS foundation trust condition 4 (FT governance) and considered the risks associated with compliance and how these have been addressed. The governance arrangements were reviewed externally in 2012 as part of the FT authorisation process and found to be robust. The trust has recently further strengthened these with the addition of a third 'quality' committee - the patient safety committee. The board committee structure is detailed in section 10 of the annual report and also outlined below.

Each committee has terms of reference and each of these was reviewed in August 2013 for scope, responsibilities and membership. Groups and committees reporting to each board committee are also detailed in the terms of reference. There is a comprehensive scheme of delegation which details items reserved by the board, those delegated to committees and those delegated to individuals. This covers a wide range of responsibilities and includes the Care Quality Commission standards and Monitor licence conditions. A system has been put in place by which assurance of compliance with these licence conditions is reported to the board.

The trust performance report is reviewed at both the finance and performance committee and trust

board at each meeting. Where there is sustained adverse performance in any indicator, this is reviewed in detail at the appropriate board committee. Further indicators relating to the quality of patient care are reviewed at the 'quality committees' - patient and staff, patient safety and clinical performance. An internal audit review found that the board had an appropriate level of oversight of trust performance.

A full review of corporate governance will be undertaken during 2014/15 to comply with the Monitor guidance on corporate governance reviews.

The operational responsibility for the trust's risk management agenda is overseen by the patient safety committee which enables patient, staff and corporate risk issues to be brought together and reported as a whole. Cross reporting takes place between the patient safety committee, audit committee, finance and performance committee and clinical performance committee to enable the full risk profile to be considered.

The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the trust and particularly of all managers. The process for the identification, assessment, reporting, action planning, review and monitoring of risks is detailed in the trust risk management strategy reporting to the board and has been central to the improvements made in this important area of our work during the year.

Staff receive training in identification, analysis, evaluation and reporting of risk. Training at induction covers the wider aspects of governance. The emphasis of our approach is increasingly on the proactive management of risk and ensuring that risk management plans are in place for all key risks.

We have a well-established board development programme and performance appraisal system. This has been largely incorporated into the normal working of the board to ensure that the development is relevant and applicable to its responsibilities.

The objectives of the development programme are to ensure that the board:

- is fit to govern a foundation trust
- is able to set performance standards (informed by research into high performing boards) in all its areas of responsibility
- has an annual process for reviewing performance against these standards that informs individual and collective development needs
- operates as a unitary function and is aware of and successfully manages, competing priorities and future challenges against the five long-term governing objectives
- advocates a culture of inquiry and improvement through reflective practice that is modelled from the top, including clarity about the values and expected behaviours of the board and thus the whole organisation
- can assure itself on all aspects of quality in clinical services.

The patient safety committee is responsible for periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective. Governance arrangements were comprehensively reviewed during 2011/12 as part of our preparation for authorisation as a foundation trust and again in 2013/14 as part of the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust.

The risk and control framework

Our risk management strategy describes our approach to risk management and outlines the formal structures in place to support this approach. The strategy has been reviewed as part of the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust.

The trust has a risk management strategy in place which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The board has overall responsibility but it delegates the work to the patient safety committee (previously the risk, governance and regulation committee), which is chaired by a non-executive director.

At the Royal Free, risk is considered from the perspective of clinical risk, organisational risk and financial risk. The management of these risks is approached systematically to identify, analyse, evaluate and ensure economic control of existing and potential risks posing a threat to our patients, visitors, staff, and reputation of the organisation. We recognise it is not possible to eliminate all elements of risk.

The use of risk registers is fundamental to the control process. Divisional and departmental risk registers are monitored regularly and are managed quarterly via the divisional board meetings. Significant risks identified (via divisional risk registers) are added monthly to the corporate risk register on receipt of the divisional risk register returns and reviewed at the trust operations board.

In addition, the corporate risk register is reviewed monthly at the trust executive committee and receives scrutiny and challenge at the patient safety committee (until January 2104, the risk governance and regulation committee). Significant risk items (which score 15 or more on the trust risk matrix) are considered by the patient safety committee and where appropriate are added to the board assurance framework.

Risks are identified through a number of different routes including third party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (both clinical and internal), information from the patient advice and liaison service, benchmarking and claims. External stakeholders include the Care Quality Commission (CQC), Monitor, the Health and Safety Executive (HSE), NHS Litigation Authority (NHSLA), Medicines and Healthcare Products Regulatory Agency (MRHA), Information Commissioner's Office (ICO) and Dr Foster. Also used are national survey results.

The divisional boards ensure that operational staff identify and mitigate risk. Corporate committees provide internal assurance to the trust board that the mitigations are effective and the risks are adequately controlled. Risk is monitored and communicated via these committees reporting through to the patient safety committee and ultimately the board. Our clinical audits, internal audit programme and external reviews of the organisation (Clinical Pathology Accreditation review, NHSLA assessment, HSE and CQC inspection) are the sources used to provide assurance that these processes are effective and risk monitoring is fully embedded.

The audit committee oversees and monitors the performance of the risk management system, internal audit (KPMG) and external audit (PwC) work closely with this committee. KPMG undertake reviews and provide assurances on the systems of control operating within the trust. The trust has in place a board assurance framework. Each board committee reviews allocated risk at each meeting and the board assurance framework is reviewed in full at the strategy and investment committee.

The grading of risks results in them being classified as low, moderate, high or extreme. The trust's risk appetite is such that any high or extreme risks require action to be taken and to be reported within 24 hours of identification of the risk.

The results of internal audit reviews are reported to the audit committee which takes a close interest in ensuring system weaknesses are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal audit recommendations are robustly tracked via reports to the audit committee. The counter fraud programme is also monitored by the audit committee.

As part of the governance arrangements, the board is satisfied that plans are in place and sufficient to ensure compliance with the CQC registration requirements. The trust has adopted a robust framework of measurement and assurance for each standard by nominating a single named lead director who is responsible for judging whether compliance is being achieved, reporting quarterly compliance to both trust executive and the patient safety committee.

Sources of assurance include:

- quarterly review of CQC standards including action plans
- papers and minutes to the trust executive committee
- papers and minutes to the patient safety committee
- internal audit review of arrangements to ensure CQC compliance found adequate assurance for our arrangements
- internal clinical audits
- external clinical audits.

The trust has developed a quality guide which articulates how the trust ensures the provision of high quality services for its patients. It describes what quality means for the trust and how the trust sets a culture of quality and high standards throughout the organisation. It complements both the trust's annual quality report, which reports on the quality of our services over a specific 12 month period and the annual complaints, litigation, incident, PALS and safety (CLIPS) report which demonstrates themes in these processes and the learning undertaken during the year to prevent further risks. The quality guide is revised annually.

The trust, having had the quality governance arrangements comprehensively reviewed by Monitor as part of the authorisation process, plans to undertake a major review of its quality governance every three years. Monitor has in 2013/14 issued guidance on corporate governance reviews. The quality and corporate governance frameworks have been reviewed as part of the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust and will be externally reviewed in 2014/15.

The trust's control and assurance processes for information governance include:

- the information governance group that reported in 2013/14 to the board's risk, governance and regulation committee and later to the patient safety committee;
- the key structures being in place, principally named senior information asset owners covering all patient and staff personal data areas;
- a trained Caldicott Guardian, a trained senior information risk owner (SIRO), and a trained data protection officer;
- the risk management and incident reporting process;
- training for staff;
- information governance risk registers; and
- the information governance toolkit.

The SIRO's annual report for 2013/14 will be submitted to the patient safety committee in June 2014.

Public bodies publish details of personal data related incidents in their annual reports. In the NHS these details must be published in a specified form. That form has been changed with effect from this year and so the numbers in this year's report are not comparable with those published in last year's. In 2013/14 there was one serious incident (summarised below), and seven other incidents (see the following table). Incidents classified at a low severity rating are excluded from public bodies' reports.

Summary of serious incidents requiring investigations involving personal data as reported to the Information Commissioner's Office in 2013/14

Date of incident	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
May 2013	Lost paperwork	Name; telephone number; minimal clinical detail	78	Individuals notified

Summary of other personal data related incidents in 2013/14

Category	Breach type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	4
C	Lost in transit	2
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	1
F	Non secure disposal – hardware	0
G	Non secure disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	0
K	other	0

At the end of March 2014, the corporate risk register had a number of risks that had a 'red' risk rating after actions and controls were taken into account. Examples included risks to the renal service continuity at outer London satellite units as a result of changes to terms and conditions of employment following the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust, national shortage of Tier 4 child and adolescent mental health services beds impacting on patient care and potential inconsistencies in the completion of the World Health Organisation surgical checklist which could trigger an external review. Appropriate action plans were in place to address the risks.

The board assurance framework highlights eight red-rated strategic risks, one of which relates to the proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust, which is being managed through close board scrutiny and the creation of an integration committee, together with the appointment of specialist third party advisers. Additional risks related to QIPP delivery, not meeting hospital acquired infection targets, pressure on EBITDA due to commissioner non-delivery of productivity and failure to reduce reported levels of bullying and harassment within the staff survey. Each of these risks have action plans in place.

The clinical performance committee is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board. Our aim is to achieve "outcomes consistently in the top 10% in the UK versus relevant peers." Its scope includes:

- clinical outcomes, including three trust clinical priorities - (C. difficile rates, MRSA rates and HSMR) - and clinical performance metrics for each clinical business unit
- research productivity and educational effectiveness

- the quality report
- the patient safety programme
- outcomes achieved and management approach taken (including, but not limited to, accountabilities, processes, clinical governance arrangements, audit, information, training and development, consequences).

The clinical performance committee recommends to the board outcome measures that should be tracked and monitors these same outcomes at both trust and service line level. Part of the role of the committee is to seek assurance that the management approach to achieving consistent high performance is robust and therefore likely to justify confidence in future performance. It seeks to understand lessons learned through comparison between service lines that perform well and those that perform less well. It also organises and prepares evidence for the signing of Monitor self-certifications on 'board statements – clinical quality'.

The clinical performance committee can commission detailed reviews of specialties where there may be a concern regarding clinical quality.

Each clinical division has a quality and safety board that regularly reviews key performance metrics in their areas to identify and take action on risk locally. Risk registers are maintained within each clinical division and along with other sources of information such as incident forms, audit and benchmarking, they are used to populate the corporate risk register.

The trust's QIPP programme is integral to the quality improvement process and all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. The board monitors a set of specific trust-wide quality metrics that may be adversely affected by cost improvement projects.

The trust conducts 'quality road map' self-assessments to provide regular, audited assurance of compliance with CQC registration requirements.

An annual patient safety programme has been developed to address specific patient safety themes formulated both from external guidance (eg surgical safety) and internal trends (eg medicines safety) using continuous quality improvement methodology. Each workstream has an executive sponsor and clinical champion, as well as leads from the individual teams involved in day-to-day care. The themes being progressed are harm free care (falls, pressure ulcers, venous thromboembolism and catheter-related infection prevention), patient handover, medicines safety, surgical safety, reduction of sepsis, acute kidney injury and nasogastric tube placement.

There is a programme of 'go see' visits, in which board directors are paired with clinical areas that they visit on a regular basis and the governors often attend these visits. All staff are encouraged and reminded to complete incident report forms across a number of formal training programmes and also through regular local reinforcement via team managers and multi-disciplinary team meetings. Core training for junior medical staff is now informed by the learning from serious incidents.

The trust participates in national in-patient and out-patient surveys and 'patient experience trackers' are used throughout the organisation to collect contemporaneous feedback from service users.

Stakeholders have many opportunities to become involved in the work of the trust and to raise issues relating to risks which impact upon them. Forums which they use include:

PATIENTS AND THE PUBLIC

- the patient advice and liaison service and specific patient representative groups
- the work of the local overview and scrutiny committees
- annual members meeting and other governor events
- the national patient survey programme
- local involvement networks (Healthwatch)
- governors' patient experience sub-group
- governors' membership engagement sub-group.

STAFF

- the annual staff survey
- governors' staff experience sub-group
- joint staff committee
- consultant staff committee
- monthly chief executive briefings

HEALTH PARTNERS

- work as a founding member of UCLPartners
- regular discussion of key issues and performance management arrangements with clinical commissioning groups and GPs
- stakeholder membership of trust working groups, for example from the voluntary sector
- joint strategic planning meetings with healthcare partners

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

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

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

Monthly finance and performance reports are presented to the finance and performance committee, trust executive committee and to the board. The trust has exceeded the target for EBITDA and generation of surplus (excluding impairments). More information about this is in the financial review section of this report.

Internal audit reports include consideration of value for money and PwC are required as part of their annual audit to satisfy themselves the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the trust has not.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The quality report and quality accounts are critical to providing information to the public as well as stakeholders on the quality of care provided. An important aspect of developing our quality accounts is that its contents are developed by talking to groups of interested parties and for their views to be reflected in our final report. The trust has produced four successive quality accounts since 2010 and the development of our 2013/14 quality report and quality accounts we aim to develop our 2013/14 quality report and quality accounts through leadership of the three governing priorities for quality:

- patient safety
- clinical effectiveness
- patient experience.

In order to set our high level quality objectives for 2014/15, the trust will undertake series of engagement exercises with the following stakeholders, for example our members council participated in an online survey during December 2013 to provide feedback considerations for our 2014/15 priorities.

The January 2014 clinical performance committee discussed possible clinical effectiveness priorities for 2014/15 and agreed the pathway to determine which priority to set. Our January 2014 user experience committee discussed the possible patient experience priorities for 2014/15 with similar discussions within our patient safety committee to identify the priorities for safety. We hosted an engagement event with external stakeholders during March 2014. Our trust executive committee proposed our 2014/15 quality improvement priorities to the board from the above engagement in March 2014 and approved the data for reporting in our draft quality accounts to assure consistency and accuracy with performance data received during 2013/14.

During 2013/14 internal audit opinion provided a substantial assurance rating.

Review of effectiveness

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

The responsibility for compliance with the Care Quality Commission essential standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The assessment of compliance and the work of internal audit through the year, including advice and support on the development of the board assurance framework, have been of great assistance. The results of external audit's work on the trust's annual accounts are a key assurance together with patient and staff surveys and NHSLA risk management standard assessments (level three compliance for maternity standards, level two compliance for general standards).

The board reviews risks to the delivery of the trust's performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety and quality and workforce. This enables the executive board and the board to focus on key issues as they arise and address them.

The audit committee has overseen the effectiveness of the trust's risk management arrangements and taken part in a review of its role and responsibilities. The audit committee is supported in this oversight role by the work of the clinical performance committee.

Assurance for a sound system of internal control places reliance on the work of internal audit. The head of internal audit opinion is provided annually and comments based on the audit programme for the year. During 2013/14 the opinion provided a substantial assurance rating and stated that no significant issue remained outstanding at the year end which would impact the opinion.

This year we achieved a financial risk rating of four in each quarter and a governance risk rating of amber-green in quarter one and green in quarters two to four in relation to Monitor's risk assessment framework.

Conclusion

No significant internal control issues have been identified in the year.

David Sloman
Chief executive

29 May 2014

Annual accounts

Foreword to the accounts

The accounts for the year ended 31 March 2014 are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

David Sloman
Chief executive

Date: 29 May 2014

Independent auditors' report to the Council of Governors of the Royal Free London NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

- give a true and fair view of the state of the NHS Foundation Trust's affairs as at 31 March 2014 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by the Royal Free London NHS Foundation Trust, comprise:

- the Statement of Financial Position as at 31 March 2014;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Cash Flows for the year then ended;
- the Statement of Changes in Taxpayers' Equity for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Strategic Report, the Directors' Report and the Director's Remuneration Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinions on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks

are satisfactorily addressed by internal controls;

- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified, on any aspect, our opinion on the Quality Report.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement set out on page 16 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of the Royal Free London NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Sarah Isted (Senior Statutory Auditor) for and on behalf of PricewaterhouseCoopers LLP

Chartered Accountants and Statutory Auditors
London

29 May 2014

a) The maintenance and integrity of the Royal Free London NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of comprehensive income for year ended 31 March 2014

	NOTE	2013/14 £000	2012/13 £000
Operating income	2	593,741	577,061
Operating expenses	3	(607,852)	(585,190)
Operating surplus/(deficit)		(14,111)	(8,129)
Investment income	7	212	465
Finance costs	8	(1,095)	(1,331)
Surplus/(deficit) for the financial year		(14,994)	(8,995)
Public dividend capital dividends payable		(6,979)	(7,410)
Retained surplus/(deficit) for the year		(21,973)	(16,405)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments and reversals charged to the revaluation reserve	10	(24,981)	(2,222)
Net gain/(loss) on revaluation of property, plant & equipment	10	1,396	6,233
Total comprehensive income for the year		(45,558)	(12,394)

All income and expenditure is derived from continuing operations.
The notes on pages 90 to 127 form part of these accounts.

Note to the statement of comprehensive income

The board of directors primarily review the trust performance on the basis of the earnings before interest, taxation, depreciation and amortisation and the reporting surplus.

	NOTE	2013/14 £000	2012/13 £000
Earnings before interest, taxation, depreciation and amortisation		32,635	32,541
Income from donated assets	2	408	1,757
Depreciation on property, plant and equipment	3	(15,453)	(13,766)
Amortisation on intangible assets	3	(1,642)	(300)
Investment income	7	212	465
Finance costs	8	(1,095)	1,331
Public dividend capital dividends payable		(6,979)	7,410
Reporting surplus		8,086	11,956
Impairments of property, plant and equipment	3	(30,059)	(28,361)
Retained surplus/(deficit) for the year as above		**(21,973)**	**(16,405)**

Statement of financial position as at 31 March 2014

	NOTE	31 March 2014 £000	31 March 2013 £000
Non-current assets:			
Intangible assets	9	4,675	4,604
Property, plant and equipment	10	249,788	288,005
Total non-current assets		254,463	292,609
Current assets:			
Inventories	13	5,674	6,141
Trade and other receivables	14.1	61,897	39,914
Non-current assets for sale	15	3,500	-
Cash and cash equivalents	16	61,686	82,655
Total current assets		132,757	128,710
Total assets		387,220	421,319
Current liabilities			
Trade and other payables	17	93,512	100,275
Other liabilities	18	7,878	8,325
Borrowings	19	1	4
Provisions	22	9,742	12,850
Total current liabilities		111,133	121,454
Net current assets/(liabilities)		21,624	7,256
Non-current assets plus net current assets/(liabilities)		276,087	299,865
Non-current liabilities			
Trade and other payables	17	400	400
Other liabilities	18	4,274	4,609
Borrowings	19	27,496	7,523
Provisions	22	1,219	1,647
Total non-current liabilities		33,389	14,179
Total assets employed:		242,698	285,686
FINANCED BY:			
Taxpayers' equity			
Public dividend capital		193,538	190,968
Retained earnings		(6,767)	15,206
Revaluation reserve		55,927	79,512
Total taxpayers' equity		242,698	285,686

The notes on pages 90 to 127 form part of these accounts. The financial statements on pages 83 to 127 were approved by the Board on 29 May 2014 and signed on its behalf by:

David Sloman Chief Executive
29 May 2014

Statement of changes in taxpayers' equity for the year ended 31 March 2014

	Total reserves £000	Public dividend capital £000	Retained earnings £000	Revaluation reserve £000
Balance at 1 April 2013	**285,686**	190,968	15,206	79,512
Retained surplus/(deficit) for the year	**(21,973)**	-	(21,973)	-
Net gain/(loss) on revaluation of property, plant, equipment (note 10)	**1,396**	-	-	1,396
Impairments and reversals (note 10)	**(24,981)**	-	-	(24,981)
New public dividend capital received	**2,570**	2,570	-	-
Balance at 31 March 2014	**242,698**	193,538	(6,767)	55,927
Balance at 1 April 2012	**291,834**	184,722	31,611	75,501
Retained surplus/(deficit) for the year	**(16,405)**	-	(16,405)	-
Net gain/(loss) on revaluation of property, plant, equipment (note 10)	**6,233**	-	-	6,233
Impairments and reversals (note 10)	**(2,222)**	-	-	(2,222)
New public dividend capital received	**6,246**	6,246	-	-
Balance at 31 March 2013	**285,686**	190,968	15,206	79,512

Statement of cash flows for the year ended 31 March 2014

	NOTE	2013/14 £000	2012/13 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit)		(14,111)	(8,129)
Depreciation and amortisation	3	17,095	14,066
Impairments	3	30,059	28,361
(Increase)/decrease in trade and other receivables		(22,096)	(8,361)
(Increase)/decrease in inventories		467	(44)
Increase/(decrease) in trade and other payables		(9,813)	28,594
Increase/(decrease) in other liabilities		(782)	8,157
Increase/(decrease) in provisions		(3,558)	4,372
Other movements in operating cash flows		(29)	(27)
Net cash inflow/(outflow) from operating activities		(2,768)	66,989
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		220	465
Purchases of intangible assets		(1,713)	(3,939)
Purchases of property, plant and equipment		(30,951)	(31,448)
Net cash inflow/(outflow) from investing activities		(32,444)	(34,922)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		(35,212)	32,067
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		2,570	6,246
Loans received from the Independent Trust Financing Facility		20,000	-
Capital element of finance lease rental payments		(1)	(4)
Interest paid		(15)	-
Interest element of finance lease		(1,058)	(1,300)
Public dividend capital dividend paid		(7,253)	(7,950)
Net cash inflow/(outflow) from financing activities		14,243	(3,008)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(20,969)**	**29,059**
Cash and cash equivalents (and bank overdraft) at beginning of the period	16	82,655	53,596
Cash and cash equivalents (and bank overdraft) at year end	**16**	**61,686**	**82,655**

Notes to the accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS foundation trust annual reporting manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2013/14 issued by Monitor. The accounting policies contained in that manual follow the international financial reporting standards and HM Treasury's financial reporting manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

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.

1.2 Consolidation

Associates

Associate entities are those over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg share dividends, are received by the trust from the associate.

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 healthcare services.

Where income is received for a specific activity which is to be delivered in the following 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.

1.4 Expenditure on employee benefits

Short-term employee benefits

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

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of secretary of state in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' 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.

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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Measurement

Valuation

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

All assets are measured subsequently at fair value. Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment, subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

Subsequent expenditure

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

Depreciation

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

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

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

De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, ie:
  - management is 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.

Donated, government grant and other grant funded assets

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

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

1.7 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, 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.

Measurement

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

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

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

Amortisation

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

1.8 Revenue government and other grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the statement of comprehensive income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the 'first in, first out' method.

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.

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

De-recognition

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

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

Classification and measurement

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

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

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

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

Assets and liabilities in this category are classified as current assets and current liabilities.

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

Loans and receivables

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

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

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

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

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the statement of financial position date.

Available-for-sale financial assets are recognised initially at fair value including transaction costs and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the 'statement of comprehensive income' as an item of other comprehensive income. When items classified as available for sale are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in finance costs in the 'statement of comprehensive income'.

Other financial liabilities

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

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

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

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 directly.

1.11 Leases

Finance leases

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

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

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the 'statement of comprehensive income'. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

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.

1.12 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation 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 the NHS Litigation Authority 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.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, 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.

1.14 Public dividend capital

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

A charge reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation 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 Loan Fund deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value added tax

Most of the activities of the NHS foundation 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.

1.16 Corporation tax

NHS foundation trusts can be subject to corporation tax in respect of certain commercial non-core healthcare activities they undertake in relation to the Finance Act 2004 amended S519A Income and Corporation Taxes Act 1988. The trust does not undertake any non-core healthcare activities which are subject to corporation tax, therefore does not have a corporation tax liability.

1.17 Foreign exchange

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

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

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

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

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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.

1.19 Losses and special payments

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

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

1.20 Transfers of functions to/from other NHS bodies and/or local government bodies

For functions that have been transferred to the trust from another NHS and/or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets and liabilities transferred is recognised within income or expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the receiving entity's accounts.

Where the transferring body recognised revaluation reserve balances attributable to the assets, the receiving entity makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets and liabilities transferred is recognised within expenses or income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.21 Cash and cash equivalents

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

1.22 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates

to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the operating cost statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation on a quarterly basis.

1.23 Critical judgements and key sources of uncertainty

The following are the critical judgements and key assumptions or estimates that management has made in the process of applying the trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Valuation of land and buildings

The trust's land and building assets are valued on the basis explained in note 1.6 and note 10 to the accounts.

Montagu Evans 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 as described in note 11 to the accounts. 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 financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made. The carrying amounts and basis of the trust's provisions are detailed in note 22 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 14 to the accounts.

Consolidation of charitable funds

The trust has assessed its relationship to the charitable fund and determined that it is not a subsidiary. This is because the trust has no power to govern the financial and operating policies of the charitable fund so as to obtain the benefits from its activities for itself, its patients or its staff.

1.24 Operating segments

The chief operating decision maker of the organisation has been determined as the trust board, which receives financial information for the organisation as a whole entity. Accordingly, no segmental information is provided in these accounts.

Accounting standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following standards and interpretations to be applied in 2013/14. The application of the standards as revised would not have a material impact on the accounts for 2013/14, were they applied in that year.

IAS 27 (Revised 2011) Separate Financial Statements

IAS 28 (Revised 2011) Investments in Associatesand Joint Ventures

IAS 32 (Revised 2011) Financial instruments: presentation

IFRS 7 Financial instruments: disclosures IFRS 9 Financial Instruments

IFRS 10 Consolidated Financial Statements IFRS 11 Joint Arrangements

IFRS 12 Disclosure of Interests in Other Entities IFRS 13 Fair Value Measurement

1.25 Restatement of balances in accordance with NHS foundation trust accounting practice

The trust was awarded foundation trust status on 1 April 2012 and has assessed that there were no changes required in its accounting policies in moving from the NHS trust accounting regime to the foundation trust regime.

2. Operating income

	2013/14 £000	2012/13 £000
2.1 Income from activities (by type)		
Strategic health authorities	-	43,825
CCGs and NHS England	476,556	-
Primary care trusts	-	411,717
Department of Health - other	-	853
Local authorities	3,424	-
NHS other	4,888	2,428
Non-NHS: private patients	20,362	21,761
Non-NHS: overseas patients (non-reciprocal)	488	872
NHS injury scheme	602	837
Non-NHS: other	119	373
Total income from activities	506,439	482,666
2.2 Other operating revenue		
Research and development	7,421	7,669
Education and training	32,969	34,381
Received from NHS charities: other charitable and other contributions to expenditure	762	776
Received from other bodies: receipt of donations for capital acquisitions	408	1,757
Non-patient care services to other bodies	4,839	17,732
Rental revenue from operating leases: minimum lease receipts	1,616	1,595
Other	39,287	30,485
Total other operating revenue	87,302	94,395
TOTAL OPERATING INCOME	593,741	577,061

Other income of £39,287k (2012/13: £30,845k) relates predominantly to the sale of goods (see note 2.5). It also includes monies received in respect of transitional relief, income disputes resolved in the year, distinction awards, UCL medical school service level agreement, testing support income, car parking income and other balances.

2.3 Income from activities arising from commissioner requested services and all other services

	2013/14 £000	2012/13 £000
Income from commissioner requested services	467,804	457,227
Income from non-commissioner requested services	38,635	25,439
	506,439	482,666

The trust has not disposed of land and buildings assets used in the provision of commissioner requested services during the year ending 31 March 2014 nor the year ending 31 March 2013.

2.4 Income from activities (by classification)

	2013/14 £000	2012/13 £000
Elective income	58,404	55,164
Non-elective income	69,531	75,474
Out-patient income	63,576	66,887
A&E income	11,320	11,281
Other NHS clinical income	275,176	250,287
Non-NHS: private patient income	20,362	21,761
Non-NHS: other clinical income	8,070	1,812
	506,439	482,666

2.5 Income from rendering of services and sale of goods

	2013/14 £000	2012/13 £000
From rendering of services	581,299	567,955
From sale of goods	12,442	9,106
	593,741	577,061

Income from the sale of goods relates to the production of pharmaceuticals.

2.6 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that would have been provided previously are no longer required.

3. Operating expenses

	2013/14 £000	2012/13 £000
Services from NHS foundation trusts	3,673	2,927
Services from NHS trusts	6,801	8,371
Services from PCTs	-	1,523
Services from CCGs and NHS England	89	-
Services from other NHS bodies	225	154
Purchase of healthcare from non NHS bodies	12,141	11,161
Employee benefits: executive directors	1,071	1,054
Employee benefits: non-executive directors	137	137
Employee benefits: staff	277,977	266,205
Supplies and services: clinical (excluding drug costs)	45,559	48,344
Supplies and services: general	7,742	7,166
Establishment	3,431	4,366
Research and development (not included in employee benefits note)	1,561	1,887
Research and development (included in employee benefits note)	4,558	4,239
Transport	7,157	5,325
Premises	14,806	16,098
Increase/(decrease) in provision for impairment of receivables	4,800	2,327
Increase/(decrease) in other provisions	688	-
Inventories written down	45	32
Drugs costs	149,491	144,294
Rentals under operating leases: minimum lease payments	1,868	2,113
Depreciation on property, plant and equipment	15,453	13,766
Amortisation on intangible assets	1,642	300
Impairments of property, plant and equipment	30,059	28,361
Audit fees payable to the external auditor: statutory audit	123	107
Audit fees payable to the external auditor: corporate finance transaction services	118	-
Clinical negligence premium	5,725	5,966
Legal fees	798	-
Consultancy costs	5,998	3,860
Training, courses and conferences	1,550	1,858
Patient travel	368	303
Car parking & security	72	82
Redundancy	208	188
Early retirements	69	56
Hospitality	104	105
Insurance	538	486
Other	1,207	2,029
	607,852	585,190

External auditor liability

The engagement letter signed on 4 March 2014 states that the liability of PricewaterhouseCoopers LLP, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1m (2012/13: £1m), in the aggregate in respect of all services.

4. Operating leases

4.1 As lessee

The operating lease payments recognised in expenses include the energy centre and imaging equipment contracts. The energy centre contract is for 15 years with no option to extend and no option to purchase the machinery. The equipment remains the property of the contractors for the period and also on contract expiry. The imaging equipment contract is for seven years; there is currently no plan to extend the lease or purchase the equipment at the end of the lease period.

	2013/14		
	Total	**Buildings**	**Other**
	£000	**£000**	**£000**
Payments recognised as an expense			
Minimum lease payments	**1,868**	72	1,796
Total	**1,868**	72	1,796
Payable:			
No later than one year	**1,673**	72	1,601
Between one and five years	**4,912**	42	4,870
After five years	**4,795**	-	4,795
Total	**11,380**	114	11,266

	2012/13		
	Total	**Buildings**	**Other**
	£000	**£000**	**£000**
Payments recognised as an expense			
Minimum lease payments	**2,113**	212	1,901
Total	**2,113**	212	1,901
Payable:			
No later than one year	**1,708**	72	1,636
Between one and five years	**5,146**	114	5,032
After five years	**5,391**	-	5,391
Total	**12,245**	186	12,059

4.2 As lessor

Operating lease income of £1,616k (2012/13: £1,595k) arises principally to leasing parts of the Royal Free's buildings.

	2013/14	**2012/13**
	£000	**£000**
Future minimum lease receipts due		
No later than one year	1,317	1,615
Between one and five years	3,621	5,278
After five years	198	1,460
Total	5,136	8,353

5. Employee benefits and staff numbers

	2013/14		
	Total	Permanently employed	Other
	£000	£000	£000
Employee benefits: gross expenditure			
Salaries and wages	**228,514**	207,157	21,357
Social security costs	**19,249**	17,960	1,289
Employer contributions to NHS Pensions scheme	**26,718**	25,598	1,120
Agency/contract staff	**11,964**	-	11,964
Total gross employee benefits	**286,445**	250,715	35,730
Costs capitalised as part of assets	**2,562**	2,546	16
Total employee benefits excluding capitalised costs	**283,883**	248,169	35,714

	2012/13		
	Total	Permanently employed	Other
	£000	£000	£000
Employee benefits: gross expenditure			
Salaries and wages	**218,387**	203,157	15,230
Social security costs	**19,018**	17,827	1,191
Employer contributions to NHS Pensions scheme	**24,380**	23,870	510
Agency/contract staff	**12,259**	-	12,259
Total gross employee benefits	**274,044**	244,854	29,190
Costs capitalised as part of assets	**2,302**	1,536	766
Total employee benefits excluding capitalised costs	**271,742**	243,318	28,424

5.2 Directors emoluments

	2013/14			
	Total	Remuneration	Employers pension contributions	Employers NI contributions
	£000	£000	£000	£000
Executive directors	**1,071**	857	111	103
Non-executive directors	**137**	127	-	10
TOTAL	**1,208**	984	111	113

	2012/13			
	Total	Remuneration	Employers pension contributions	Employers NI contributions
	£000	£000	£000	£000
Executive directors	**1,054**	851	119	84
Non-executive director**s**	**137**	127	-	10
TOTAL	**1,191**	978	119	94

5.3 Staff numbers

	2013/14		
	Total	Permanently employed	Other
	Number	Number	Number
Average staff numbers			
Medical and dental	**824**	305	519
Administration and estates	**1,142**	1,030	112
Healthcare assistants and other support staff	**786**	760	26
Nursing, midwifery and health visiting staff	**1,487**	1,452	35
Nursing, midwifery and health visiting learners	**4**	-	4
Scientific, therapeutic and technical staff	**770**	732	38
Bank and agency staff	**718**	-	718
TOTAL	**5,731**	4,279	1,452
Of the above: staff engaged on capital projects	**31**	14	17

	2012/13		
	Total	Permanently employed	Other
	Number	Number	Number
Average staff numbers			
Medical and dental	**809**	288	521
Administration and estates	**1,150**	1,028	122
Healthcare assistants and other support staff	**741**	696	45
Nursing, midwifery and health visiting staff	**1,462**	1,413	49
Nursing, midwifery and health visiting learners	**4**	-	4
Scientific, therapeutic and technical staff	**752**	721	31
Bank and agency staff	**672**	-	672
TOTAL	**5,590**	4,146	1,444
Of the above: staff engaged on capital projects	**29**	23	6

5.4 Staff sickness absence

	2013/14	2012/13
	Number	Number
Total days lost	39,414	37,814
Total staff years (full time equivalent)	5,013	4,917
Average working days lost	7.9	7.7

5.5 Ill health retirements

	2013-14		2012-13	
	£000	Number	£000	Number
Early retirements due to ill health	69	3	56	2

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. This information has been supplied by NHS Pensions

5.6 Exit packages

The disclosures reports the number and value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

5.6.1 Staff exit packages

	2013/14			2013/12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	5	7	12	2	7	9
£10,001-£25,000	2	3	5	7	1	8
£25,001-£50,000	4	-	4	3	-	3
Total number of exit packages by type (total cost)	11	10	21	12	8	20
Total resource cost (£000)	209	79	288	239	44	283

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 the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

5.6.2 Non-compulsory departure payments

	2013/14		2012/13	
	Agreements Number	**Total value of agreements £000**	**Agreements Number**	**Total value of agreements £000**
Contractual payments in lieu of notice	10	79	8	44
Total	10	79	8	44
Of which: non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

5.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Subject to the Barnet and Chase Farm Hospitals NHS Trust acquisition, the trust expects its contributions in 2014/15 to be in line with those costs for 2013/14.

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 the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014 is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Accounts, published annually. These accounts can be viewed on the NHS pensions website. 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 scheme (taking into account its recent demographic experience) and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The scheme regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury,and consideration of the advice of the scheme actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and on the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971 and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index has been used and replaced the Retail Prices Index.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice the final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Pension Scheme and contribute to money purchase AVC run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

6. Better payment practice code

Measure of compliance	2013/14		2012/13	
	Number	£000	Number	£000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	79,765	292,103	77,478	255,359
Total non-NHS trade invoices paid within target	55,553	221,837	58,725	200,418
Percentage of non-NHS trade invoices paid within target	69.65%	75.94%	75.80%	78.48%
NHS payables				
Total NHS trade invoices paid in the year	2,264	35,814	3,593	40,822
Total NHS trade invoices paid within target	1,571	31,911	2,859	36,254
Percentage of NHS trade invoices paid within target	69.39%	89.10%	79.57%	88.81%

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

7. Investment income

	2013/14	2012/13
	£000	£000
Bank interest	212	465
Total investment income	212	465

8. Finance costs

	2013/14	2012/13
	£000	£000
Interest expense		
Loans from the Independent Trust Financing Facility	11	-
Finance leases	1,058	1,300
Other	4	-
Sub-total	1,073	1,300
Provisions: unwinding of discount	22	31
Total	1,095	1,331

9. Intangible non-current assets

	Total	Software purchased	Development expenditure
	£000	£000	£000
Cost or valuation			
At 1 April 2013	**5,341**	273	5,068
Reclassifications	**1,713**	311	1,402
Disposals	**(50)**	-	(50)
At 31 March 2014	**7,004**	584	6,420
Amortisation			
At 1 April 2013	**737**	37	700
Provided during the year	**1,642**	114	1,528
Disposals	**(50)**	-	(50)
At 31 March 2014	**2,329**	151	2,178
Net Book Value at 31 March 2014	**4,675**	433	4,242
Net Book Value at 31 March 2014 comprises:			
Purchased	**4,675**	433	4,242
Total at 31 March 2014	**4,675**	433	4,242

	Total	Software purchased	Development expenditure
	£000	£000	£000
Cost or valuation			
At 1 April 2012	**1,414**	160	1,254
Reclassifications	**3,939**	125	3,814
Disposals	**(12)**	(12)	-
At 31 March 2013	**5,341**	273	5,068
Amortisation			
At 1 April 2012	**449**	40	409
Provided during the year	**300**	9	291
Disposals	**(12)**	(12)	-
At 31 March 2013	**737**	37	700
Net Book Value at 31 March 2013	**4,604**	236	4,368
Net Book Value at 31 March 2013 comprises:			
Purchased	**4,604**	236	4,368
Total at 31 March 2013	**4,604**	236	4,368

All intangible assets have finite lives and as such are amortised on a straight line basis over their useful economic life. The useful life is reviewed at each annual reporting date. The trust's intangible assets have not been revalued at 31 March 2014 or 31 March 2013 as they are considered unique. As such there is no revaluation reserve relating to intangible assets.

Intangible assets are amortised over the following periods:

	Min. life years	Max. life Years
Software purchased	3	5
Development expenditure	3	5

10. Property, plant and equipment

	Total	Land	Buildings excl. dwellings	Dwelling	Assets under constr.	Plant & mach.	Transport equip.	IT	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2013	**353,926**	94,021	156,213	196	12,197	73,543	79	14,808	2,869
Additions: purchased	**36,072**	-	-	-	36,072	-	-	-	-
Additions: donated	**21**	-	-	-	21	-	-	-	-
Impairments (to statement of comprehensive income)	**(30,059)**	(2,112)	(27,431)	-	(516)	-	-	-	-
Impairments (to revaluation reserve)	**(23,324)**	(22,457)	(2,524)	-	-	-	-	-	-
Elimination of accumulated depreciation on revaluation	**(6,947)**	-	(6,945)	(2)	-	-	-	-	-
Reclassifications	**(1,713)**	-	27,148	-	(37,838)	4,984	-	3,754	239
Revaluations	**1,396**	1,174	222	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	**(3,500)**	(3,500)	-	-	-	-	-	-	-
Disposals	**(18,984)**	-	-	-	-	(16,613)	(36)	(2,300)	(35)
At 31 March 2014	**305,231**	67,126	146,683	194	9,936	61,914	43	16,262	3,073
Depreciation									
At 1 April 2013	**65,921**	-	-	-	-	54,023	79	10,534	1,285
Provided during the year	**15,453**	-	6,945	2	-	6,140	-	2,198	168
Elimination of accumulated depreciation on revaluation	**(6,947)**	-	(6,945)	(2)	-	-	-	-	-
Disposals	**(18,984)**	-	-	-	-	(16,613)	(36)	(2,300)	(35)
At 31 March 2014	**55,443**	-	-	-	-	43,550	43	10,432	1,418
Net Book Value at 31 March 2014	**249,788**	68,783	153,489	194	9,936	18,364	-	5,830	1,655

	Total	Land	Buildings excl. dwellings	Dwelling	Assets under constr.	Plant & mach.	Transport equip.	IT	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value at 31 March 2014 comprises:									
Purchased	**232.639**	67,126	130,160	194	9,936	17,738	-	1,655	5,830
Finance leases	**8,144**	-	8,144	-	-	-	-	-	-
Donated	**9,005**	-	8,379	-	-	626	-	-	-
Total at 31 March 2014	**249,788**	67,126	146,683	194	9,936	18,364	-	1,655	5,830

	Total	Land	Buildings excl. dwellings	Dwelling	AUC & POA	Plant & mach.	Transport equip.	IT	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2012	**382,842**	87,973	182,690	301	27,674	67,309	79	13,841	2,975
Additions: purchased	**31,963**	-	-	-	31,963	-	-	-	-
Additions: donated	**963**	-	-	-	963	-	-	-	-
Impairments (to statement of comprehensive income)	**(28,361)**	-	(28,361)	-	-	-	-	-	-
Impairments (to revaluation reserve)	**(2,222)**	(27)	(2,195)	-	-	-	-	-	-
Elimination of accumulated depreciation on revaluation	**(33,893)**	-	(33,788)	(105)	-	-	-	-	-
Reclassifications	**-**	-	37,709	-	(48,403)	9,379	-	1,262	53
Revaluations	**6,233**	6,075	158	-	-	-	-	-	-
Disposals	**(3,599)**	-	-	-	-	(3,145)	-	(295)	(159)
At 31 March 2013	**353,926**	94,021	156,213	196	12,197	73,543	79	14,808	2,869
Depreciation									
At 1 April 2012	**89,647**	-	27,226	90	-	52,114	79	8,847	1,291
Provided during the year	**13,766**	-	6,562	15	-	5,054	-	1,982	153
Elimination of accumulated depreciation on revaluation	**(33,893)**	-	(33,788)	(105)	-	-	-	-	-
Disposals	**(3,599)**	-	-	-	-	(3,145)	-	(295)	(159)
At 31 March 2013	**65,921**	-	-	-	-	54,023	79	10,534	1,285
Net Book Value at 31 March 2013	**288,005**	94,021	156,213	196	12,197	19,520	-	4,274	1,584
Net Book Value at 31 March 2013 comprises:									
Purchased	**272,898**	94,021	141,106	196	12,197	19,520	-	4,274	1,584
Finance leases	**4,995**	-	4,995	-	-	-	-	-	-
Donated	**10,112**	-	10,112	-	-	-	-	-	-
Total at 31 March 2013	**288,005**	94,021	156,213	196	12,197	19,520	-	4,274	1,584

Revaluation reserve balance for property, plant and equipment									
At 1 April 2013	**79,512**	72,871	2,895	-	-	3,746	-	-	-
Net movement arising from revaluation	**(23,585)**	(21,283)	(2,302)	-	-	-	-	-	-
At 31 March 2014	**55,927**	51,588	593	-	-	3,746	-	-	-
At 1 April 2012	**75,501**	66,823	4,932	-	-	3,746	-	-	-
Net movement arising from revaluation	**4,011**	6,048	(2,037)	-	-	-	-	-	-
At 31 March 2013	**79,512**	72,871	2,895	-	-	3,746	-	-	-

Additions to assets under construction

	2013/14 £000	2012/13 £000
Buildings excluding dwellings	25,355	22,232
Plant & machinery	5,095	9,376
Information Technology	5,457	1,265
Furniture & Fittings	165	53
Balance at the year end	36,072	32,926

During the year assets to the value of £21k were donated to the Trust (2012/13: £963k).

A full valuation exercise was carried out on the trust's land and buildings by Montagu Evans. The purpose of this exercise was to determine a fair value for those assets as at 31 March 2014 (2012/13: DVS).

The valuation was undertaken having regard to International Financial Reporting Standards as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 8th Edition.

Fair value is defined as "the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants at the measurement date." Fair values are determined as follows:

- for non-specialised operational assets, this equates in practice to Existing Use Value (EUV), as defined below.
- for specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost approach subject to the assumption of continuing use.

The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UKVS 1.3 as:

"The estimated amount for which an asset should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction after proper marketing and where the parties had acted knowledgeably, prudently and without compulsion – assuming that the buyer is granted vacant possession of all parts of the asset required by the business, and disregarding potential alternative uses and any other characteristics of the asset that would cause its market value to differ from that needed to replace the remaining service potential at least cost."

Where a non-specialised operational property is valued to Fair Value reflecting the Market Value assuming continuance of existing use, the total value has been apportioned between the residual amount (the land) and the depreciable amount (the building).

Depreciated Replacement Cost (DRC) is the valuation approach adopted for reporting the value of specialised operational property for financial accounting purposes. RICS GN 6, entitled "Depreciated Replacement Cost Method of Valuation for Financial Reporting", at para 2.3 defines DRC as:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis.

Property, plant and equipment is depreciated over the following periods:

	Min. life years	Max. life years
Buildings excluding dwellings	4	95
Dwellings	4	95
Assets under construction and payments on account	3	20
Plant & machinery	5	20
Transport equipment	7	7
Information technology	3	5
Furniture & fittings	7	7

11. Analysis of impairments and reversals

	2013/14 Property, plant and equipment £000	2012/13 Property, plant and equipment £000
Abandonment of assets under construction	516	-
Changes in market price	29,543	28,361
Impairments charged to operating surplus	30,059	28,361
Impairments charged to the revaluation reserve	24,981	2,222
Total impairments	55,040	30,583
Impairments charged to operating surplus, of which:		
Department expenditure limits	516	-
Annually managed expenditure	29,543	28,361
	30,059	28,361

The impairments recognised above arise as a result of the revaluation exercise undertaken in the year, as described in note 10.

12. Commitments

Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014 £000	31 March 2013 £000
Property, plant and equipment	8,551	17,501
Total	8,551	17,501

13. Inventories

	Total £000	Drugs £000	Consumables £000	Energy £000
Balance at 1 April 2013	**6,141**	4,292	1,656	193
Additions	**134,034**	134,034	-	-
Inventories recognised as an expense	**(134,456)**	(134,391)	(48)	(17)
Write-down of inventories (including losses)	**(45)**	(45)	-	-
Balance at 31 March 2014	**5,674**	3,890	1,608	176
Balance at 1 April 2012	**6,097**	4,685	1,265	147
Transfers by absorption	**(672)**	(672)	-	-
Additions	**145,042**	144,605	391	46
Inventories recognised as an expense	**(144,294)**	(144,294)	-	-
Write-down of inventories (including losses)	**(32)**	(32)	-	-
Balance at 31 March 2013	**6,141**	4,292	1,656	193

14. Trade and other receivables

	31 March 2014 Current £000	31 March 2013 Current £000
NHS receivables: revenue	40,477	13,136
NHS receivables: capital	-	401
Receivables due from NHS charities: revenue	1,051	1,513
Other receivables with related parties: revenue	102	1
Provision for impaired receivables	(19,746)	(15,690)
Prepayments	3,540	2,292
Accrued income	8,163	5,090
Interest receivable	4	12
PDC dividend receivable	814	540
VAT receivable	1,763	675
Other receivables: revenue	25,707	31,944
Other receivables: capital	22	-
Total	61,897	39,914

The great majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As these organisations are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

14.1 Provision for impairment of receivables

Balance at 1 April	15,690	13,676
Increase in provision	4,800	2,327
Amounts utilised	(744)	(313)
Balance at 31 March	19,746	15,690

The trust has impaired receivables based on age and any specific details known.

14.2 Analysis of impaired receivables

Ageing of impaired receivables		
0-30 days	2,641	1,601
30-60 days	1,797	1,500
60-90 days	537	403
90-180 days	651	814
Over 180 days	14,120	11,372
Total	19,746	15,690
Ageing of non-impaired receivables past their due date		
0-30 days	10,765	17,248
30-60 days	3,480	9,256
60-90 days	2,096	1,869
90-180 days	2,937	3,407
Over 180 days	1,578	88
Total	20,856	31,868

15. Non-current assets held for sale

	Land	Total
	£000	£000
Net book value of non-current assets for sale at 1 April 2013	-	-
Plus assets classified as available for sale in the year	3,500	**3,500**
Net book value of non-current assets for sale at 31 March 2014	3,500	**3,500**

Coppett's Wood hospital has been reclassified as held for sale. The property is vacant and surplus to trust requirements. The property has undergone soft market testing already and is expected to be actively marketed early in the new financial year with a sale in late summer 2014.

16. Cash and cash equivalents

	31 March 2014	31 March 2013
	£000	£000
Opening balance	82,655	53,596
Net change in year	(20,969)	29,059
Closing balance	61,686	82,655
Made up of:		
Cash with Government Banking Service	60,925	82,363
Commercial banks	761	292
Closing balance	61,686	82,655
Patients' money held by the trust, not included above	11	14

17. Trade and other payables

	Current	
	31 March 2014	31 March 2013
	£000	£000
Receipts in advance	805	-
NHS payables: revenue	10,252	16,420
Amounts due to other related parties: revenue	-	45
Other trade payables: capital	8,700	5,650
Other trade payables: revenue	18,032	25,117
Social security costs	2,952	2,878
Other taxes payable	3,171	3,184
Other payables	7,598	8,195
Accruals	42,002	38,786
Total	93,512	100,275

	Non-current	
	31 March 2014	31 March 2013
	£000	£000
Amounts due to other related parties: revenue	400	400
Total	400	400

	Total	
	31 March 2014	31 March 2013
	£000	£000
Receipts in advance	**805**	**-**
NHS payables: revenue	**10,252**	**16,420**
Amounts due to other related parties: revenue	**400**	**445**
Other trade payables: capital	**8,700**	**5,650**
Other trade payables: revenue	**18,032**	**25,117**
Social security costs	**2,952**	**2,878**
Other taxes payable	**3,171**	**3,184**
Other payables	**7,598**	**8,195**
Accruals	**42,002**	**38,786**
Total	**93,912**	**100,675**
Included in NHS payables are outstanding pension contributions:	3,843	3,316

18. Other liabilities

	31 March 2014		
	Total £000	Current £000	Non-current £000
Other deferred income	**7,710**	7,710	-
Lease incentives	**4,442**	168	4,274
Total	**12,152**	7,878	4,274

	31 March 2013		
	Total £000	Current £000	Non-current £000
Other deferred income	**8,157**	8,157	-
Lease incentives	**4,777**	168	4,609
Total	**12,934**	8,325	4,609

19. Borrowings

	31 March 2014		
	Total £000	Current £000	Non-current £000
Loans from Independent Trust Financing Facility	**20,000**	-	20,000
Obligations under finance leases	**7,497**	1	7,496
Total	**27,497**	1	27,496

	31 March 2013		
	Total £000	Current £000	Non-current £000
Obligations under finance leases	**7,527**	4	7,523
Total	**7,527**	4	7,523

The trust has an unsecured loan of £20,000,000 (2012/13: £nil). The loan was taken out on 24 March 2014 for a 20-year term. Repayments will commence on 18 September 2015. The loan carries interest at 2.96%.

20. Finance lease obligations as lessee

The trust has entered into two contracts to lease accommodation under finance leases, whereby the assets were made available for use and rental payments commenced on 1 April 2000 and 1 June 2005.

	31 March 2014		31 March 2013	
	Minimum lease payments £000	Present value of lease payments £000	Minimum lease payments £000	Present value of lease payments £000
Amounts payable under finance leases (buildings)				
Within one year	1,016	1	1,168	4
Between one and five years	4,181	5	4,973	16
After five years	28,113	7,491	42,502	7,507
	33,310	7,497	48,643	7,527
Less: future finance charges	(25,813)	-	(41,116)	-
Present value of lease obligations	7,497	7,497	7,527	7,527

21. Contingencies

	31 March 2014 £000	31 March 2013 £000
Contingent liabilities		
Other (legal)	64	35
Gross value of contingent liabilities	64	35
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	64	35

22. Provisions

	31 March 2014			31 March 2013		
	Total	Current	Non-current	Total	Current	Non-current
	£000	£000	£000	£000	£000	£000
Pensions relating to other staff	1,264	183	1,081	**1,231**	180	1,051
Legal claims	94	94	-	**77**	77	-
Redundancy	4,239	4,239	-	**1,634**	1,155	479
Other	5,364	5,226	138	**11,555**	11,438	117
Total	10,961	9,742	1,219	**14,497**	12,850	1,647

	Total	Pensions relating to other staff	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000
Balance at 1 April 2013	**14,497**	1,231	77	1,634	11,555
Arising during the year	**3,543**	197	17	2,741	588
Utilised during the year: accruals	**(57)**	(46)	-	-	(11)
Utilised during the year: cash	**(4,401)**	(138)	-	(51)	(4,212)
Reversed unused	**(2,643)**	(2)	-	(85)	(2,556)
Unwinding of discount	**22**	22	-	-	-
Balance at 31 March 2014	**10,961**	1,264	94	4,239	5,364
Expected timing of cashflows:					
Within one year	**9,742**	183	94	4,239	5,226
Between one and five years	**870**	732	-	-	138
	349	349	-	-	-
After five years	**10,961**	1,264	94	4,239	5,364

	Total	Pensions relating to other staff	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000
Balance at 1 April 2012	**10,125**	1,352	1,031	682	7,060
Arising during the year	**8,242**	43	50	1,634	6,515
Utilised during the year: accruals	**(236)**	(45)	-	-	(191)
Utilised during the year: cash	**(764)**	(134)	(26)	(100)	(504)
Reversed unused	**(2,901)**	(17)	(978)	(582)	(1,324)
Unwinding of discount	**31**	32	-	-	(1)
Balance at 31 March 2013	**14,497**	1,231	77	1,634	11,555
Expected timing of cashflows:					
Within one year	**12,850**	180	77	1,155	11,438
Between one and five years	**1,647**	1,051	-	479	117
	14,497	1,231	77	1,634	11,555

Staff pensions are calculated using a formula supplied by the NHS Pensions Agency. These pensions are the costs of early retirement of staff resulting from reorganisation.

Legal claims relate to an action against the trust which is not covered by the NHS Litigation Authority. IAS 37 allows for the non-disclosure of further information which may prejudice the outcome of litigation.

Other provisions include sums held in respect of additional charges arising from provision of services, settlements of legal claims, dilapidations associated with leases and other contractual challenges. No further information has been disclosed as IAS 37 allows the withholding of information which may seriously prejudice the trust.

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities as at 31 March 2014 is £58,156k (31 March 2013: £45,874k).

23. Financial instruments

23.1 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. Due to the service provider relationship that the trust has with NHS England and with clinical commissioning groups (CCGs) since 1 April 2013 (and the way those organisations are financed) the NHS trust is not exposed to the degree of financial risk faced by business entities. In addition, 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. Financial assets and liabilities are typically generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities. The trust does not undertake speculative treasury transactions.

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

23.2 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.

23.3 Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability. The borrowings are for up to 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.

23.4 Credit risk

As the majority of the trust's income comes from binding contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

23.5 Liquidity risk

The trust's operating costs are incurred under contracts with NHS England and CCGs, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from internally generated funds, with any borrowing managed by the trust's appropriate board committee. Liquidity is also regulated through Monitor's financial risk rating. The trust is therefore not exposed to significant liquidity risks. The fair value of financial liabilites as at 31 March 2013 has been restated to exclude current liabilities.

23.6 Fair values of financial assets

The fair value of financial assets is equal to their book value.

23. Financial instruments

23.2 Financial assets by category

	31 March 2014 Loans and receivables £000	31 March 2013 Loans and receivables £000
Trade and other receivables excluding non-financial assets	55,780	52,097
Cash and cash equivalents at bank and in hand	61,686	82,655
Total	117,466	134,752

23.3 Financial liabilities by category

	31 March 2014 Other £000	31 March 2013 Other £000
Borrowings excluding finance lease and PFI liabilities	20,000	-
Obligations under finance leases	7,497	7,527
Trade and other payables excluding non financial assets	87,789	94,613
Provisions under contract	4,457	8,214
Total	119,743	110,354

23.4 Maturity of financial liabilities

	31 March 2014 £000	31 March 2013 £000
In one year or less	91,730	101,835
In more than one year but not more than two years	1,570	622
In more than two years but not more than five years	4,212	390
In more than five years	22,231	7,507
Total	119,743	110,354

23.5 Fair values of financial liabilities

	31 March 2014		31 March 2013 (restated)	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Loans	20,000	20,000	-	-
Obligations under finance leases	7,496	7,496	7,527	7,527
Non-current trade and other payables excluding non-financial assets	400	400	400	400
Provisions under contract	117	117	8,214	8,214
Total	28,013	28,013	16,141	16,141

24. Related party transactions

During the year none of the Department of Health (DH) ministers, trust board members or members of the key management staff, trust governors or parties related to any of them, has undertaken any material transactions with Royal Free London NHS Foundation Trust.

The trust holds a 20% interest in UCL Partners Limited ("UCLP"), a company limited by guarantee, acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. The contributions paid by the trust are included within operating expenditure. The most recent available signed financial statements for UCLP have been prepared for the year ending 31 March 2013; the reported assets, liabilities, revenues and profit/loss are not material to the trust.

The Department of Health is regarded as a related party. During the years ending 31 March 2014 and 31 March 2013 the trust has had a significant number of material transactions with the department and with other entities for which the DH is regarded as the parent department. In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies.

Transactions with government bodies greater than 0.5% of trust income, together with all transactions for other related parties are as follows:

24. Related party transactions

2013/14	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
University College London NHS Foundation Trust	2,370	2,946	3,215	3,071
Barnet And Chase Farm Hospitals NHS Trust	2,833	3,921	5,458	4,665
Barts Health NHS Trust	10,880	1,977	1,574	111
Imperial College Healthcare NHS Trust	3,246	10	448	42
NHS Barnet CCG	27	69,966	405	1,643
NHS Brent CCG	-	12,422	377	-
NHS Camden CCG	-	62,853	321	5,345
NHS Central London (Westminster) CCG	-	3,480	-	1,108
NHS East And North Hertfordshire CCG	-	4,437	-	139
NHS Enfield CCG	-	10,833	-	409
NHS Haringey CCG	-	13,056	-	488
NHS Harrow CCG	-	3,998	-	390
NHS Herts Valleys CCG	-	8,904	247	7
NHS Islington CCG	-	9,628	-	817
NHS England	62	253,566	603	13,934
Health Education England	-	32,959	208	285
NHS Litigation Authority	6,064	-	1	-
NHS Trust Development Authority	-	3,753	-	3,755
HM Revenue & Customs	-	-	3,171	1,763
National Insurance Fund	19,249	-	2,952	-
NHS Pension Scheme	26,718	-	3,843	-
NHS Blood & Transplant	3,033	1,742	-	73
UCL Partners Limited	100	268	-	102
Royal Free Charity	1,145	762	-	1,051

2012/13	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Barnet PCT	1,636	86,525	2,919	255
Brent Teaching PCT	-	16,079	-	262
Bristol PCT	-	5,083	-	659
Camden PCT	518	80,091	2,796	162
*Croydon PCT	-	98,904	-	1,166
Enfield PCT	-	16,422	-	28
Hertfordshire PCT	-	16,870	529	16
Hillingdon PCT	-	2,990	-	41
Islington PCT	2	18,075	1,065	44
South East Essex PCT	-	13,615	1,683	50
Westminster PCT	-	5,787	-	277
University College London Hospitals NHS Foundation Trust	1,995	3,300	3,179	2,063
London Strategic Health Authority	50	79,017	263	2,561
East of England Strategic Health Authority	-	8,742	-	-
HM Revenue & Customs - Other taxes and duties	-	-	3,184	-
NHS Blood and Transplant	3,098	-	247	-
NHS Litigation Authority	6,248	-	11	-
Department of Health: NHS Supply Chain	7,979	-	-	-
UCL Partners Limited	100	-	-	-
Royal Free Charity	-	776	-	1,513
Circus Space	1	-	-	-
Central and East London Comprehensive Local Research Network	-	226	-	-

* Croydon PCT was the host organisation for the London Specialised Commissioning Group. The values above reflect transactions and balances with both organisations.

25. Prudential borrowing limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

26. Events after the end of the reporting period

There have been no adjusting or non-adjusting events since the balance sheet date to the date of signing these accounts.

27. Absorption accounting

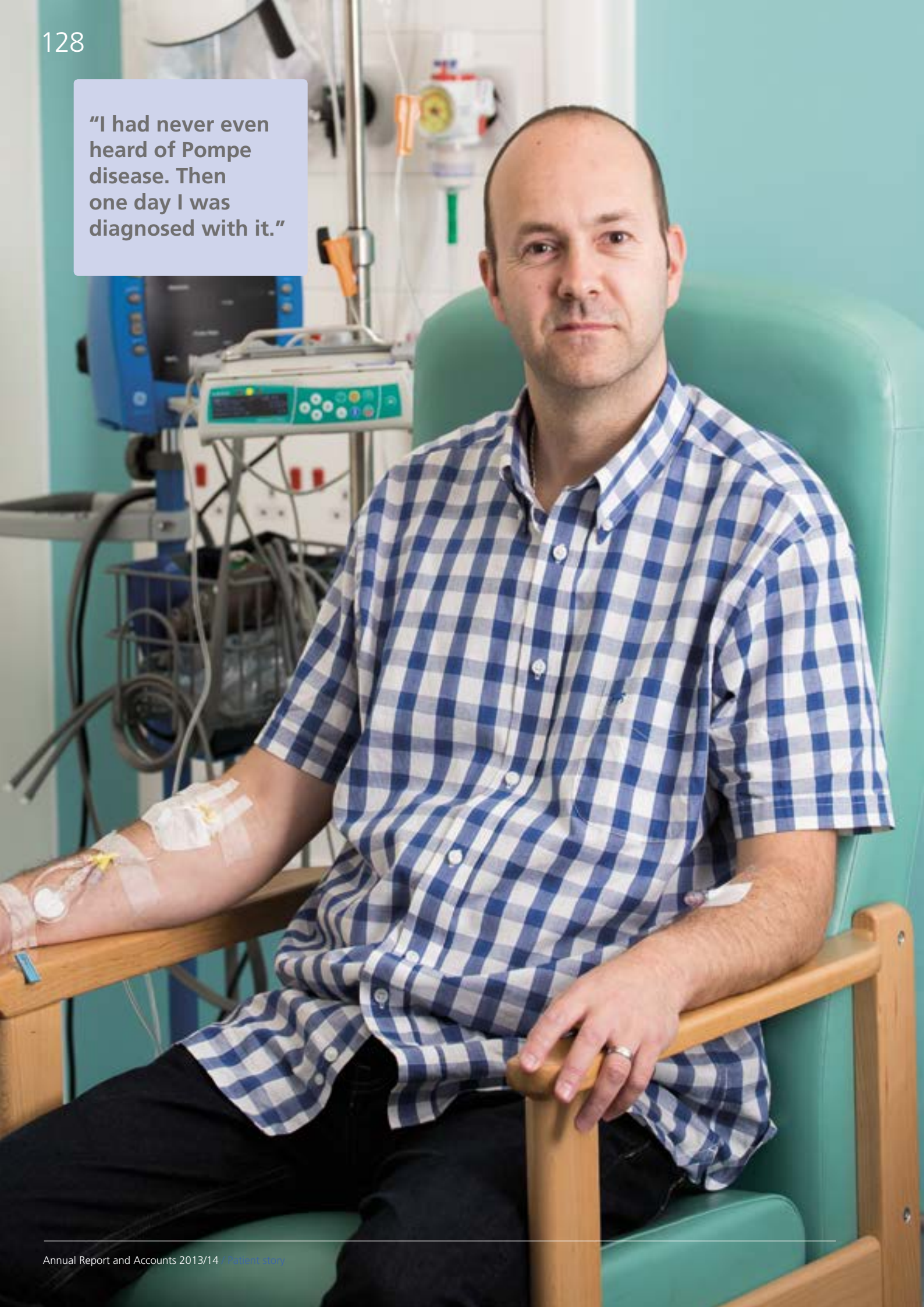
On 1 April 2012 the services provided at the Royal National Throat, Nose and Ear Hospital were transferred to University College London Hospital NHS Foundation Trust. Non-current assets with a carrying value of £1 and inventory with a carrying value of £672,000 was sold at nil gain or loss and has been accounted for using absorption accounting.

28. Losses and special payments

	Total cases 2013/14		Total cases 2012/13	
	Number	£000	Number	£000
Losses:				
Cash losses	13	10	3	2
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	149	734	100	386
Stores losses	2	48	10	32
	164	792	113	420
Special payments:				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	1	2	1	7
Special severance payments	-	-	-	-
Ex-gratia payments	13	13	8	5
	14	15	9	12
Total losses and special payments	178	807	122	432

The amounts are reported on an accruals basis but excluding provisions for future losses.

There were no cases individually over £250,000 in the year (2012/13: none).



"I had never even heard of Pompe disease. Then one day I was diagnosed with it."

Meet Andy

Andy Jackson lives in Southampton and works as a commercial manager for busy local house builder Barratt David Wilson.

Andy, who is married to Cindy and has four children, has been living with Pompe disease for over two years. Like many people, until the day of his diagnosis Andy had never heard of the rare muscle wasting disease, which isn't curable and can affect simple day-to-day tasks.

"My illness affects all the things that I used to take for granted, such as bending and lifting and running around after the kids. It was such a shock.

"It's a rare genetic condition and only three centres in the UK specialise in treatment. Luckily for me, my consultant quickly recognised the symptoms and referred me to the lysosomal storage disorders unit at the Royal Free.

"I had the chance to take part in a clinical trial. Since then I've been coming into the hospital's brand new Institute for Immunity and Transplantation every two weeks for enzyme replacement therapy.

"I drive up early in the morning and my regular nurse, Allison Warwick, prepares my drug and attaches me to the drip and the therapy takes about five and a half hours. "I'm closely monitored throughout and have my vital signs, blood and temperature taken frequently.

"At first, the thought of a clinical trial was scary. But the doctors and clinical nurses soon put my mind at rest and I wanted to use their expertise and knowledge in a positive way. "I have already seen minor improvements and my progress is being constantly evaluated. As well as helping me, I know the clinical trial will help patients in the future and give us a better understanding of the condition.

"The new institute is much better than the old ward where I used to be treated. But most importantly for me, it's a place where I can spend time with patients in a similar situation to me and it really helps to talk and share our experiences. I see the same staff every fortnight and we are all on first name terms. I'm treated like a friend rather than a patient."

QUALITY REPORT
PART ONE

We have strengthened our focus on safety.

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It gives me great pleasure to introduce the Royal Free's 2013/14 quality report, which assures our local population, patients and commissioners that we continuously strive to provide the highest level of clinical care.

We have now completed our second year as a foundation trust and I am pleased to report that we are meeting all the quality objectives set for us by Monitor, the regulator of foundation trusts.

It is 18 months since we last had a patient with an acquired methicillin resistant staphylococcus aureus (MRSA) bacteraemia. We have also made progress in our control of C. difficile infection, focusing on the way we use antibiotics that sometimes cause this infection. Cases have fallen from 50 in 2013/14 to 35 this year.

At a time when there has been increased pressure on accident and emergency departments, we have been able to maintain performance against the waiting time targets.

In the past two years we have concentrated on our World Class Care programme, designed to improve patient and staff experience and in recent months we have further strengthened our focus on safety with a new patient safety programme. This will build on work we have already undertaken in a number of areas including the management of sepsis, reducing hospital acquired pressure ulcers and minimising the risk of patient falls. Much of this work is undertaken jointly with other organisations within our academic health science network, UCLPartners.

We continue to invest in our clinical, research and teaching facilities. Our patron HRH The Duke of York opened the first phase of the new Institute of Immunity and Transplantation, which we are developing with UCL and the Royal Free Charity. We also opened the latest phase of our new intensive care unit which provides modern facilities for our sickest patients. Our new simulation centre, which allows staff to practise surgical techniques using the latest simulation technology, was opened by Sir Bruce Keogh, medical director of the NHS.

During the past year we have begun the detailed planning for our proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust planned for July 2014. We firmly believe that the enlarged organisation will be able to deliver even better local care and the specialist services we are renowned for. The expanded organisation is being designed by the clinicians of both existing trusts, closely working with commissioners, local GPs and representatives from our local population. The overriding aim is to build upon the best of both organisations.

I believe the evidence provided in this quality report demonstrates our continuing commitment to providing the highest quality clinical care.

I confirm that to the best of my knowledge the information provided in this document is accurate.

David Sloman
Chief Executive

29 May 2014

QUALITY REPORT
PART TWO

Priorities for improvement and statement of assurance from the board

In this part of the quality report we review our performance against our key quality priorities for 2013/14 and provide examples that illustrate how individual services and specialities are focused on quality improvement. We also provide key data relating to our performance and outline our priorities for improvement in 2014/15.

Performance against our key quality objectives

We place great importance on constantly improving our services and the quality of our patient care. Last year we committed to three key quality improvement objectives. These were:

Priority one: World class care including staff satisfaction and patient experience

Priority two: To further develop our clinical outcome measures

Priority three: To launch a patient safety programme across the trust.

Over the following pages, we set out how we have performed against these objectives.

Priority one:
World class care including staff satisfaction and patient experience

Priority two:
To further develop our clinical outcome measures

Priority three:
To launch a patient safety programme across the trust.

Performance against our three key quality objectives

Priority one: World class care for patients and staff

Continuous quality improvements enable the Royal Free to deliver the highest standards of patient care and ensure that our dedicated workforce is well supported and the personal and professional needs of staff are met.

Last year, a key quality objective committed to providing world class care and work to embed our World Class Care values has been a priority for the benefit of patients and staff across the trust.

Our World Class Care values (WCC) were launched at the Royal Free in April 2012 and are a promise to deliver world class care every day.

The values govern our behaviours towards our patients and our colleagues and were developed by patients and staff in a series of events called 'In your shoes' during which individual patients described their experiences to individual members of staff.

Discussions with staff then focused on how improvements could be made to the way we interact with our patients. We also looked at how the working lives of our staff could be improved. Research shows that how staff feel has a significant effect on how patients feel while in our care.

Training sessions introduced the values to teams and 3,181 members of staff – 63% of the workforce - attended. Staff then took the actions back to their areas of work for discussion and implementation.

During 2013, our corporate induction and the recruitment, probation and appraisal policies and procedures were reviewed to ensure they aligned with the world class care ethos.

In recruitment, new staff are assessed against our World Class Care values as well as their knowledge, skills and experience. Work continues to ensure that potential candidates are aware of and endorse the values, helping to make the Royal Free a fair, diverse and desirable place to work.

The appraisal process was also reviewed to ensure that all staff are appraised against the WCC values in addition to work objectives. Documentation has been redesigned to make it more user friendly and staff have been given training in the new process.

We reviewed the probation process to include our values as part of the performance measures against which new starters are measured. The values are now included in the first formal review and final review.

Workshops have been held to ensure that managers adopt appropriate management styles to support the values. These workshops were rolled out in targeted areas across the trust where bullying and harassment was highlighted as an issue.

Both our patient improvement plans and staff improvement plans are closely linked and monitored by our patient and staff experience committee.

We believe that staff who are well treated and feel appreciated at work are likely to provide a better

experience for the patients they care for. Each quarter we make awards to individuals and teams who have demonstrated particular dedication to our ethos.

The findings from the national NHS staff survey results for 2013 placed the trust in the top 20% of trusts for staff engagement and shows continuous improvement.

The engagement score is calculated using three key findings around staff ability to contribute towards improvement, staff recommendation of the trust as a place to work and staff motivation at work. The trust scored in the highest 20% for the first two questions and above average for the third.

In comparison with other acute trusts nationally, the trust scored average or above on 18 scores and below average, or in the worst 20% of trusts, on 10 scores. This represents a small improvement compared to the previous year.

The trust results continue to improve slightly with this year seeing positive movement in the following areas:

- Percentage of staff reporting having had an appraisal from 78% in 2012 to 91% in 2013 (national average 84%), although it should be noted that actual achievement for staff appraisals was 76%.
- Percentage of staff receiving health and safety training in the last 12 months from 66% in 2012 to 76% in 2013 (national average 76%).
- Percentage of staff reporting good communication between senior management and staff from 29% in 2012 to 36% in 2013 (national average 29%).

There were a number of areas that improved from the 2012 trust results, however the improvement was not significant enough to position the trust to be better than the national average. These are as follows:

- The percentage of staff suffering work related stress in the last 12 months reduced by 2% from 40% in 2012 to 38% in 2013 (national average 37%).
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months reduced by 6% from 38% in 2012 to 32% in 2013 (national average 29%).
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months decreased by 4% from 38% in 2012 to 34% in 2013 (national average 24%). This area is identified in the trust's bottom ranking scores and needs to remain within our staff experience improvement plan for 2014/15.
- Percentage of staff feeling pressure in the last three months to attend work when unwell reduced by 3% from 33% in 2012 to 30% in 2013 (national average 28%).
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion increased by 2% from 78% in 2012 to 80% in 2013 (national average 88%).
- Percentage of staff experiencing discrimination at work in the last 12 months decreased by 2% from 23% in 2012 to 21% in 2013 (national average 11%).

Priority 2: Continue to develop our clinical performance metrics

We have appointed an associate medical director for clinical performance who leads on the further development of measures, or metrics, we use to assess our clinical performance.

We have published online additional detail about most of our metrics and have added current data where available.

Last year we analysed the national clinical audit programmes to which we contribute to see where we had not performed as well as we would have liked and have focused our improvement plans on these areas.

WE HAVE SEEN IMPROVEMENTS IN

- Timely referral from GP for patients requiring carotid intervention
- Survival after bowel cancer surgery
- Microbiological stool examination in children with inflammatory bowel disease
- Gene testing for cystic fibrosis in bronchiectasis
- Adherence to antibiotic prescribing guidelines in pneumonia
- Referral to pulmonary rehabilitation for patients receiving non-invasive ventilation.

We have identified three aspects of diabetes care for which it has proved challenging to make the improvements we wanted. This is now an improvement priority for clinical effectiveness in the coming year (see Priorities for Improvement for 2014/15).

We have identified shared metrics with UCLH which will provide the greatest opportunity to learn from one another.

In developing our patient-defined metrics, we have looked first to the national clinical audits which have already developed metrics in partnership with patients. The national audits which have introduced these include diabetes,

epilepsy and inflammatory bowel disease. By participating in these national schemes we will be able to compare our performance with other organisations and learn useful lessons about what works well.

We held an open event at which patients were invited to have their say on what we measure. We described our performance across many clinical metrics and are using patients' comments as well as other patient feedback to select new metrics.

Priority 3: Patient safety programme

The development of a patient safety programme was one of our key quality objectives for 2013/2014. We aim to be a national leader in patient safety and have designed a patient safety programme to improve our patient safety culture and capability generally.

Patient safety culture and capability

Governance arrangements

In the past year we have strengthened our emphasis on excellence in patient safety with the appointment of an associate medical director for patient safety and a lead nurse for patient safety. The patient safety programme reports to the newly established patient safety programme board, chaired by our deputy chief executive. The trust has also established a board-level patient safety committee to provide oversight of patient safety across the organisation. We have also been successful in a joint bid with Bart's Health for a patient safety 'Darzi' Fellow, a junior doctor who will be now able to spend one year of their training in service improvement.

Incident reporting

We have implemented an online web-based system for reporting and learning from patient safety incidents. This large cross-organisational implementation has increased our ability to report and respond to safety incidents at pace. It will also allow us to track trends in safety incidents in the organisation more readily so that we can target our improvement work. The organisation has also substantially improved the speed and effectiveness in which it investigates serious incidents against the national reporting framework.

Patient safety education

The patient safety programme successfully bid for a £235,000 patient safety education grant from Health Education England. This has been used to strengthen our simulation training through investment in equipment and staff for onsite re-enactments of serious incidents and simulation training of high risk procedures. We have also invested in a course to deliver safety training to our most junior doctors and 150 incident managers.

Priority clinical workstreams

Patient handover

A project is underway to improve communication and team working in our 'hospital at night' team, who work with acutely ill patients. A multidisciplinary approach has been introduced which once further refined will be introduced to other clinical areas. Nurse handover and in particular safety briefings have been improved.

Medicines safety

A medicines safety committee has been set up to review medication incidents and oversee improvements in prescribing safety. A priority has been to reduce incidents relating to the administration of penicillin to penicillin-allergic patients. One tool has been a video which has seen a reduction of penicillin prescribing errors of 85%. We are also focusing on reducing 'missed doses' of medicines as well as improving the safety of anticoagulation and insulin prescribing.

Surgical safety

A key priority for 2013/2014 has been the implementation of the National Patient Safety Agency 'five steps to safer surgery', informed by the World Health Organisation Surgical Checklist. This has been shown to improve team-working and communication in theatre, reducing surgical errors such as retained swabs or wrong site surgery (both defined as safety 'never events'). The improvement team has initially targeted the middle three aspects of the 'five steps'. In 2013/2014 there have been no surgical 'never events'.

'Sepsis 6' success'

We launched our sepsis reduction programme in 2010. This is designed to spot sepsis earlier and implement a bundle of six specific treatments quickly. Mortality of patients on the sepsis pathway has been reduced by 10% and the length of time that patients suffering from sepsis have to stay in hospital has been halved. During the year, 80% compliance has been achieved and there have been no serious untoward incidents relating to sepsis within the trust for 18 months.

The sepsis improvement team has achieved national recognition. In November 2013 they won the Nursing Times award in the emergency and critical care category and in December 2013 the Royal Free Hospital Sepsis 6 app was highly

commended by the Health Education Award Committee. In April 2014 the team presented its work at the International Forum on Quality and Safety in Healthcare in Paris.

Acute kidney injury

Acute kidney injury (AKI), or acute kidney failure, is also a priority area for improvement. The trust has led the development of the North Central London Acute Kidney Injury Network to improve collaborative team working among different organisations caring for patients with AKI. This has included implementation of an AKI care bundle for basic ward care, collaborative audit, the development of an extensive online and mobile app educational package and implementation of pathology electronic alerting.

The project was acknowledged as a national exemplar case study in the recent Future Hospital Commission (FHC) report and was selected as one of two case studies presented at the February 2014 FHC launch event.

The work has been extended across London, our AKI team securing a £200,000 NHS England innovation award to further develop systems to identify patients with AKI early and assess risk of deterioration. The team has also won an NHS England Small Business Research and Innovation Grant to develop a tool to aid referral and decision making when patients develop AKI.

Venous thromboembolism prevention

This collaboration between anticoagulation services, pharmacy and ward teams has enjoyed continued success. Trust-wide compliance with thrombosis risk assessment was persistently above 95%, with a mean compliance rate of 96.4%. Risk assessing for thrombosis, then using preventative medication when appropriate, reduces the likelihood of patients developing a blood clot in the legs or lungs during hospitalisation.

Nasogastric tube placement

The nutrition team has developed clear policies for the insertion of nasogastric tubes and checks on them, working closely with ward staff. Compliance remains high and there have been no ‘never events’ attributed to nasogastric tubes during the year.

Priorities for improvement 2014/15

To help us provide the best possible care to our patients, each year we set three quality improvements priorities, which are monitored by the trust board.

One focuses on patient experience, one on clinical effectiveness and one on patient safety. Before setting these, we seek the views of our patients, staff and the local community.

We invited representatives from our stakeholders to give their opinions on what our priorities should be. These included staff, commissioners and our governors.

The trust board considered the responses and agreed the following three priorities for 2014/15.

Priority one: World class patient information to reflect our world class care

A key priority for 2014/15 will be to ensure that our World Class Care values are embedded in all aspects of our work with patients and staff.

Our World Class Care programme emphasises consistency in patient care and the standards include communicating clearly and providing reassurance.

Building on our World Class Care values, we have set a key quality improvement priority for the year ahead to improve patient information across the trust.

The project is being supported by the Royal Free Charity.

Providing quality assured patient information reflects our world class care standards and puts these values into practice.

Between July and November 2013, we carried out a short-term patient information project to look at the quality and access of patient information across the trust.

We held a range of interviews with key stakeholders, did documentary analysis and a review of patient information on our website.

We also undertook a trust-wide stocktake and looked in particular at how patient information is provided to out-patients.

The project revealed that despite our reputation for high quality care, the way we provide patient information is not consistent and is fragmented with no centralised overview or dedicated resource to maintain or develop provision.

Whilst there is evidence of good practice, this knowledge and learning is not shared across the trust.

Currently new or revised patient information is produced in a number of ways and in different areas. This fragmented approach is costly to the trust and health professionals, but most importantly to patients in terms of negative impact on their experience and, potentially, health outcome.

Patient information on our website also varies greatly, with the majority of the literature at least four years old.

With website 'hits' reaching almost 400 a day, demand for patient information is high and there is an expectation that the Royal Free will provide accurate and up-to-date information for patients. This expectation is reflected in national policy with quality assured, accessible patient information a mandatory requirement.

It is anticipated that we can transform the way we provide patient information over the next 18 months.

Starting in April 2014, we plan to improve the provision of patient information in the following ways:

- Centralise the provision of patient information and appoint a patient information manager with a dedicated budget
- Define our role as a patient information provider to ensure consistent, easy access to maintained, quality assured patient information for both patients and health professionals
- Consider marketing the improvement of patient information as part of our World Class Care programme and establish an ongoing marketing and communications programme
- Look at how we produce patient information – internally, contracted externally or a combination of the two
- Introduce a phased approach to improving patient information and engage with key stakeholders throughout
- Involve patients in the development of all patient information
- As an interim measure, review racks in out-patients to ensure that literature on display is not out of date, is appropriate to the clinic and the trust
- Collate all current patient information onto a patient information database in a standardised format
- Review literature published before 2010 with the relevant department
- Establish and introduce three pilot sites for patient information - ophthalmology, renal and

pre-assessment - and over a nine month period develop and test the process for producing patient information and the setting up of a new patient information system with a centralised ratification and production process

- As part of the pilot scheme, improve the way information is distributed and displayed, eg racking, use of screens and provision in consulting rooms
- Explore how our navigators and volunteers could help with the way we provide patient information, eg signposting and replenishing racks
- Explore the potential of a partnership with the NHS nationally and with key charities to establish an exemplar model for patient information provision
- Set up a new patient information system and patient information policy which is available on the intranet, along with associated templates and resources (eg online training) to support staff in producing patient information
- Work towards Information Standard certification.

Priority 2: In-patient diabetes care

Many patients with kidney and vascular disease also suffer from diabetes.

Indeed, because of the particular range of specialist services we offer on any one day at the Royal Free hospital, nearly a quarter of our in-patients will have diabetes. In addition, many patients on our specialist liver unit will require help with blood sugar control.

Over the past few years, a national audit on in-patients with diabetes has helped us identify where we need to improve aspects of our diabetes care. Our own monitoring has also highlighted concerns, for example, medication errors related to insulin.

Diabetes is therefore one of our key priorities in 2014/15. Our specific aims are to:

- Improve meals and mealtimes for our in-patients with diabetes
- Improve the management of insulin and other diabetic medications on our wards
- Improve foot assessments for patients with diabetes.

We will explore innovative solutions to these themes and consult with our academic health science partnership to learn from experience at other organisations. Progress will be monitored by our clinical performance committee.

Priority three – To continue our patient safety programme

Our key priorities for the patient safety programme for 2014/15 are set out below:

Patient safety culture and capability

A key objective for the coming year is to improve trust-wide communication on safety issues to ensure that we improve dissemination of learning from incidents.

We will further strengthen our incident investigation and processes for addressing safety issues throughout the organisation. We also seek to further improve education and mandatory training in patient safety.

Priority clinical workstreams

Priority clinical areas for improvement are as follows:

- **Surgical safety**
  We aim to be more than 95% compliant with all aspects of the 'five steps to safer surgery' guidance.
- **Medicines safety**
  We will focus our efforts on insulin prescribing safety and reduction of medication 'missed dosages'.
- **Procedural safety**
  We have started a programme of work to reduce complication rates from central venous line insertions.
- **Action on abnormal diagnostic images**
  We have started a programme of work to ensure all abnormal x-ray images are actioned promptly.
- **Falls and pressure ulcers**
  These priority areas for patient safety will be the subject of further structured improvement work across the trust.

Existing improvement work in sepsis, acute kidney injury, venous thromboembolism prevention, handover and nasogastric feeding will continue.

Statements of assurance from the board

This section contains eight statutory statements concerning the quality of services provided by the Royal Free NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statement.

INFORMATION ON REVIEW OF SERVICES

During 2013/14 the Royal Free London NHS Foundation Trust provided and/or sub-contracted 27 relevant health services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to the trust on the quality of care in 27 of these relevant health services.

ADDITIONAL INFORMATION

In this context we define each service as a distinct clinical directorate that is used to plan, monitor and report clinical activity and financial information – this is commonly known as service line reporting. Each individual service line can incorporate one or more clinical services.

INFORMATION ON PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2013/14 35 national clinical audits and three national confidential enquires covered relevant health services that the Royal Free London NHS Foundation Trust provides.

During 2013/14 the Royal Free London NHS Foundation Trust participated in 100% of national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in during 2013/14 are outlined in the table.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audits for inclusion in quality report 2013/14	Data collection completed in 2013/14	RFL eligiblity to participate	RFL participated in 2013/14	Rate of case ascertainment (%)*
National Diabetes Audit	√	√	√	99.8%
National In-patient Diabetes Audit	√	√	√	96 cases
Patient Reported Outcome Measures: elective surgery	√	√	√	533 cases
National Institute for Cardiovascular Outcomes Research (ICNARC): adult cardiac interventions (coronary angioplasty)	√	√	√	100%
Myocardial Ischaemia Natial Audit Project: acute myocardial infarction and other ACS	√	√	√	100%
National Heart Failure Audit 2012/13	√	√	√	209/325=64%
Trauma Audit & Research Network: severe trauma	√	√	√	123 cases
Renal Registry: renal replacement therapy	√	√	√	1995 cases
College of Emergency Medicine: sepsis	√	√	√	50 cases (100%)
College of Emergency Medicine: moderate or severe asthma in A&E	√	√	√	50 cases (100%)
Royal College of Paediatrics and Child Health: National Paediatric Diabetes Audit	√	√	√	66 cases
British Thoracic Society: paediatric asthma	√	√	√	9 cases
National Joint Registry	√	√	√	97%
Cardiac rhythm ranagement audit	√	√	√	100%
Falls & Fragility Fractures: hip fracture	√	√	√	167 cases (100%)
Falls & Fragility Fractures: anaesthetic sprint audit	√	√	√	100%
National Neonatal Audit	√	√	√	100%
National Vascular Registry	√	√	√	79 cases
Intensive Care National Audit and Research Centre case mix programme database: Adult Critical Care	√	√	√	0%
Sentinel Stroke National Audit Programme	√	√	√	>90%
National Lung Cancer Audit	√	√	√	88/86 (102%)
National Bowel Cancer Audit	√	√	√	81/106=76%
National Oesophago-gastric Cancer Audit	√	√	√	97%
National Comparative Audit of Blood Transfusion: use of anti-D	√	√	√	14 cases
Inflammatory bowel disease (adult)	√	√	√	30 cases (100%)
Inflammatory bowel disease (paediatric)	√	√	√	7 cases
ICNARC: cardiac arrest	√	√	√	219 cases
British Thoracic Society: emergency use of oxygen	√	√	√	49 cases
National Pulmonary Hypertension Audit	√	√	√	100%
National Audit of Seizure Management in Hospitals	√	√	√	30 cases (100%)
College of Emergency Medicine: paracetamol overdose	X	√	√	Still open
National childhood epilepsy audit (Epilepsy 12)	X	√	√	Still open
National Emergency Laparotomy Audit	X	√	√	Still open
National Chronic Obstructive Pulmonary Disease Audit Programme	X	√	√	Still open

National clinical audits for inclusion in quality report 2013/14	Data collection completed in 2013/14	RFL eligibility to participate	RFL participated in 2013/14	Rate of case ascertainment (%)*
Rheumatoid & early inflammatory arthritis	X	√	√	Still open
British Thoracic Society: paediatric bronchiectasis	√	x	n/a	n/a
National Comparative Audit of Blood Transfusion: patients in neuro-critical care units	√	x	n/a	n/a
Paediatric Intensive Care (PICANet)	√	x	n/a	n/a
Congenital Heart Disease Audit	√	x	n/a	n/a
National Adult Cardiac Surgery Audit	√	x	n/a	n/a
Head & Neck Cancer Audit	√	x	n/a	n/a
Prescribing Observatory for Mental Health	√	x	n/a	n/a
National Audit of Schizophrenia	√	x	n/a	n/a
Total:				
Clinical Outcome Review Programmes (previously NCEPOD - National Confidential Enquiry into Patient Outcome and Death and Centre for Maternal and Child Death Enquiries):				
Lower limb amputation	√	√	√	100%
Tracheostomy	√	√	√	100%
Suicides & Homicides	X	x	x	-
Maternal, newborn and infant (MBRRACE-UK)	√	√	√	Open

In addition, the Royal Free London NHS Foundation Trust participated in the following national audits by submitting data in 2013/14
National Endoscopy Audit: colonoscopy completion rates
National Comparative Audit of Blood Transfusion: patient information & consent
Health Protection Agency: surgical site infection rates
British Association of Urological Surgeons: nephrectomy audit
British Association of Urological Surgeons: surveillance & treatment of renal masses
Baseline Survey of HIV Perinatal, Paediatric and Young People's Pathways
UK Neonatal Collaborative Necrotising Enterocolitis Audit
National Audit of Cardiac Rehabilitation
British Association of Endocrine and Thyroid Surgeons: thyroid and parathyroid surgery
British Society of Rheumatology: National Gout Audit

Royal Free London NHS Foundation Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2013/14
NCEPOD: Managing the flow
NCEPOD: Measuring the units
College of Emergency Medicine: ureteric colic
College of Emergency Medicine: fractured neck of femur
College of Emergency Medicine: feverish children
National Audit of Dementia
British Thoracic Society: adult asthma
British Thoracic Society: adult pneumonia
British Thoracic Society: adult bronchiectasis
British Thoracic Society: non-invasive ventilation

* The proportion of registered cases, against the total number of cases you could have submitted, or those required by the terms of that audit or enquiry

ADDITIONAL INFORMATION

Intensive Care National and Research Centre (ICNARC) case mix programme database (CMPD) adult critical care: despite making significant improvements to our data quality for this audit, ICNARC were unable to accept our data for 2013/14. We are working to ensure our 2014/15 data will be accepted.

The reports of 32 national clinical audits were reviewed by the provider in 2013/14 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National clinical audit	Actions to improve quality
In-patient diabetes (adult)	Develop strategy for in-patient diabetes care Improve meals and mealtimes for patients with diabetes Improve foot assessment Improve management of diabetic medication, including insulin
Diabetes (adults)	Develop pathway for insulin pump patients with poor glucose control
Dementia	Improve discharge planning and assessment of carers' current needs by assessing patients within 24 hours of admission Develop dementia volunteer roles Introduce carers' clinic and carer education
Inflammatory bowel disease (adult)	Improve access to an in-patient specialist dietitian Improve access to specialist ward and additional toilet facilities Develop guidelines for acute severe gastritis Introduce further training in care of inflammatory disease
Renal colic	Improve pain assessment
Fractured hip	Introduce new regional analgesia technique Improve pain assessment
Childhood epilepsy	Improve access to EEG
Feverish children	Incorporate fever discharge checklist into electronic patient management system
Elective infra-renal aneurysm repair	Continue development of multidisciplinary team and specialist pre-operative assessment

ADDITIONAL INFORMATION

The 32 national clinical audit reports reviewed were published in calendar year 2013.

The reports of 195 local clinical audits were reviewed by the provider in 2013/14 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

We intend to improve the clinical effectiveness of our services by:

DEVELOPING OR REVISING A NUMBER OF CARE PATHWAYS, INCLUDING:

- Out-of-hospital cardiac arrest
- Primary angioplasty for non-STEMI heart attack
- Alcohol disorders in A&E
- Delirium in A&E
- Fractured hip in A&E
- Upper gastro-intestinal bleeding in A&E
- Elective cardioversion of patients with atrial fibrillation
- Wound drain management after complex breast reconstruction
- Fluid management after complex breast reconstruction
- Anticoagulation after liver transplantation
- Pain management for hip fracture patients
- Opioid prescribing in palliative care
- Incidental findings on imaging
- Organ donation.

CONTINUING IMPLEMENTATION OF REVISED OR EXISTING CARE PATHWAYS, INCLUDING:

- Enhanced recovery after hepatobiliary surgery
- Rehabilitation after intensive care
- Platelet transfusion
- Transport of critically-ill patients
- Nutritional support for elderly patients
- Organ transplantation
- Chest pain in A&E
- Head injuries in A&E
- Respiratory infections in A&E
- Back pain in A&E
- Epilepsy in A&E
- Cytomegalovirus treatment for transplant patients
- Hepatitis B screening for patients receiving chemotherapy
- Avoiding perioperative hypothermia
- Venous thromboembolism prophylaxis in orthopaedics.

ADDRESSING FURTHER TRAINING NEEDS, IDENTIFIED THROUGH OUR LOCAL CLINICAL AUDIT PROGRAMME, IN THE FOLLOWING AREAS:

- Enhanced recovery pathway
- Continence care
- Pain management for hip fracture patients
- Anti-psychotic prescribing
- Pain assessment in cognitive impairment
- Safe management of epidural analgesia on wards
- Monitoring immunosuppressant therapy.

WE INTEND TO IMPROVE THE PATIENT EXPERIENCE THROUGH INTRODUCTION OR REVIEW OF THE FOLLOWING ASPECTS OF CARE:

- Online pre-assessment for surgery
- Pre-operative starvation advice for children
- Early mobilisation after Caesarean section
- Advice to patients prior to DEXA scans
- Communication of biopsy results to patients in dermatology
- Patient recall following chlamydia and gonorrhoea test-positive results.

WE INTEND TO IMPROVE SAFETY BY:

- Monitoring safety and efficacy of new investigations: for example
- hepatitis virus infection
- thyroid disease
- intra-operative assessment of tumour spread (one-step nucleic acid molecular assay of sentinel lymph nodes)
- Monitoring safety and efficacy new drugs and procedures, for example:
  - Antivirals for hepatitis C
  - Sildenafil for digital ulcers in systemic sclerosis
- Associating liver partition and portal vein ligation for staged hepatectomy
- Radiofrequency ablation of renal cell cancers
- Selective internal radiation therapy
- Electrochemotherapy
- Epidural adhesiolysis
- Sugammadex.

REDUCING RADIATION EXPOSURE FOR THE FOLLOWING:

- Radio-iodine for thyroid disease
- Investigation of amyloidosis
- Routine use of post-operative x-ray.

IMPROVING THE DOCUMENTATION (WHERE POSSIBLE MAKING USE OF ELECTRONIC PRESCRIBING) OF THE FOLLOWING:

- Falls screening
- Pain assessment in cognitive impairment
- Consent prior to surgery
- Indications for anti-psychotic therapy
- Disease severity scoring for patients on anti-TNF therapy
- Tumour staging in nephrectomy patients
- Protection of central nervous system for lymphoma patients at high-risk
- Minimum datasets for histopathology specimens
- Community patient medication.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 4,562.

ADDITIONAL INFORMATION

The above figure includes 2,550 patients recruited into studies on the NIHR portfolio and 2,012 patients recruited into studies that are not on the NIHR portfolio. This figure is somewhat lower than that reported last year.

The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

INFORMATION ON USE OF CQUIN PAYMENT FRAMEWORK

A proportion of the Royal Free London NHS Foundation Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for quality and innovation (CQUIN) payment framework.

Further details of the agreed goals for 2013/14 and for the following 12-month period are available electronically by emailing rfquality@nhs.net. In 2012/13 a total of £8,518,438 of the trust's income was conditional upon achieving quality improvement and innovation goals. In 2013/14 the trust received £8,833,805, which was 94.6% of the total we could have received.

ADDITIONAL INFORMATION

Our CQUIN payment framework for 2013/14 was agreed with NHS North East London Commissioning Support Unit and NHS England as follows:

CQUIN scheme priorities 2013/2014	Objective rationale
Venous thromboembolism	Venous thromboembolism (VTE), or clotting of the blood, is a significant cause of mortality, long-term disability and chronic ill health. We closely analyse every case to discover root cause.
Friends and family test	This national initiative will provide timely, detailed feedback from patients about their experience in order to improve services for the user. There is significant room for improving the level of feedback received from patients across England.
Dementia	A quarter of beds in the NHS are occupied by people with dementia. Their length of stay is longer than people without dementia and they often receive suboptimal care. Half of those admitted have never been diagnosed before admission and referral to appropriate specialist community services is often poor. Improvement in assessment and referral will give significant improvements in the quality of care and substantial savings.
NHS safety thermometer	Participation in data collection is an important step in reducing harm in four areas of concern highlighted nationally. A particular focus is on reducing incidents of pressure ulcers in hospital and the local community.
COPD (chronic obstructive pulmonary disease) discharge bundle	Use of the bundle has been proven to improve the care of patients admitted to hospital with an exacerbation of COPD, improve their understanding of the disease, reduce future reliance on hospital care and reduce chances of further admissions.
Prevention – stop smoking and alcohol screening	Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. Simple advice from a clinician, during routine patient contact, can have a small but significant effect on smoking cessation. Alcohol-related problems represent a significant share of potentially preventable attendances to accident and emergency departments and urgent care centres, as well as emergency admissions. Screening for alcohol risk has been shown to reduce subsequent attendances and alcohol consumption.
Integrated care	There is a significant number of frail older people admitted to hospital. Identification and assessment of these patients, sharing information with GPs and participating in multidisciplinary meetings help to improve care and reduce the cost of treating these patients.
National quality dashboard	The aim is to ensure that providers implement and routinely use the required clinical dashboards for specialised services
Highly specialised services	This covers very rare diseases whose treatment is carried out at a very limited number of centres in the UK. These centres must participate in an annual workshop to encourage learning and the spread of best practice.
Bone marrow transplantation	To improve the gathering of various aspects of donor data for these procedures to inform better safety and effectiveness.
Renal transplant and dialysis	To increase the use of a national online renal database for dialysis and transplantation patients, empowering them to better manage their condition and medications by allowing easier access to test results and therefore monitoring of their progress.
Haemophilia	Joint health and preventing joint damage/progression is the key driver to many aspects of haemophilia care. The aim is to establish a baseline for patients against which future care can be assessed. There is also a drive for centres to record patients' treatment data in an electronic format that is accessible to the patients to encourage shared responsibility for the use of very expensive treatment products.

INFORMATION ON CARE QUALITY COMMISSION STATEMENT OF ASSURANCE

The Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with the Care Quality Commission with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2013/14.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

ADDITIONAL INFORMATION

This year we had two inspections. In October 2013, the Care Quality Commission undertook a re-inspection of the Royal Free Hospital site following the implementation of actions to ensure the safe storage of medicines. The inspection confirmed that we were compliant with all 16 essential standards.

The second inspection in February 2014 saw nine inspectors visit a number of wards and departments as part of a routine unannounced inspection. Inspectors found that our patients rated our care and services very highly and enjoyed attending for their care with us. The trust met all seven standards being assessed, including consent to care and treatment, care and welfare of the people who use our services, cleanliness and infection control and supporting staff.

INFORMATION ON DATA QUALITY

The Royal Free London NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.1% admitted patient care;
- 99.2% for out-patient care;
- 93.5% for accident and emergency care;

which included the patient's valid General Medical Practice Code was:

- 99.7% for admitted patient care;
- 99.9% for out-patient care; and
- 100% for accident and emergency care.

ADDITIONAL INFORMATION

The figures above are taken directly from the SUS data quality dashboard provider view, which is based on the provisional April 2013 to January 2014 SUS data at the month 10 inclusion date.

INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

The Royal London NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 69% and was graded red from the Information Governance Toolkit Grading scheme.

ADDITIONAL INFORMATION

Information governance is the process that ensures we have necessary safeguards in place for the use of patient and personal information, as directed by the Department of Health and set out within national standards.

Our score on the information governance toolkit was one per cent lower than last year because of lower training rates.

During 2013/14 the trust was audited by the Information Commissioner's Office and the trust was given 'reasonable assurance', meaning that there are arrangements for data protection compliance in place at the trust.

The toolkit colour scoring is green if all the standards were achieved, or red if one or more is not achieved.

For the Royal Free London NHS Foundation Trust there was only one requirement, that relating to training coverage, where the level was not achieved.

PAYMENT BY RESULTS CLINICAL CODING AUDIT

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

ADDITIONAL INFORMATION

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system.

Meet Lisa

Today Lisa Davies from Hertfordshire works as a clinical trial manager, with the aim of helping other patients and 'giving something back'.

But 35 years ago she was born with a rare kidney disease - autosomal recessive polycystic kidney disease (ARPKD) - and her parents were told she would not survive beyond her first birthday.

"Most babies with ARPKD die in the womb but I was born a bit premature by emergency c-section as I was breech. No-one suspected anything until a medical student was asked to make routine checks. The student said that my kidneys felt really big. I was sent off for tests and it was discovered I had an extremely rare form of kidney disease.

"In those days, dialysis and transplants were unheard of for babies. Each year doctors said I wouldn't make it to my next birthday and so it went on. I carried on as normal and my parents never told anyone how serious things were as they didn't want me treated any differently. At the age of 12 my kidneys seriously deteriorated. I was tissue typed and checks were carried out to make sure I was strong enough to be added to the transplant waiting list.

"When I was 13 my kidneys failed completely and I started dialysis. Then two years later, one Sunday morning in May 1994, the phone rang. I was in bed, a typical teenager. Mum was cooking the roast. A kidney was available. I was terrified, mum and I were in tears. Dad took control and told us to get in the car."

Lisa was one of three patients called in to the hospital that day to see who would be the best match for the donor organ. It was a tense wait but that evening Lisa was taken down to theatre.

"It was a traumatic time, I suffered a massive rejection and doctors had to fight to get it under control. I needed a second operation as there was a blockage, so the kidney had to be reconnected. I spent seven weeks in hospital. After that though, life basically became normal for me. I sat my GCSEs and A levels and did well, went to university to study biochemistry, met my husband and got married. I felt like I had been given a second chance.

"Suddenly in 2004 I became ill. A routine appointment discovered my transplant only functioning at three per cent. I was taught how to self-dialyse at home and started to wait for another transplant. With so many antibodies built up over the years I would not find a match from 99 per cent of the population. Then on 14 January this year, after 10 years back on dialysis, the Royal Free called and said they thought they had found a match.

"I felt utter disbelief. I expected to spend the rest of my life on dialysis. The doctors joked that the stars had aligned. I had the transplant and just five days later I went home.

"I now feel really well. I will be eternally grateful to both my donors and their families. I have had amazing doctors, nurses and surgeons who have looked after me all these years; I am lucky to have known them."

"I've been told by many doctors that reading my medical history I shouldn't be here now. Let alone living a normal life. It's a lot to do with my determination but also to everyone at the Royal Free who have made it possible."

Our quality performance indicators

As a foundation trust we are required to report against the following core set of indicators in 2013.

Indicator	Royal Free Performance Jul 11 - Jun 12	Royal Free Performance Jul 12 - Jun 13	National Average Performance Jul 12 - Jun 13	Highest Performing NHS Trust Performance Jul 12 - Jun 13	Lowest Performing NHS Trust Performance Jul 12 - Jun 13
The value and banding of the summary hospital-level mortality indicator for the trust	74.3 (3)	80.7 (3)	101.9 (2)	62.6 (3)	115.6 (1)

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.

The latest data available covers the 12 months to June 2013. During this period the Royal Free had a mortality risk score of 80.7, which represents a risk of mortality 19.3% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked eight lowest amongst English NHS Trusts.

The banding (figure in brackets) is calculated 1 to 3 with 3 being the lowest (best) banding.

The Royal Free London NHS Foundation Trust has taken the following actions to improve the mortality risk score and so the quality of its services by:

Presentation of a monthly SHMI report to the trust board and a quarterly report to the clinical performance committee. Any statistically significant variations in the mortality risk rate are investigated, appropriate action taken and a feedback report provided to the trust board and the clinical performance committee at their next meetings.

Indicator	Royal Free Performance Jul 11 - Jun 12	Royal Free Performance Jul 12 - Jun 13	National Average Performance Jul 12 - Jun 13	Highest Performing NHS Trust Performance Jul 12 - Jun 13	Lowest Performing NHS Trust Performance Jul 12 - Jun 13
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	24.8%	25.5%	19.6%	44.1%	0.0%

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care, whereas the SHMI does not take palliative care into account.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve the mortality risk score and so the quality of its services by:

Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding. Any statistically significant variations in percentage of palliative care coded deaths will be investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings.

Indicator	Royal Free Performance 2011/12	Royal Free Performance 2012/2013	National Average Performance 2012/2013	Highest Performing NHS Trust Performance 2012/2013	Lowest Performing NHS Trust Performance 2012/2013
Patient reported outcome measures scores for:					
(i) groin hernia surgery	0.05	0.07	0.08	0.13	0.03
(ii) varicose vein surgery	0.08	0.09	0.10	0.17	0.02
(iii) hip replacement surgery	0.39	0.38	0.43	0.54	0.32
(iv) knee replacement surgery	0.26	0.27	0.32	0.37	0.20

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

The NHS asks patients about their health and quality of life before they have an operation and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improve the quality of care provided.

A negative score indicates that health and quality of life has not improved whereas a positive score suggests there has been improvement.

While the trust is not receiving a negative score against any of the outcome measures, knee replacement surgery has been identified as an outlier by the Care Quality Commission (CQC). The CQC produces a quarterly Intelligent Monitoring Report for all NHS Trusts. The CQC has developed the system to monitor a range of key indicators for NHS acute and specialist hospitals. The most recent report (March 2014) has identified the negative nature of patient feedback following knee replacement surgery as a risk.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve the patient reported outcome measure scores, and so the quality of its services by:

Reviewing the initial consultation process to ensure that expected outcomes are clear and patient expectations are realistic, improving patient information to ensure that risks and benefits are outlined clearly and reviewing information provided at discharge to help patients achieve good outcomes post operatively.

Indicator	Royal Free Performance 2011/12	Royal Free Performance 2012/2013	National Average Performance 2012/2013	Highest Performing NHS Trust Performance 2012/2013	Lowest Performing NHS Trust Performance 2012/2013
The percentage of patients re-admitted to the trust within 28 days of discharge for patients aged:					
(i) 0 to 15	7.18	5.86	9.55	5.1	14.94
(ii) 16 or over	12.34	13.36	11.33	7.74	13.8
Note: Trusts with zero re-admissionss have been excluded from the data					

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

The Royal Free carefully monitors the rate of emergency re-admissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of re-admission is seen as evidence of good quality care.

The rate of re-admissions at the Royal Free is below (better) than the national average for children and over (worse) for adults. The trust has undertaken detailed enquiries into patients classified as re-admissions with our public health doctors, by working with GPs and identifying the underlying causes for re-admissions. This is supporting the introduction of new clinical strategies designed to improve the quality of care provided and reduce the incidence of re-admissions. In addition the trust has identified a number of data quality issues affecting the re-admission rate, including the incorrect recording of planned admissions. The trust is working with its staff to improve data quality in this area.

Indicator	Royal Free Performance 2011/12	Royal Free Performance 2012/2013	National Average Performance 2012/2013	Highest Performing NHS Trust Performance 2012/2013	Lowest Performing NHS Trust Performance 2012/2013
The trust's commissioning for quality and innovation indicator score with regard to its responsiveness to the personal needs of its patients	66.9	65.6	68.1	84.4	57.4

Actions to be taken to improve performance

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals' responsiveness to the personal needs of their patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is below (worse than) the national average.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve its responsiveness to the personal needs of its patients, the patient reported outcome measure scores and so the quality of its services by:

Working through its comprehensive patient experience improvement plan overseen by the user experience committee, a sub-committee of the trust board. During February 2014 the trust received an unannounced inspection by the CQC. The inspection is designed to question whether services are safe, effective, caring, well led and responsive to people's needs.

The final report, recently received by the trust, confirms that all standards have been met and an action plan is being developed to help further improve patient care.

Indicator	Royal Free Performance 2011/12	Royal Free Performance 2012/2013	National Average Performance 2012/2013	Highest Performing NHS Trust Performance 2012/2013	Lowest Performing NHS Trust Performance 2012/2013
The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	72.6%	76.2%	64.5%	93.7%	39.6%

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results.

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs significantly better than the national average on this measure.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve this percentage score and so the quality of its services by:

Activities to enhance engagement of staff. These have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends:

The trust has implemented its World Class Care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our World Class Care programme anticipates even greater clinical and staff engagement.

Indicator	Royal Free Performance Jul 13 - Sep 13	Royal Free Performance Oct 13 - Dec 13	National Average Performance Oct 13 - Dec 13	Highest Performing NHS Trust Performance Oct 13 - Dec 13	Lowest Performing NHS Trust Performance Oct 13 - Dec 13
The percentage of patients who were admitted to hospital and were risk assessed for venous thromboembolism during the reporting period	96.1%	98.0%	96.0%	100.0%	78.0%

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

Many deaths in hospital result each year from Venous Thromboembolism (VTE). These deaths are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.

The Royal Free performed better than the 95% national target and performed better than the national average.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve this rate and so the quality of its services by:

Continuing to report its rate of hospital acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. In addition the thrombosis unit conducts a detailed clinical audit into each reported case of HAT with findings shared with the wider clinical community.

Indicator	Royal Free Performance 2011/12	Royal Free Performance 2012/2013	National Average Performance 2012/2013	Highest Performing NHS Trust Performance 2012/2013	Lowest Performing NHS Trust Performance 2012/2013
The rate per 100,000 bed days of cases of C. difficile infection that have occurred among patients aged two and over	19.3	30.5	16.3	0	30.8

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre, compared to internal trust data and data hosted by the Health Protection Agency.

C. difficile can cause severe diarrhoea and vomiting. The infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of C. difficile infections is a key government target.

Royal Free performance was significantly higher (worse) than the national average during 2012/13.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services by:

Fully implementing the recommendations following reviews of our infection control. The trust asked for independent scrutiny, by a national expert, of our infection control processes. The trust also invited two other national experts to review adherence to infection control policy. The action plan arising from the reviews has been considered at the trust executive committee, the clinical performance committee and trust board. In addition the trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code.

It is also important to note the significant improvement in performance since October 2013. The trust has now recorded five consecutive months where compliance with the in-month trajectory has been achieved.

Indicator	Royal Free Performance Oct 11 - Mar 12	Royal Free Performance Oct 12 - Mar 13	National Average Performance Oct 12 - Mar 13	Highest Performing NHS Trust Performance Oct 12 - Mar 13	Lowest Performing NHS Trust Performance Oct 12 - Mar 13
The number and rate of patient safety incidents that occurred during the reporting period	451 (0.94)	2,528 (6.3)	5,048 (7.5)	2,290 (3.2)	11,495 (13.7)
The number and percentage of such patient safety incidents that resulted in severe harm or death	13 (2.8%)	25 (1%)	23.2 (0.4%)	2 (0.1%)	74 (1.4%)

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS). However the trust has advised NRLS that data submitted between October 2011 and March 2012 was incomplete due to technical issues with exporting data. The trust worked with the NRLS staff and the issues were resolved, as a result there was an increase in reported incidents for the period October 2012 to March 2013.

The Royal Free London NHS Foundation Trust has since taken the following actions to improve this rate and so the quality of its services by:

1) Purchase of a web-based reporting tool with the aim of simplifying the process for staff to report incidents and to export data to NRLS. Experience from other trusts has indicated that the introduction of a web-based tool significantly increases the volume of forms submitted by staff. The web-based system went live during February 2013.

2) Development of a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.

We have robust processes in place to capture incidents. There are risks however at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.

There is also clinical judgement in the classification of an incident as ‘severe harm’ as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process.

Our quality performance indicators

Auditors' statement

Our external auditors PricewaterhouseCoopers LLP (PwC) are required under Monitor's '2013/14 Detailed Guidance for External Assurance on Quality Reports' to perform testing on two national indicators. A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PwC is included below.

Data quality definitions

The following information includes the definitions of the quality indicators which were subject to the external assurance process.

Clostridium Difficile (C. difficile)

Descriptor: Number of *Clostridium difficile* infections for patients aged two or more on the date the specimen was taken.

Data definition: A C. difficile is defined as a case where the patient shows clinical symptoms of the infection and using the local trust C. difficile infections diagnostic algorithm (in line with DH guidance) is assessed as a positive case. Positive diagnoses on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken.

Accountability: Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample is taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

To illustrate:

admission day

admission day + 1

admission day + 2

admission day + 3 – specimens taken on this day or later are trust appointed

Royal Free London NHS Foundation Trust declares all positive tests to the Health Protection Agency, who apportion the case based on their own algorithm on the basis that results after a hospital stay of 48 hours are likely to be hospital acquired. There have been 35 cases in the current year.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Descriptor: Percentage of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer within a given period for all cancers.

Data definition: All cancers two month urgent referral to treatment wait.

Denominator: Total number of patients receiving first definitive treatment for cancer following an urgent GP referral for suspected cancer, with a given period for all cancers.

Numerator: Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer, within a given period for all cancers.

As a foundation trust we are required to report against the following core set of indicators in 2013.

About the 62-day pathway: The audit focused on those patients referred urgently by their GP to the trust with suspected cancer who should be seen, diagnosed and treated within 62 days.

Starting the 62-day pathway: The starting point for this period is the receipt of the referral. The original referral can be received either:

- direct from the general medical practitioner or general dental practitioner
- via Choose and Book.

Receipt of referral is day 0 for the 62-day period.

Ending the 62-day pathway: The period end is the first definitive treatment. This start date may differ slightly for different treatments.

The percentage of patients treated within 62 days for 2013/14 was 93.3%.

A scrub nurse prepares the da Vinci robot, with which our surgeons perform minimally invasive surgery.

Emergency re-admissions within 28 days of discharge from hospital

Descriptor: Emergency re-admissions within 28 days of discharge from hospital.

Data definition: Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.

Numerator: The number of finished and unfinished continuous in-patient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator). This includes those where the patient dies, but excludes the following: those with a main specialty upon re-admission coded under obstetric; those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

Denominator: The number of finished continuous in-patient spells within selected medical and surgical specialties, with a discharge date up to March 31 within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.

The percentage of emergency re-admissions within 28 days of discharge for the current year was 11.7%.

PART 3
OTHER INFORMATION

Quality performance indicators

An overview of the quality of care based on performance against key national indicator priorities is detailed within our annual report.

This section of the Royal Free's quality report contains an overview of quality of care offered by the trust based on performance against indicators selected by the board in consultation with our stakeholders. They cover three dimensions of quality:

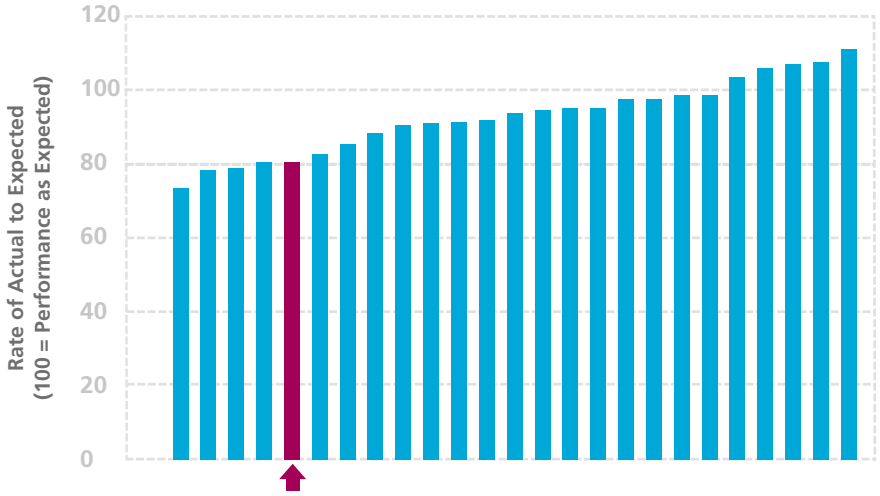
- Patient safety
- Clinical effectiveness
- Patient experience.

Patient safety indicators

SHMI relative risk mortality

Royal Free comparison with English teaching hospitals

12 months to end of June 2013



SHMI (summary hospital mortality indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.

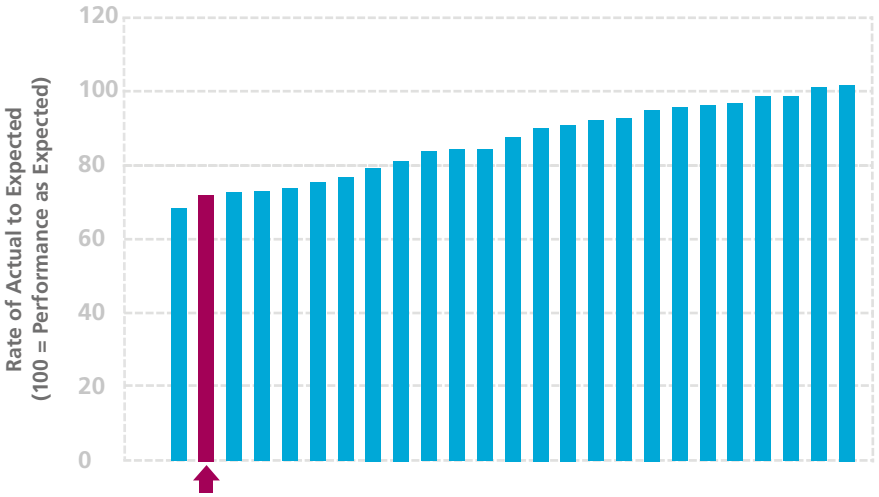
The observed volume of deaths is shown alongside the expected number (casemix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected with a figure of 105 indicating a performance five per cent higher (worse than) expected.

For the 12-month period ending June 2013, the most recent period for which data is available, the Royal Free's SHMI ratio was 80.7 or 19.3% better than expected. For this period the Royal Free had the fifth lowest rate of any English teaching trust.

HSMR relative risk of mortality

Royal Free comparison with English teaching hospitals

12 months to End of December 2013



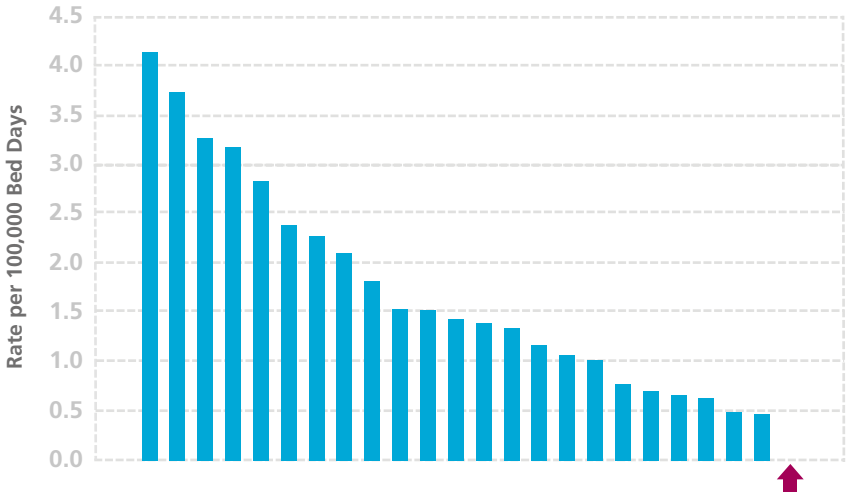
The most recent HSMR (hospital standardised mortality ratio) data shows that for the 12 months to the end of December 2013 we recorded the second lowest relative risk of mortality of any English teaching trust with a relative risk of mortality of 72.5, which is 27.5% below (statistically significantly better than) expected.

These are the two nationally accepted measures of mortality in hospital trusts. Therefore these are included as our complementary indicators to measure the trusts performance.

MRSA bacteraemia: rate of infection per 100,000 bed days

Royal Free comparison with English teaching hospitals

April 2013 to Jan 2014



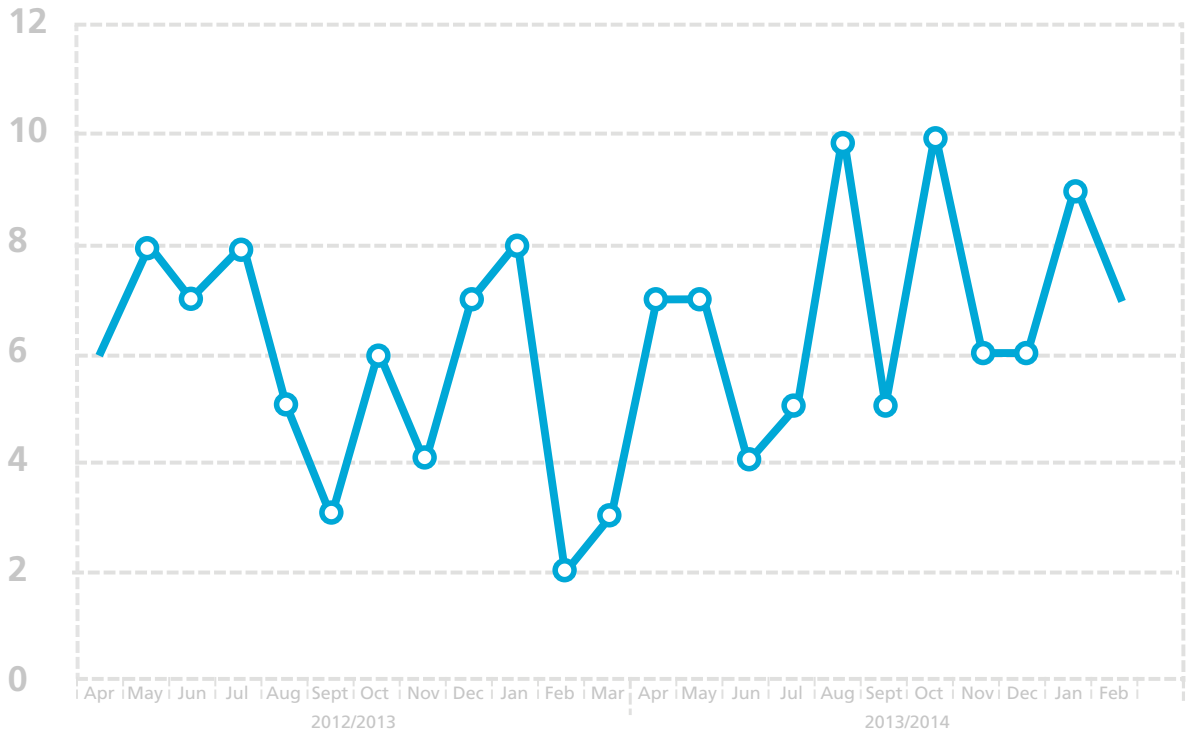
MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness.

Reducing the rate of MRSA infections is a key government target. The infection rate is seen as an indicator of the degree to which hospitals prevent the risk of infection by ensuring their facilities are clean and their staff comply with infection control procedures.

During 2013/14 the Royal Free had zero attributable cases of MRSA, compared to the previous year's total of one. This means the Royal Free is the joint best performing trust out of 25 English teaching hospitals during this period.

Venous thromboembolism (VTE)

2012-14 YTD

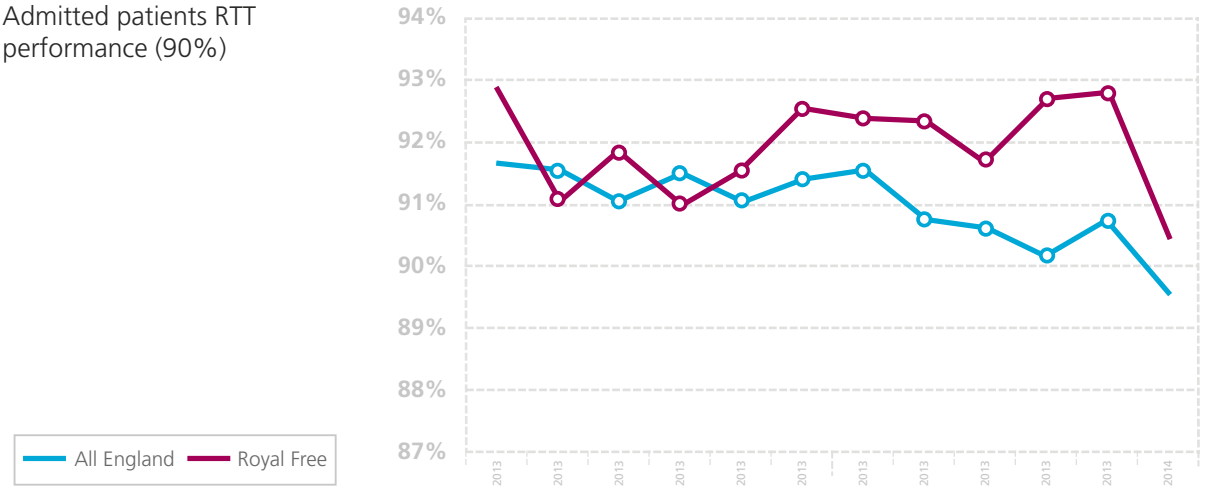


Many deaths in hospital result each year from hospital acquired thromboembolism (HAT). Some of these deaths could be prevented. The government has therefore set hospitals a target requiring 95% of patients to be assessed in relation to this risk. The Royal Free met or performed better than the target for 2013/14.

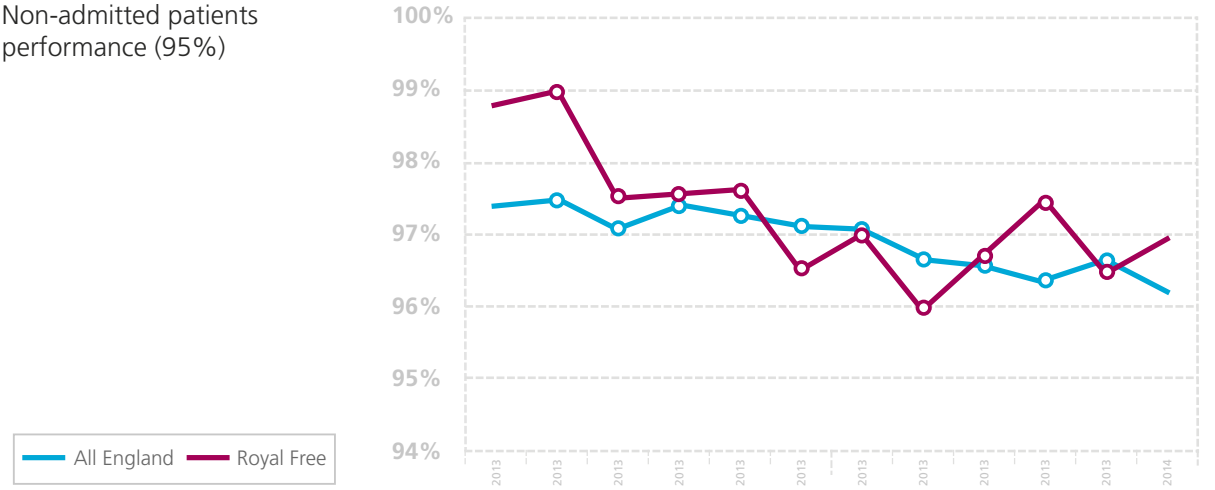
We recorded 67 cases of HAT in 2012/13 and 76 cases in 2013/14. We report our HAT rate to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence are subject to investigation with a feedback report provided to the trust board and clinical performance committee. In addition the thrombosis unit conducts a detailed clinical audit into each reported case and findings are shared with the wider clinical community.

Clinical effectiveness

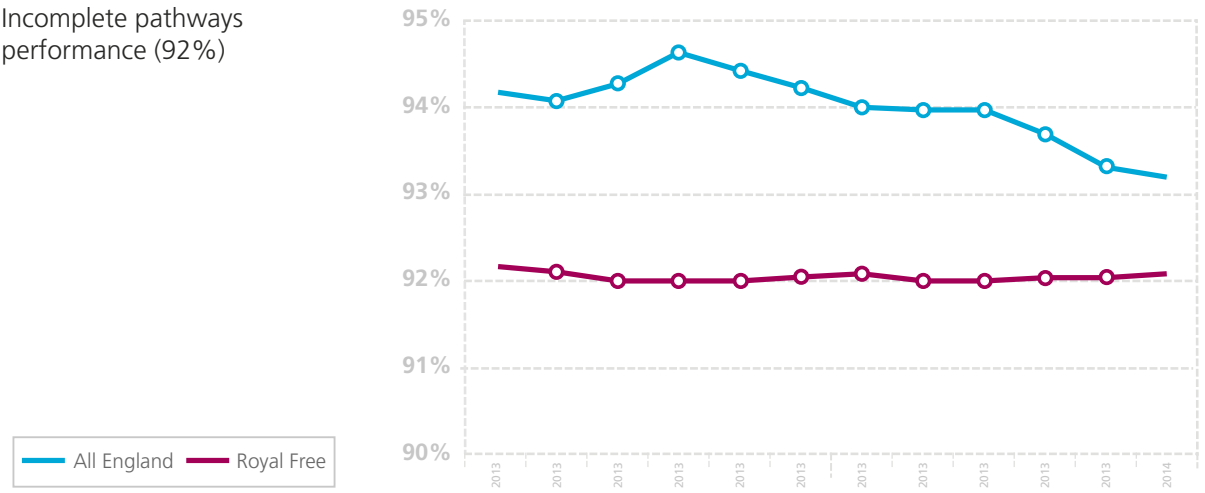
Admitted patients RTT performance (90%)



Non-admitted patients performance (95%)



Incomplete pathways performance (92%)



A maximum waiting of 18 weeks from referral to treatment is a key government access target.

We have consistently remained above the 90% standard for patients requiring admission, with the Royal Free performing better than the average performance of English acute trusts in all but two months.

However, as the chart illustrates, the proportion of patients treated within 18 weeks has reduced during January 2014, as it has across the NHS. This is mainly due to seasonal pressures with extra capacity being made available for emergency rather than elective patients.

The standard requires that 95% of out-patients are treated within 18 weeks. The Royal Free has consistently outperformed this measure and outperformed the English NHS trusts in all but four months during the year.

Longer waits for treatment for patients with incomplete pathways suggest that some patients may be actively waiting for treatment for longer than the 18 week standard. The Government has therefore set an additional target requiring 92% of patients actively waiting for treatment to have waited less than 18 weeks.

The trust has achieved this standard each month throughout the period February 2013 to January 2014.

The Royal Free will prioritise waiting list reductions in key specialties in the first half of 2014/15. This will ensure that performance improves and patients have shorter waits for admission and treatment.

Proportion of elective activity treated as a day case

Royal Free comparison with English teaching hospitals

12 months to December 2013

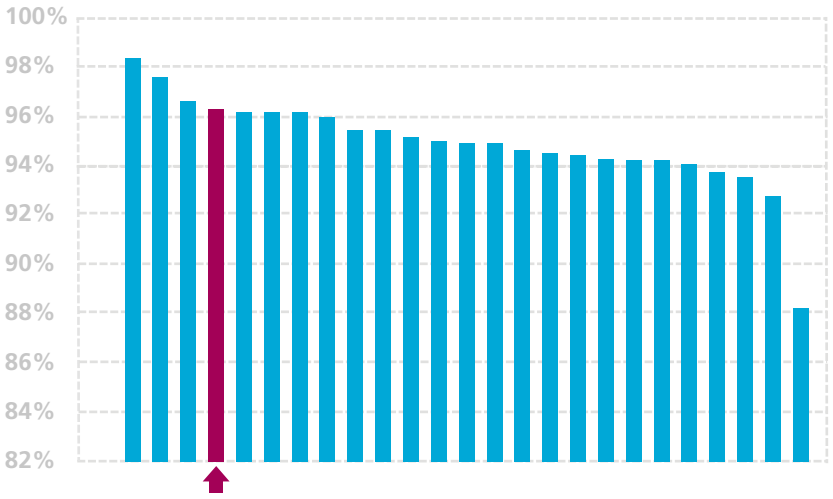
Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patient's perspective and in terms of efficient use of resources.

The graph compares the Royal Free's performance to the performance of English teaching trusts.

Proportion of A&E attendances seen within four-hour target

Royal Free comparison with English teaching hospitals

April - Dec 2013



The accident and emergency department is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.

Historically, patients often had to wait a long time from arrival in A&E to be assessed and treated.

The graph summarises the Royal Free's performance in relation to meeting the four-hour maximum wait time standard compared to the performance of English teaching hospitals.

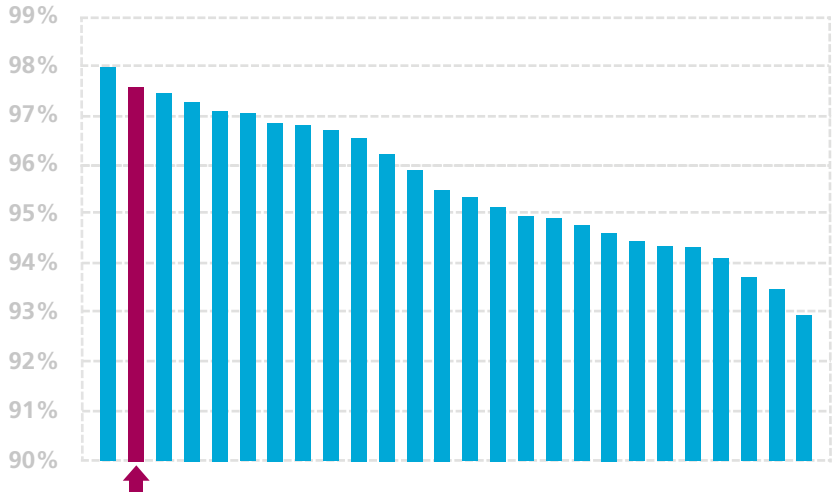
A higher percentage is good as it reflects short waiting times. During the year the Royal Free was the fourth best performing teaching trust

All cancers two-week wait

Proportion of patients treated within two weeks

Royal Free comparison with English teaching trusts Jan - Dec 2013

Royal Free

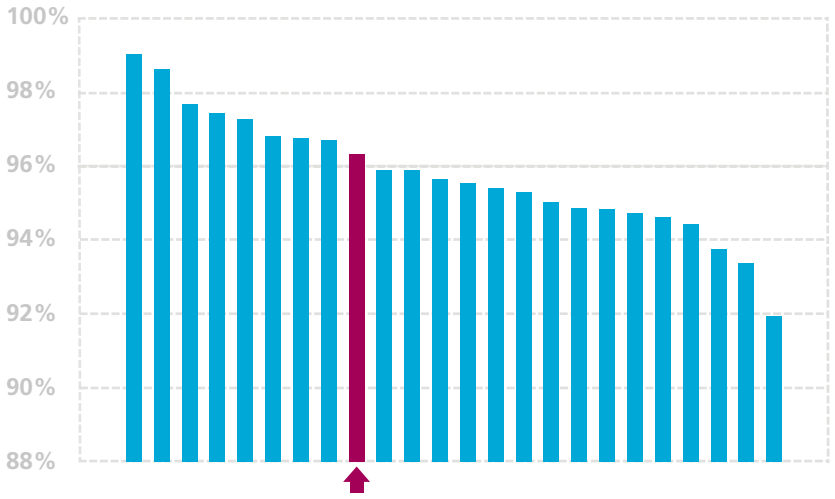


All cancers two-week wait: symptomatic breast

Proportion of patients treated within two weeks

Royal Free comparison with English teaching trusts Jan - Dec 2013

Royal Free

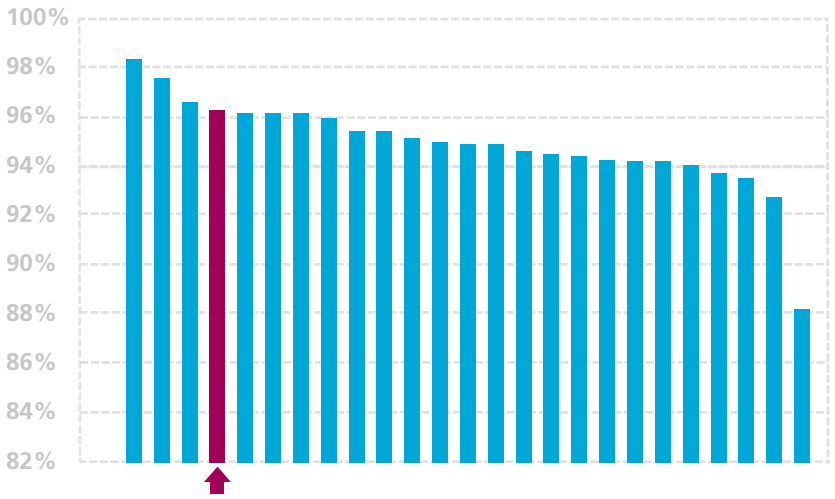


All cancers 31-day diagnosis to first treatment

Proportion of patients treated within 31 days

Royal Free comparison with English teaching trusts Jan - Dec 2013

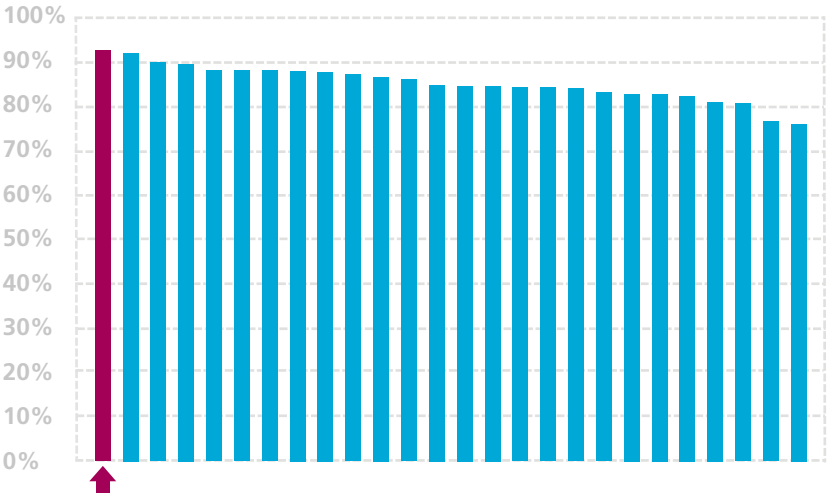
Royal Free



All cancers 62-day urgent GP referral to treatment

Proportion of patients treated within 62 days

Royal Free comparison with English teaching trusts Jan - Dec 2013



Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed, diagnosed and treated, the better the clinical outcomes and survival rates.

National targets require 93% of patients urgently referred by their GP to be seen within two weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

For the most recent period for which national data is available, January to December 2013, the Royal Free performed better than the national targets on all these measures and was the second best performing English teaching hospital for two-week waits, the fourth best for 31-day waits and the best performing in relation to the 62-day target.

The graphs present the Royal Free's performance relative to English teaching trusts' performance.

Relative risk of re-admission within 28 days of discharge

Royal Free comparison with English teaching hospitals

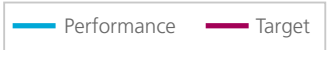
12 months period to December 2013

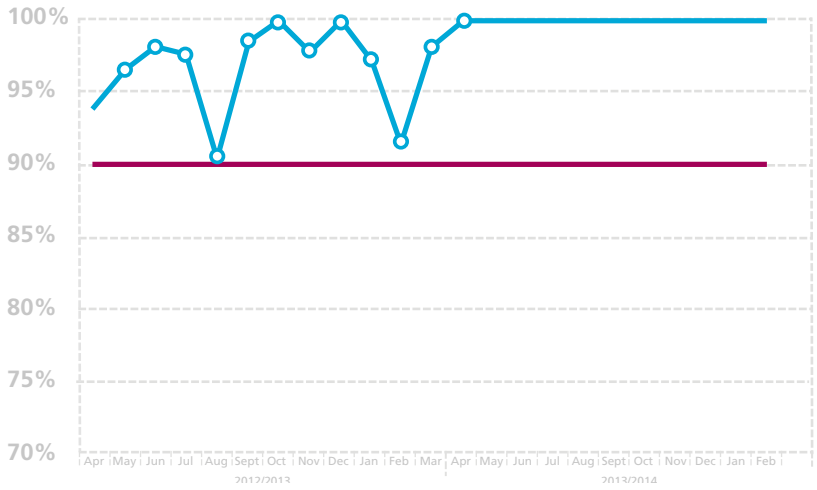
We carefully monitor the rate of emergency re-admissions as a measure of the quality of care and the appropriateness of discharge. We work with commissioners, GPs and local authorities to reduce the rate of re-admissions.

A low, or reducing, rate of re-admission is seen as evidence of good quality care. The chart presents our performance relative to English teaching hospital performance with the Royal Free being the fifth best performing.

PROMS survey completion rate

2012-14 YTD





We are required to record national patient reported outcomes measures in four clinical procedures:

- Inguinal hernia
- Varicose veins
- Knee replacement
- Hip replacement

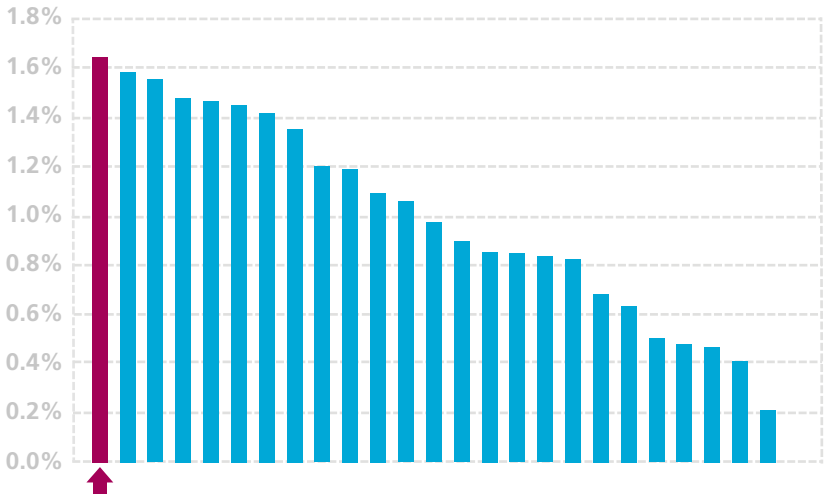
The trust has achieved or exceeded the 90% target for every month of the past two years.

Patient experience indicators

Last minute cancellations to elective admissions

% of admissions cancelled at last minute

Royal Free comparison with English teaching hospitals Jan - Dec 2013



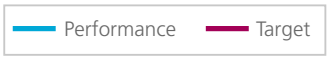
Cancelling operations on the day of, or following admission, is extremely upsetting for patients and results in longer waiting times for treatment.

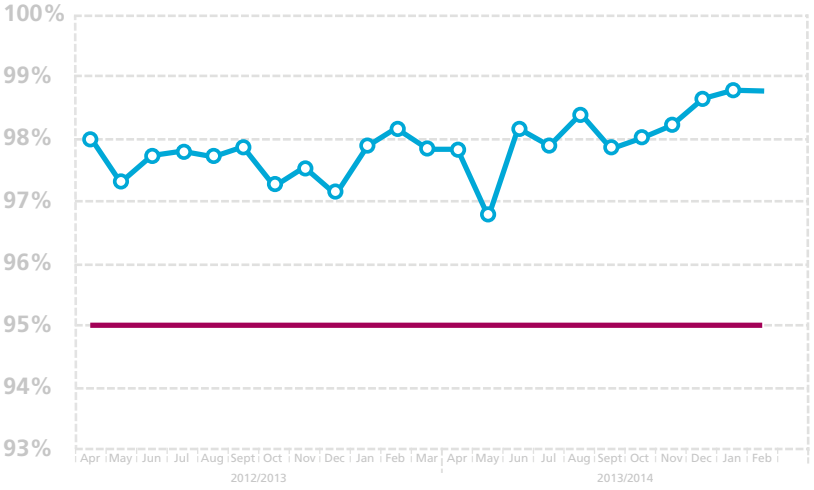
This year there has been an increase in the number of cancelled operations. In part this has been due to an increase in emergency activity with the trust having to prioritise admissions especially for those patients attending A&E. However during November 2013, the Royal Free introduced a control of cancellations policy which prioritised the reduction of cancellations in order to improve patient experience. The impact was immediate and significant.

For 2014/15 the trust will look closely at the expected, planned and emergency activity particularly over the winter months to ensure there is sufficient emergency capacity without the need to inconvenience patients by cancelling planned operations.

Ward cleanliness score

2012-14 YTD

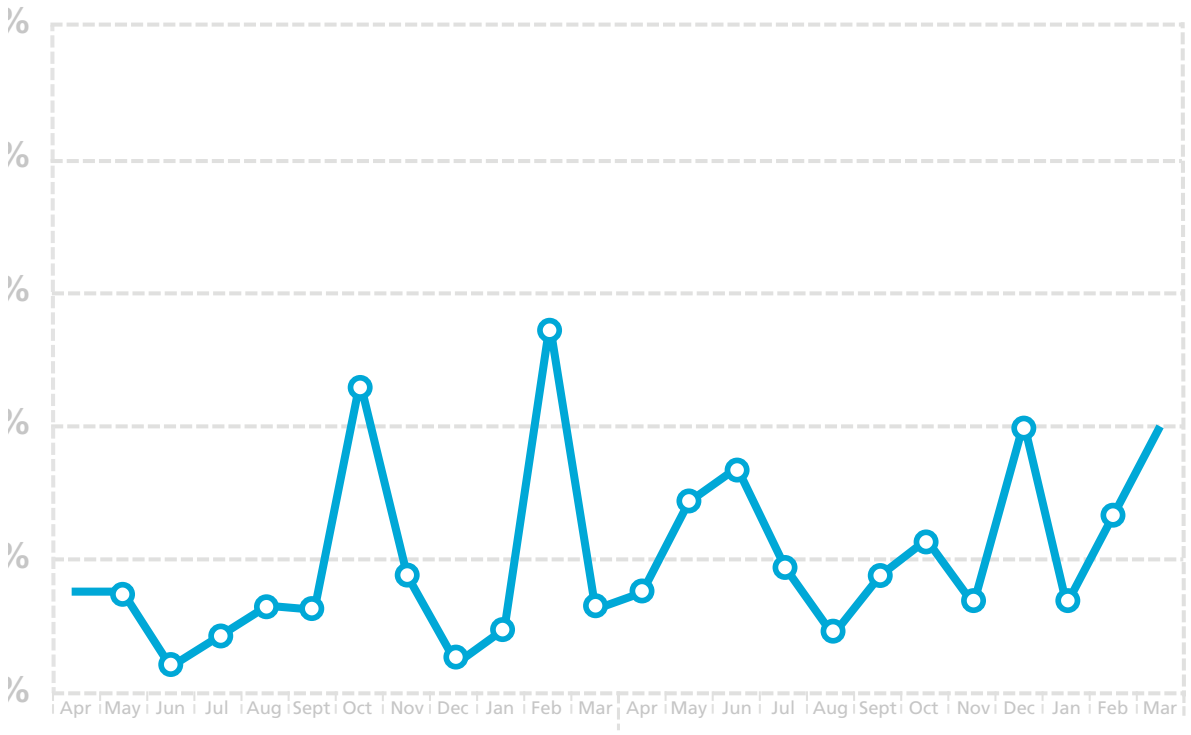




Ward cleanliness scores are derived from assessments undertaken by the patient environment action team, which includes patients, patient representatives and members of the public.

The scores were well above the required standard throughout the year.

Proportion of patients occupying an acute bed whose transfer of care was delayed (2012-14 YTD)



A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because the hospital has not properly organised the patient's transfer once the patient is well enough to leave.

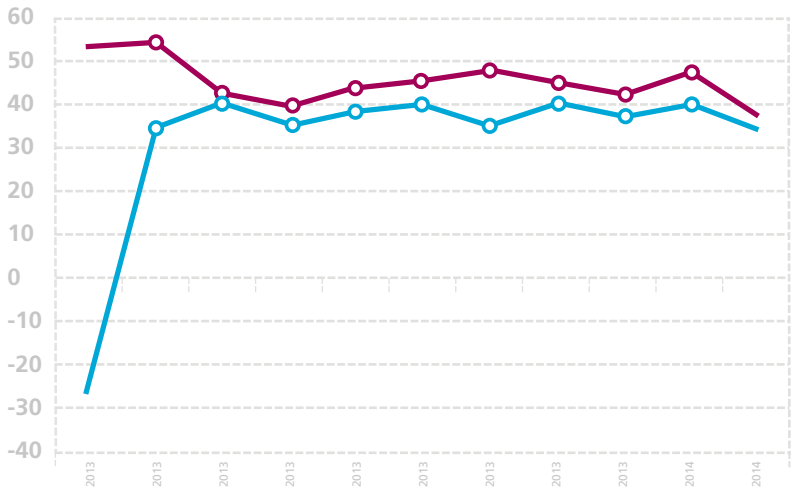
It means patients are not cared for in an appropriate environment for their needs and is an inefficient use of taxpayers' money. The aim therefore is to reduce the number of delayed transfers.

Through more effective working with our community partners and better internal organisation, the rate of delayed transfers of care has reduced significantly since 2009. However we have seen a recent increase, particularly in the winter months when the pressure on services is at its greatest. Most of these delays were associated with patients waiting for further NHS care provision. These included patients waiting for general, stroke and neurological rehabilitation and continuing healthcare-funded placements.

The trust is working with its partners and commissioning agencies to improve the position for 2014/15.

Friends and family test score

Patients who would recommend the hospital to friends and family



The friends and family test (FFT) was introduced in April 2012. Its purpose is to improve patient experience of care and identify the best performing hospitals in England.

FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

Appendices to quality report

Statements from clinical commissioning boards and overview and scrutiny committees

Appendix A

The views of our patients, local community, governors and staff are essential in helping us maintain and develop high quality clinical services. We carried out a series of exercises to ensure we engaged our various stakeholders and partners as much as possible in developing this quality report.

We sent this year's draft quality report to the following organisations for comment on 28 April 2014:

- Healthwatch Barnet
- Healthwatch Camden
- Barnet Health Oversight and Scrutiny Committee
- Camden Health Oversight and Scrutiny Committee
- North and East London Commissioning Support Unit
- Barnet Clinical Commissioning Group
- Camden Clinical Commissioning Group
- Council of governors

Our external auditor, PricewaterhouseCoopers LLP, also reviewed our quality report and we have incorporated its preliminary comments into the final version.

The following statements have been received from our stakeholders.

Healthwatch Barnet

Performance against key quality objectives

We welcome the improving rates of staff appraisals which now exceed the national average. We note the improvements in health and safety training and good communications. Whilst these now exceed the national averages and we note the trust's efforts in achieving this, we are concerned about the effect on the patients. We will separately ask the trust for further clarification on training issues and for reassurance on patient safety. We also ask for reassurance that what may be seen as a negative communication culture and issues of potential discrimination between staff are not taking place within patient care.

The quality account for 2013 included an aim to "maintain and develop our programme of engagement activities with patients and the public, ensuring that the voice of our service users is central to our business". The quality account 2014 does not appear to include a summary of work in this area or show if this has been achieved. We also note with concern the trust's lower than national average performance relating to quality and innovation and responsiveness to personal needs of patients.

Appendix E provides a summary of patient engagement activity and whilst we understand that the quality account must cover a number of subjects, more details and examples of outcomes or improvements to the service as a result of patient engagement would provide further reassurance, particularly about how priorities are selected. This could also incentivise more patients to become active within the trust's forums for patient engagement.

Priorities for improvement 2014-15

World class patient information. In a period of change and development for health services, we welcome this priority and would request that there is consistent and on-going patient consultation about their and their families' and carers' communication needs and priorities.

In-patient diabetes care. We are aware of the trust's performance in this area, not always meeting national average values/performance and so welcome this priority for 2014-15.

Patient safety programme. As noted above, we are keen to see further progress in these areas.

Quality performanceindicators

We note that the trust had identified potential data issues as a cause of the worse than average re-admission rates for adults and with patient safety incidents. We are keen to see further explanation of the data issues and reassurance or further action taken by the trust to reduce this. We also note the success in achieving the MSRA rates and note the C. difficile infection rates and the efforts taken by the trust to reduce this as it is a key Government target and an area of crucial concern for patient care.

Whilst we understand that pressure on services during winter months is a nation wide issue, we also know that this is a time when patients can be extremely vulnerable. We welcome the trust's commitment to improvements (and working with other partners where appropriate) in referrals to treatment, planned and emergency admissions and delayed transfers.

Care Quality Commission reports

We are pleased to see the positive CQC report of February 2014.

We note that there are issues with response times to complaints and that the trust is developing processes to improve this. We have received patient feedback on their frustration and distress when they have not received a response and resolution in a timely manner. As complaints are a key and timely source of patient feedback, we strongly recommend that this is treated as a matter of priority.

Healthwatch Camden

- The report indicates the progress made in achieving quality objectives and there is a lot good news for the population of Camden.
- The trust is also working to acquire Barnet and Chase Farm Hospitals NHS Trust. It is hoped this large managerial task does not slow down the ambitious quality agenda.
- We note that the trust performs well against the National Quality Indicators, being in the top 20% of high performing trusts.
- There is still some way to go with the care of staff who need a good working experience and to feel valued, as this makes a big difference with the patients being cared for.
- Many of the clinical outcomes are very good. However, there is a lot to do in order to stop the cancellation of operations. This causes great distress to patients. We are pleased that improvements are happening in this area and urge that there should be continued focus to reduce the number of cancellations.
- Patient safety is of great concern to the public, so we are pleased that the board continues to give oversight of this important aspect of care.

- We are also pleased to note the implementation of the five safer steps to surgery and that no 'never' events have taken place.
- We note that there is work to improve the services for diabetic patients, particularly regarding foot assessments; we hope this will improve outcomes for people with the damaging and potentially disabling complications of diabetes. Overall, this was a helpful and informative report.

Barnet Health Oversight and Scrutiny Committee

- The Committee scrutinised the Royal Free London NHS Foundation Trust Quality Account and wish to put on record the following comments:
- The Committee noted the high quality of care provided by the Royal Free London NHS Foundation Trust.
- The Committee welcomed the fact that the Royal Free London NHS Foundation Trust had met all of their targets, except the target on C. difficile.
- The Committee welcomed the action that the trust was taking in relation to working with partners to increase dementia awareness and welcomed the fact that the trust had a dementia lead.
- The Committee welcomed the actions being taken to improve quality in relation to dementia as a result of the National Clinical Auditor in 2013/14.
- The Committee noted that approximately a quarter of in-patients at the Royal Free London NHS Foundation Trust have diabetes and welcomed the innovative work that the trust is undertaking in relation to care of patients with diabetes.
- The Committee welcomed that there were zero attributable cases of MRSA at the Royal Free London NHS Foundation Trust during 2013/14. It is pleased to note that the various methods used to achieve the zero rate are being passed on to other trusts as examples of best practice.
- The Committee welcomed that the percentage of staff employed by or under contract to the trust who would recommend the trust as a provider to their family or friends had increased from 72.6% in 2012 to 76.2% in 2013.
- The Committee noted that the Performance Indicator for the percentage of patients re-admitted to the trust within 28 days of discharge for patients aged (i) 0 to 15 and (ii) 16 or over used old data, and requested that the final version of the quality account be updated with any available data from years 2012/13 onwards where possible.
- The Committee noted that other NHS trusts tend to include references to complaints and, whilst noting that the Royal Free London NHS Foundation Trust would be limited by the regulator, advised that they would welcome a section on complaints in the quality accounts.

However, the Committee wished to express concern in relation to the following:

- The Committee noted that the rate per 100,000 bed days of cases of C. difficile infection that have occurred among patients aged two and over had risen from 19.3 in 2011/12 to 30.5 in 2012/13, compared to the National Average Performance 2012/2013 of 16.3. The Committee were told that the Royal Free London NHS Foundation Trust had seen an improvement of those results over the last six months.
- The Committee note the independent auditor's limited assurance report to the council of governors of the Royal Free London NHS Foundation Trust on the annual quality report and expressed concern over the reporting that a significant proportion of the staff themselves felt bullied, under stress or discriminated against.
- The Committee noted that the number and rate of patient safety incidents that occurred during the reporting period October 2011 – March 2012 and October 2012 – March 2013 had increased from 451 to 2,528. The Committee noted that the data submitted between October 2011 and March 2012 was incomplete due to technical issues with exporting data, and that the Trust had taken actions to improve its reporting rate.

Camden Health Oversight and Scrutiny Committee

Camden Health Oversight and Scrutiny Committee will not be providing formal comment on these accounts this year.

North and East London Commissioning Support Unit which includes comments on behalf of Barnet Clinical Commissioning Group and Camden Clinical Commissioning Group

- NHS Barnet Clinical Commissioning Group is responsible for the commissioning of health services from Royal Free London NHS Foundation Trust.
- NHS Barnet Clinical Commissioning Group welcomes the opportunity to provide this statement in response to the Trust's quality accounts. We confirm that we have reviewed the information contained within the account and checked this against data sources where this is available to us as part of existing contract and performance monitoring discussions. We can confirm that this is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for Royal Free London Foundation Trust and how this work will enable real focus on improving the quality and safety of health services for the populations it serves.
- We can confirm that the content of the account complies with the prescribed information, form and content as set out by the Department of Health. We believe that the account represents a fair, representative and balanced overview of the quality of care at Royal Free London Foundation Trust. We have discussed the development of this quality account with trust colleagues over the year and have been able to contribute our views through consultation processes.
- This account has been reviewed within NHS Barnet Clinical Commissioning Group, by associate commissioning colleagues in Camden and by NHS North and East London Commissioning Support Unit.
- The CCG feels that the following areas have not been sufficiently reflected in the quality account and have discussed this with the trust.
- Whilst the trust identifies the use of training and staff surveys to improve staff skills, there is little or no indication of the trust's absence and vacancy rates. There is no evidence to indicate that the trust is at full establishment and whether or not they have any recruitment initiatives ongoing.
- The trust has not identified the number of Serious Incidents that have been reported regarding falls, pressure ulcers and prescription errors. There is also no indication as to the time taken to review and close these incidents and there is no evidence supplied to demonstrate that the trust has initiated any action plans to address common themes.
- There is no mention of the trust's Serious Incidents apart from the actions put in place to prevent a reoccurrence of nasogastric tube and surgical errors. The trust still has a number of grade 2 serious incidents where evidence of completed actions has not been submitted. This remains an area of concern for the CCG.
- The report does not refer to complaints and there has been no reference to complaint numbers, themes or responses times and it is unclear within the account if data from complaints, audit and incidents has been used for triangulation to inform wider learning.
- Although it is appreciated that patient stories and evidence of patient engagement is included within the trust annual accounts, it would have been helpful to see some evidence within the quality account document.
- Throughout the past year Barnet CCG and the trust have worked successfully together through the Clinical Quality Review Group meetings to review evidence and resolve issues related to all aspects of clinical quality. Areas of focus have included developing a stronger evidence base, patient involvement and improvements to patient safety.
- This document incorporates all the essentials required for inclusion into a quality accounts document; however there is an absence of some information regarding known quality issues, as outlined above, that raises some concern.
- Overall we welcome the vision described within the trust's quality accounts and we agree on the priority areas. Barnet CCG will continue to work with Royal Free London Foundation Trust to continually improve the quality of services provided to patients.

Council of governors

Governors forming the membership engagement sub-group have had the opportunity to review the draft quality account on behalf of the council of governors of the Royal Free London Foundation Trust. These governors consider that the report provides a comprehensive and accurate summary of the work done by the trust in 2013/14 to improve services for patients. Much of this information has been shared with the council of governors by:

- Regular provision of the trust performance report
- Copies of the minutes of the trust board
- Updates in the chief executive's briefing to the council
- Briefings from non-executives on individual board committee work programmes.

The governors are clear in their responsibility to hold to account the non-executive directors, collectively and individually, for the performance of the board, and focus their attention on ensuring that high quality services are available both for the local population and for patients from further afield requiring specialist services.

To help them carry out their statutory responsibilities, governors attend each of the three quality-focused board committees and provide challenge to the trust in the robustness and timeliness of improvement plans to enhance both patient and staff experience.

It is pleasing to note that progress has been made on the quality priorities in 2013/14; governors in their own priority-driven sub-groups have focused their attention on a number of specific areas, including those involving patient and staff experience issues. But while progress has been made it is disappointing it has not always been made as quickly as should have been the case.

The quality objectives outlined for 2014/15 are clearly described and are linked to each domain for quality – it will be important that progress against these is reported regularly; the areas chosen are of national and local importance.

Quality objectives... are of national and local importance.

Appendix B

Response to comments

In response to comments received from commissioners, local Healthwatch organisations and overview and scrutiny committees we have outlined our responses in the following table.

Stakeholders	Comments	Royal Free London NHS Foundation Trust response or changes
Barnet Healthwatch	We note that the trust had identified potential data issues as a cause of the worse than average re-admission rates for adults and with patient safety incidents. Issues with response times to complaints and that the trust is developing processes to improve this. As complaints are a key and timely source of patient feedback, we strongly recommend that this is treated as a matter of priority.	The trust acknowledges there is more to do with improving our current rate of re-admission and has provided details in the accounts of the work in place with our public health colleagues and primary care partners (see page 39) on re-admission and the trust's intended actions. The trust's board level patient and staff experience committee receives quarterly complaints' response performance data. During 2013/14 overall there has been an improvement in the trust rate of response. The trust recognises that patient feedbacks through complaints are an important aspect of how we understand the views of our patients and service users. The director of nursing monitors patients' complaints on a weekly basis with senior nursing staff and the central complaints team.
Camden Healthwatch	There is still some way to go with the care of staff who need a good working experience and to feel valued, as this makes a big difference with the patients being cared for. Many of the clinical outcomes are very good. However, there is a lot to do in order to stop the cancellation of operations; this causes great distress to patients. We are pleased that improvements are happening in this area, and urge that there should be continued focus to reduce the number of cancellations. Patient safety is of great concern to the public, so we are pleased that the board continues to give oversight of this important aspect of care.	The trust recognises and will continue work to improve experiences of staff which we provide more details of in our annual report section Supporting our dedicated staff. During 2013/14 we put additional focus on cancelled operations and have seen a reduction in the numbers. The development of our safety programme remains a key priority for the trust and we give details of our intentions for improvement during 2014/15 on pages 156-158.

Stakeholders	Comments	Royal Free London NHS Foundation Trust response or changes
Barnet Overview and Scrutiny Committee	The Committee note the independent auditor's limited assurance report to the council of governors of the Royal Free London NHS Foundation Trust on the annual quality report and expressed concern over the reporting that a significant proportion of the staff themselves felt bullied, under stress or discriminated against. The Committee noted that the number and rate of patient safety incidents that occurred during the reporting period October 2011 – March 2012 and October 2012 – March 2013 had increased from 451 to 2,528. The Committee noted that the data submitted between October 2011 and March 2012 was incomplete due to technical issues with exporting data, and that the trust had taken actions to improve its reporting rate.	The trust recognises and will continue work to improve experiences of staff which we provide more details of in our annual report section Supporting our dedicated staff. The trust would ask the Committee to note that 451 incidents was a low figure which related to reporting issues at that time.
Commissioners North East London Clinical Support Unit	The CCG feels that the following areas have not been sufficiently reflected in the quality account and have discussed this with the trust. Whilst the trust identifies the use of training and staff surveys to improve staff skills, there is little or no indication of the trust's absence and vacancy rates. There is no evidence to indicate that the trust is at full establishment and whether or not they have any recruitment initiatives ongoing. The trust has not identified the number of Serious Incidents that have been reported regarding falls, pressure ulcers and prescription errors. There is also no indication as to the time taken to review and close these incidents and there is no evidence supplied to demonstrate that the trust has initiated any action plans to address common themes. There is no mention of the trust's Serious Incidents apart from the actions put in place to prevent a re-occurrence of nasogastric tube and surgical errors. The trust still has a number of grade 2 serious incidents where evidence of completed actions has not been submitted. This remains an area of concern for the CCG. The report does not refer to complaints and there has been no reference to complaint numbers, themes or responses times and it is unclear within the account if data from complaints, audit and incidents has been used for triangulation to inform wider learning. Although it is appreciated that patient stories and evidence of patient engagement is included within the trust annual accounts, it would have been helpful to see some evidence within the quality account document.	Information providing an overview of the trust workforce and our intended actions in response to the national staff survey is reported within the annual accounts in section Supporting our dedicated staff. The trust will consider in future how best to represent workforce data in future accounts. During 2013/14 the trust made significant improvements in the timeliness of completed serious incidents investigations. However we recognise further work on improvements are required. The trust has established a board-level patient safety committee in 2013/14 which is increasing the board-level scrutiny of serious incidents investigations. The patient safety programme also aims to improve our incident reporting and investigations. We will be reporting progress to CCGs via our regular review meetings with the commissioners.

Appendix C

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14.

The content of the quality report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2013 to May 2014
- Papers relating to quality reported to the board over the period April 2013 to May 2014
- Feedback from commissioners dated 15/05/14
- Feedback from governors dated 13/05/2014
- Feedback from local Healthwatch organisations dated 12/05/14
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/07/2013
- The latest national patient survey 2013
- The latest national staff survey 2013
- The head of internal audit's annual opinion over the trust's control environment dated 16/05/14
- CQC quality and risk profiles dated 15/03/2014.

The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

The performance information in the quality report is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report and these controls are subject to review to confirm that they are working effectively in practice;

The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

Dominic Dodd
Chairman

29 May 2014

David Sloman
Chief executive

29 May 2014

Appendix D

Independent auditors' limited assurance report to the Council of Governors of Royal Free London NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of the Royal Free London NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Free London NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

	Specified Indicators	Specified indicators criteria
1	Number of Clostridium difficile infections	Page 159 of Quality Report
2	Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Page 159 of Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the quality report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2013/14" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to the date of signing this limited assurance report (the period);
- Papers relating to quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;
- Feedback from the Commissioners, North and East London Commissioning Support Unit, Barnet Clinical Commissioning Group and Camden Clinical Commissioning Group dated 15/05/2014;
- Feedback from governors dated 15/05/2014;
- Feedback from local Healthwatch organisations, Healthwatch Camden and Healthwatch Barnet, dated 12/05/2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/07/2013;
- Feedback from other stakeholders involved in the sign-off of the Quality Report, London Borough of Barnet overview and scrutiny committee dated 12/05/2014;
- The latest national patient survey dated 2013;
- The latest national staff survey dated 2013;
- Care Quality Commission quality and risk profiles dated 15/03/2014;
- Intelligent Monitoring Reports dated 13/03/2014; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2014.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of the Royal Free London NHS Foundation Trust as a body, to assist the Council of Governors in reporting the Royal Free London NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and the Royal Free London NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for Quality Reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability.

The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by the Royal Free London NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the *"Detailed requirements for quality reports 2013/14";*
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

PricewaterhouseCoopers LLP
Chartered Accountants
London
29 May 2014

The maintenance and integrity of the Royal Free London NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix E

A guide to quality within the trust

March 2014

This guide describes how we ensure we provide patients with high quality services.

It describes what quality means for the trust and how we set a culture of quality and high standards throughout the organisation.

The guide was originally adapted from the quality governance memorandum prepared for our 2011 foundation trust application and has most recently been revised and updated for inclusion in the trust's 2013/14 quality account. It is based on the quality governance framework used by Monitor, the regulator of foundation trusts. Quality governance is divided into four main domains: strategy, cultures and capabilities, processes and structures and metrics.

What is quality?

The term 'quality' can be used in different ways. In some circumstances it describes how a product measures up to a predetermined specification: did it do what it said on the tin? In other contexts quality is measured against expectation: was it what I thought it would be? Frequently it is simply used to mean excellence - a quality product.

At the Royal Free our focus is on excellence and we therefore aim to provide services of the highest possible quality. This is reflected in our World Class Care values, which are also embedded in our corporate objectives and reflect our governing objectives:

- **To deliver excellent patient outcomes, teaching and research.** Our aim is to be in the top 10% of our relevant peers. This means maintaining our excellent infection control and patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service line level.
- **To offer excellent patient and staff experience.** Our aim is again to be in the top 10% of our relevant peers. The main challenge here is addressing the variability of the patient experience and ensuring we engage all staff in the running and development of the trust and give our staff the skills, resources and support they need to perform to the optimum of their ability.
- **To deliver excellent financial performance and value for taxpayers' money.** To be in the top 10% of our relevant peers, we must have a major focus on productivity and service transformation as we meet the financial challenges ahead.
- **To be safe and compliant with the law and the standards and targets set by our regulators and other relevant bodies.** This includes health and safety legislation, the CQC regulatory standards and the standards and targets within the NHS operating framework.
- **To build a strong organisation fit for the future.** We must ensure that we have the infrastructure, processes and people in place to enable us to deliver the four objectives described above.

In autumn 2011 we launched our World Class Care programme, designed to improve patient and staff experience within the trust. As part of this we listened to hundreds of our patients and staff members and have worked with them to develop a set of commitments and standards which we expect all staff to adopt. The standards are:

- to be positively **welcoming**
- to be actively **respectful**
- to **communicate** clearly
- to be visibly **reassuring**

The Royal Free already demonstrates high quality performance in many areas. For example:

- The trust consistently has one of the lowest hospital standardised mortality rates (HSMR) and summary hospital-level mortality indicators (SHMI) in England
- No MRSA bacteraemia has occurred within the trust for 18 months
- The trust has the second highest number of highly-cited research publications of English NHS trusts.

There are also areas in which we know quality must improve. These include:

- The administrative processes which support patients and staff
- Levels of reported bullying by staff
- Overall patient experience
- Rates and timeliness of serious incident reporting

Strategy

How quality drives the trust's strategy

Each year the board approves three

high-level quality improvement objectives that are published in our annual quality account. These are agreed following extensive consultation with external stakeholders including the trust's governors, Barnet and Camden Healthwatch, Barnet and Camden health scrutiny committees and local CCGs. In addition our trust members complete an online survey. Internally, discussions are held at executive and board level and with staff groups.

Our 2013/14 quality improvement objectives were:

- In the area of patient experience, to continue our World Class Care programme. Our specific aims were to identify and share learnings from the world class ward programme; continue our work around supporting teams to consistently give world class care through the delivery of core and bespoke development programmes, integrating these with our response to the Francis report and the Secretary of State for Health's requirement to conduct listening events with staff; and maintain and develop our programme of engagement activities with patients and the public, ensuring that the voice of our service users is central to our business.
- In the area of clinical effectiveness, to continue the development of our specialty-based clinical outcome metrics. Our specific aims were to appoint an associate medical director for clinical performance; complete the publication of current data for all our speciality level metrics; develop achievable improvement plans for these metrics, taking into account what other trusts have been able to achieve, both nationally and among UCLPartners; continue work within our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations; begin the development of patient-defined clinical performance metrics.
- In the area of patient safety, to launch a patient safety programme with a focus on key areas of patient safety that have arisen from our analysis of clinical incidents occurring within the trust, patient complaints, national guidance and from discussion with our stakeholders, including patients and governors.

The clinical performance committee and trust board receive regular updates on progress against these objectives.

The trust also drives quality improvement through its Quality, Innovation, Productivity and Prevention (QIPP) programme, led by the director of integrated care; and the Commissioning for Quality and Innovation (CQUIN) scheme led by the director of planning. The QIPP programme incorporates transformational and transactional aspects of clinical management to support the delivery of quality services while at the same time reducing costs over the next five years. The programme responds both to financial pressures, resulting from flat income and expected increase in demand, and our commitment to delivering high quality services. There are currently more than 70 active QIPP projects. The CQUIN programme is agreed each year with our commissioners following extensive discussion and, where appropriate, co-development.

In addition to our annual high-level quality objectives, QIPP, and CQUIN programmes, the trust demonstrates its commitment to innovation through its approach to quality improvement. This has included development of adult and paediatric early warning systems, the first introduction in the UK of Schwartz Rounds, introduction of the productive ward, participation in the Institute of Health Improvement's Safer Patient Initiative and improvement work aimed at early recognition of sepsis. Most recently the trust has launched a new patient safety programme under the sponsorship of the deputy chief executive. Our improvement work is increasingly developed in partnership with other NHS organisations, usually through UCLPartners, our academic health science network. Our system-wide work on the management of deteriorating patients is a prime example of this approach. A selection of other quality improvement initiatives is described each year within our annual quality account. In the latest quality account, published in June 2013, we reported on projects to:

- Improve diagnosis and treatment of heart failure
- Improve waiting times for cancer patients
- Help patients with diabetes receive safer care
- Cure haemophilia through gene therapy
- Prevent elderly patients having unnecessary admissions to hospital
- Improve in-patient care of the elderly.

In recent years the board has been particularly concerned that improvements occur with respect to patient and staff experience, particularly through our World Class Care programme.

The trust communicates and discusses quality initiatives with staff, patients and other external stakeholders in a variety of ways. These include the annual quality account, which we publish with our annual report and financial accounts in this single document, regular electronic briefings by the chief executive, meetings of governors, and staff engagement sessions.

How the board is aware of potential risks to quality

Our risk management strategy outlines the trust's approach to risk and details the processes in place to manage risk. The trust maintains a risk register and a board assurance framework (BAF), both of which are reviewed and revised on a regular basis. The trust executive committee reviews the risk register, with additional oversight and assurance provided by the patient safety and compliance committee. Additional review is undertaken at the clinical performance committee and the audit committee. The risk register is populated from a variety of sources including risk registers maintained within each clinical division, incident forms, audits, benchmarking and external reviews. The BAF is regularly reviewed at the strategy and investment committee and is also reviewed at other board committees. The risk register and board assurance framework both contain actions to mitigate risk; these are regularly reviewed.

The trust board also uses a variety of other mechanisms to assess potential risks to quality. These include our programme of 'Go see' visits, in which directors are paired with clinical areas that they visit on a regular basis; regular reports to the board from the director of infection prevention and control; a range of inspections by external regulators that are monitored by the patient safety committee (formerly the risk, governance and regulation committee); our quality road map self-assessment process for CQC outcomes; and a wide range of metrics used to monitor performance. The trust participates in national in-patient and out-patient surveys and collects data for the friends and family test through a telephone-based methodology. The trust encourages external stakeholders to identify risks to quality through a variety of formal and informal means. These include the patient advice and liaison service (PALS), patient representative groups, Healthwatch, public board meetings, local commissioners, council of governors and the local health scrutiny committees. The board's patient and staff experience committee has the key responsibility for monitoring and improving the quality of patient and staff experience.

The QIPP programme is a key component of the trust's quality improvement process. However, we recognise that there is also a potential for some QIPP projects that primarily focus on cost reduction to have an adverse effect on quality. To avoid this, all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. QIPP projects are separately reviewed by the medical director and the director of nursing for any potential negative impact on quality. A separate clinical advisory group, consisting of clinicians not directly involved in developing QIPP programmes, also provides additional scrutiny. In addition the board monitors a set of specific trust-wide metrics that may be adversely affected by cost improvement projects.

Capabilities and culture

How the board ensures it has the necessary leadership, skills and knowledge to deliver the quality agenda

In 2013/14, the trust board consisted of five executive directors (including the chief executive) and six non-executive directors (including the chairman). Three of the executive directors and one of the non-executive directors have clinical backgrounds. In addition, board meetings are attended by a number of other executives, including the three divisional directors who are practicing clinicians. Board members have a wide range of experience and backgrounds, including other NHS organisations, other public sector bodies and the private sector.

The current board committee structure is shown in figure 1 on page x and has been designed to ensure that integrated quality governance is aligned with our governing principles and corporate objectives. A non-executive director chairs all board committees, with the exception of the trust executive committee. Three clinical divisions, established around strong clinical leadership, support the board.

Quality is central to the agendas of the board and all its committees, with a regular focus on quality metrics. Recent examples where the board has clearly taken a central role in quality improvement include the focus on infection control, with a sustained reduction in acquired MRSA bacteraemias and renewed focus on reduction in Clostridium difficile infections, the development of around 90 clinical outcome metrics, mostly at specialty level and a focus on scrutiny of the results of national clinical audits.

The board participates in a comprehensive continuing development programme, which has included an external assessment of its skills and capabilities. Regular board seminars provide the opportunity for directors to expand their knowledge and skills of specific issues including quality governance.

How the board promotes a quality-focused culture throughout the trust

The board has promoted a number of quality strategies and initiatives that have been developed and implemented with extensive staff engagement. As already described, these include the development of the annual quality account, the drive to improve infection control, the QIPP programme, the patient safety programme, the development of clinical outcome metrics for each clinical business unit and, most importantly, our World Class Care programme. These and other quality-focused programmes have helped promote a quality-focused culture

throughout the organisation. Senior executives are directly involved in specific quality improvement initiatives; for example the director of nursing is responsible for the falls reduction programme, our infection control programme and the World Class Care programme; the medical director is responsible for the development of clinical outcome metrics; the director of integrated care is responsible for the QIPP programme; the deputy chief executive sponsors our patient safety programme.

The board actively encourages staff to participate in quality initiatives. Our EUREKA scheme encouraged staff to suggest quality schemes as part of the QIPP programme. Annual staff achievement awards recognise those individuals and teams who have made a significant contribution to high quality within the trust. Using our clinical incident reporting system, we encourage staff to report errors and adverse events that have, or could have, an adverse impact on quality. This has been strengthened by our recent implementation of the Datix web system for electronic reporting of incidents.

Staff members receive training and experience in service improvement methodology through direct participation in quality improvement projects, such as our theatre improvement project and our work on sepsis management. Quality improvement projects are reported and communicated by a number of means, including the annual quality account, a weekly electronic newsletter to staff, a quarterly newsletter to staff, information to members and monthly briefings of staff by the chief executive.

The trust carries out robust recruitment and human resources practices that ensure we have a high quality workforce that is safe and responsible in delivering care. We review our policies and procedures regularly with service user involvement and our staff are equipped with the right skills and professional training to keep us compliant with our external and regulatory obligations. We have recently focused on embedding our World Class Care values in our recruitment processes.

Processes and structures

Roles and accountabilities in relation to quality governance

The trust board is ultimately responsible for the quality of service provided by the Royal Free. It agrees the overall strategic direction for continuous quality improvement, encapsulated by the top 10% aspiration within the governing objectives; sets a culture which promotes the delivery and development of high quality services; and monitors how the trust performs against objectives. Trust board meetings do not treat quality as a separate agenda item as we believe quality should form an integrated part of discussions and decisions in all areas, clinical and non-clinical. Each year the board agrees three high-level quality improvement goals that are published in the annual quality account.

The chief executive's scheme of delegation describes the responsibilities of individual executive directors. The medical director has overall accountability for the quality of clinical services and is responsible for clinical performance and patient safety; the director of nursing is responsible for CQC compliance and patient experience.

Board committees are aligned with the governing objectives and have a key role in quality governance:

- The **clinical performance committee** meets quarterly and is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board, namely 'outcomes consistently in the top 10% in the UK versus relevant peers'. It monitors performance against the trust's three high-level quality objectives, reviews data concerning mortality by specialty and diagnostic group, reviews national clinical audits and undertakes reviews of specialties where concerns may have arisen regarding clinical quality. It is working with service lines to develop a series of outcome measures which, whenever possible, will be benchmarked against other organisations.
- The **patient and staff experience committee** meets quarterly and is responsible for seeking and securing assurance that the trust's services are delivered to its customers (GPs and patients) so as to achieve the high levels of performance expected of them by the board, namely 'recommendation rates consistently in the top 10% in the UK versus relevant peers'.
- The **patient safety committee** is a new committee which has replaced the risk, governance and regulation committee. It meets monthly and monitors patient safety through review of patient safety metrics such as falls and pressure ulcers, review of serious incidents and oversight of the patient safety programme. It is also responsible for ensuring that the trust is fully compliant with all its regulatory duties.
- The **trust executive committee** meets weekly. The role of the committee is to support and advise the chief executive in running the trust, in meeting the requirements of the operating framework and on strategic priorities and objectives.
- The **finance and performance committee** meets monthly and is responsible for seeking and securing assurance that the trust achieves the high levels of financial and operational

performance expected by the board, namely 'consistently in the top 10% in the UK versus relevant peers'.

- The **integration committee** meets monthly and is responsible for overseeing the integration plan, providing assurance to the trust board on progress on integration of the Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust. Ensuring sufficient oversight is given to realising the benefits articulated in the integrated business plan for the acquisition.
- The **strategy and investment committee** now meets bi-monthly and is responsible for ensuring that the trust's strategy and major investment decisions support the achievement of its governing objectives.
- The **audit committee** meets five times a year. It provides the board with an independent and objective review of the effectiveness of the organisation's governance, risk management and internal control systems. It receives evidence and gathers assurance from a variety of sources about the overall quality of care provided by the trust.
- The **remuneration committee** meets as required and consists of the trust chairman and non-executive directors. It is responsible for all decisions concerning the remuneration and terms of service for corporate managers.

Beneath the level of board committees, other committees and working groups also play an important role in quality governance. These include groups that have a focus on a specific issue, such as the committee that ensures the trust is compliant with the Human Tissue Act, to those with a broader remit such as the education committee. Our 2011 review of quality governance recommended that the majority of these groups should report into the trust executive committee, as this is the board committee that meets most regularly and is able to address operational issues most rapidly. It also provides a key link to the trust's clinical divisions. Reports from these groups are also made available to other board committees on a regular or ad hoc basis as appropriate.

The trust's clinical services operate within three divisions: transplantation and specialised services, urgent care and surgery and associated services. Each division contains a number of service lines (clinical business units). Divisions focus on quality within a variety of fora including divisional quality and safety boards to provide a specific divisional focus to quality governance.

Processes for escalating and resolving issues and managing performance

The trust committee and reporting structure has already been described. In addition, the trust uses other mechanisms to gather and escalate quality issues. These include the risk register and the board assurance framework, risk management reports, clinical audit programmes and our internal audit plan. The trust has a whistle-blowing policy that is available to all staff on our intranet.

How the board actively engages patients, staff and stakeholders

To emphasise our patient-focused approach, each board meeting begins with 'patient voices' in which an executive director reads one recent letter of complaint and one of praise.

The board actively encourages patients, staff and other stakeholders to engage in our drive for high quality through a variety of means.

Examples include:

- The extensive engagement that is undertaken for our annual quality account
- Patient focus groups that have been established in a number of specific areas
- The trust's council of governors and membership which have been in place since 2008, initially in shadow form and since April 2012 with full powers. The board consults the council and members concerning quality and responds to quality issues raised by the governors. Governors sit on the clinical performance committee, the patient and staff experience committee and the patient safety committee
- Board members and governors regularly undertake 'go see' visits to clinical areas, which involve speaking with patients
- The patient and staff experience committee regularly reviews the results of patient and staff feedback.
- The board regularly engages with local Healthwatch and health scrutiny committees
- The trust meets commissioners, including GP representatives, in a monthly clinical quality group attended by the trust medical director and director of nursing
- The trust has a director of integrated care who is responsible for working with commissioners and GPs to develop high quality community-based services
- We are one of the few acute trusts to have a public health team that works within the trust and with our local community to promote health and well being improvement.

The trust is committed to making its quality performance outcomes as accessible as possible. For example, our comprehensive board performance dashboard is included within the published papers of our quarterly public board meetings. Our quality account includes a comprehensive set of quality data together with easily understandable descriptions of each metric. Performance metrics are also discussed with commissioners at regular monthly quality review meetings. We have recently begun placing performance metrics on our external internet site.

Measurement

How appropriate quality information is analysed and challenged

The trust already generates a large volume of metrics relating to the quality of operational performance, patient safety, patient experience and clinical outcomes. The trust metrics library currently consists of more than 200 measurements. This is supplemented by metrics provided by external agencies such as Dr Foster. Additional metrics are also under development, eg the clinical performance committee has developed clinical outcome metrics at clinical business unit level and six education and research metrics at organisational level.

Since the appointment of a director of information management and technology in 2010, the board performance dashboard has undergone extensive development. This now provides a comprehensive set of clinical and non-clinical metrics and includes:

- Metrics related to national priorities and regulatory requirements, eg A&E metrics
- Metrics specifically related to safety, clinical effectiveness and patient experience
- Metrics specifically related to early warning of quality deterioration, eg patient falls, average length of stay
- Metrics related to adverse events and harm, eg never events, MRSA rates
- Monitor's risk ratings
- RAG rating and an overall commentary on performance.

The board dashboard is focused on those metrics that are most relevant to the governing principals and corporate objectives. Further metrics are reviewed in other trust committees: for example the operations board reviews a comprehensive set of operational performance metrics and the user experience committee reviews patient and staff survey metrics. Divisional dashboards include division-specific metrics. The trust executive committee reviews a ward-based 'heat map' of patient experience, workforce and safety metrics on a monthly basis. The patient safety and compliance committee reviews the trust's quarterly self-assessment of compliance with CQC standards.

The trust is currently implementing service line reporting within its clinical business units. This will facilitate better analysis of metrics at specialty and consultant level. Consultant-level outcomes are monitored at the clinical performance committee.

Each metric is overseen by a board committee and/or executive director.

How the board assures the robustness of quality information

The data quality committee is responsible for monitoring and reviewing the quality of data captured by the trust's systems. This is supplemented by internal audit reviews and external reviews such as the Audit Commission's audit of our 'payment by results' systems and processes. External auditors also review the quality of data in our most recent quality account. Action plans are agreed following data audits and monitored by the relevant committee.

The accuracy of coding is reviewed as part of the payment by results audit and is reported in the quality account. The trust has established a clinical data quality group to drive improvement in clinical documentation and coding quality.

The trust is increasingly using electronic systems to capture and report key metrics and the information team is currently developing the automation of such reporting.

The trust actively encourages participation in national clinical audits and confidential enquiries. The clinical performance committee reviews the outcome from these audits and when concerns arise will undertake specific reviews.

How quality information is used effectively

The trust dashboard includes red, amber, green rating of individual metrics against targets and shows trends of performance overtime. Wherever possible, the trust also benchmarks performance against comparable organisations. All reports include the most recently available data. The trust is increasingly working towards on-demand electronic availability of metrics from its extensive metrics library.

The regular review of metrics has helped drive a number of improvements in quality. Examples include:

- Improvement in MRSA rates and C. difficile
- Improvement in the number of cancelled operations
- Improvement in early intervention in sepsis.

All metrics are now presented in a consistent format within the board dashboard using statistical process control methodology.

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